Mr Amar Bharatkumar Patel

Ruddington Dental Practice

Inspection Report

89 Wilford Road
Ruddington
Nottingham
Nottinghamshire
NG11 6BN
Tel: 0115 9848024
Website: www.ruddingtondental.co.uk

Date of inspection visit: 19 January 2016
Date of publication: 10/03/2016

Overall summary

We carried out an announced comprehensive inspection on 19 January 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Ruddington Dental Practice is situated on the ground floor of premises close to the centre of Ruddington, a village on the southern outskirts of Nottingham. The practice was registered with the Care Quality Commission (CQC) in August 2013. The practice provides regulated dental services to patients in the Ruddington and West Bridgeford areas of Nottingham. The practice provides mostly private dental treatment. Services provided include general dentistry, dental hygiene, crowns and bridges, and root canal treatment.

The practice is open: Monday: 9 am to 5:30 pm; Tuesday: 9 am to 6 pm; Wednesday: 9 am to 7 pm; Thursday: 9 am to 5:30 pm; Friday: 9 am to 5 pm. The practice is closed at the weekend. Access for urgent treatment outside of opening hours is by ringing the practice and following the instructions on the answerphone message. NHS patients should ring the 111 telephone number.

The practice has two dentists, one of whom is the principal dentist and owner of the business. There is also one part time dental hygienist, five dental nurses, and one trainee dental nurse. Three of the dental nurses also worked on reception.

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

Summary of findings

Our key findings were:

- The practice had recorded accidents, significant events and complaints, and learning points were identified and shared with staff.
- When necessary apologies were given to patients when things had gone wrong.
- All staff had received whistle blowing training and were aware of these procedures and how to use them. All staff had access to the staff handbook which contained the whistleblowing policy.
- Patients spoke very positively about the dental service they received.
- Patients said they were treated with dignity and respect.
- Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Staff had been trained to deal with medical emergencies.
- There was the necessary equipment to deal with medical emergencies.
- The practice followed the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control.
- Patients' care and treatment was planned and delivered in consultation with the patient and recall intervals are in line with National Institute for Health and Care Excellence (NICE) Patients said they were involved in making decisions about their treatment, and patient care records reflected this.
- Options for treatment were identified and explored and discussed with patients.
- Patients' confidentiality was maintained.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice recorded any accidents and significant events and learning points were shared with staff.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts and took appropriate action including sharing information with staff.

Staff had been trained 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.

The practice had the necessary emergency equipment including an automated external defibrillator (AED) and oxygen.

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

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

Equipment used in the decontamination process was maintained by a specialist company and regular frequent checks were carried out to ensure equipment was working properly and safely.

X-rays were carried out safely in line with published guidance, and X-ray equipment was regularly serviced to make sure it was safe for use.

Are services effective?

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

Patients were clinically assessed by a dental professional before any treatment began. This included completing a health questionnaire or updating one for returning patients. The practice used a recognised assessment process to identify any potential areas of concern in patients' mouths, jaws and neck.

The practice was following National Institute for Health and Care Excellence (NICE) guidelines for the care and treatment of dental patients. Particularly in respect of recalls, wisdom tooth removal and the use of antibiotics.

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

Are services caring?

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

Staff understood the need for confidentiality, and took steps to ensure patients' that confidentiality was maintained. This was at the reception desk, in the treatment room and with regard to record keeping.

Patients were treated with dignity and respect.

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

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

Summary of findings

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

Are services responsive to people's needs?

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

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

The practice had ground floor treatment rooms, so that patients with restricted mobility could access the practice and receive treatment.

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

There were systems for patients to make formal complaints, and these were acted upon, and apologies given when necessary.

Are services well-led?

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

There was a clear management structure. Staff were aware of their roles and responsibilities.

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

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

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

Ruddington Dental Practice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an announced, comprehensive inspection on 19 January 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor. Before the inspection we reviewed information we held about the provider together with information that we asked them to send to us in advance of the inspection. During our inspection visit, we reviewed a range of policies and procedures and other documents including dental care records. We spoke with five members of staff.

Before the inspection we asked the practice to send us information which we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, the details of the staff members, their qualifications and proof of registration with their professional bodies.

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

During the inspection we spoke with two dentists, and three dental nurses, one of whom also worked on reception. We reviewed policies, procedures and other documents. We received feedback from five patients about the dental service

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There were procedures for recording, investigating, responding to and learning from accidents, significant events and complaints. Documentation showed the last recorded accident had occurred in July 2014, this being an injury to a member of staff. The cause had been identified and steps taken to ensure this was not repeated.

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

The practice had recorded one significant event in the last year. The most recent incident related to a security issue which had resulted in a change to practice protocol.

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 principal dentist by e mail and were analysed and information shared with staff if and when relevant. The most recent MHRA alert the practice had been received in 2011.

Reliable safety systems and processes (including safeguarding)

The practice had policies for safeguarding vulnerable adults and children. These policies had been reviewed in November 2015. The policies identified how to respond to any concerns and how to escalate those concerns. Discussions with staff showed that they were aware of the safeguarding policies, knew who to contact and how to refer concerns to agencies outside of the practice when necessary. A flow chart and the relevant contact phone numbers were on display in staff areas of the practice.

The principal dentist was the identified lead for safeguarding in the practice and had received enhanced training in child protection to support them in fulfilling that role. Staff training records showed that all staff at the practice had undertaken training in safeguarding adults and children.

The practice had a policy and procedure to assess risks associated with the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. The policy directed staff to identify and risk assess each substance at the practice. Steps to reduce the risks included the use of personal protective equipment (gloves, aprons and masks) for staff, and the safe and secure storage of hazardous materials. There were data sheets from the manufacturer on file to inform staff what action to take if an accident occurred for example in the event of any spillage or a chemical being accidentally splashed onto the skin. We saw that chemicals were stored securely at the practice.

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

There was a policy for the safe handling of sharp instruments. We saw one dentist was using a safe system for syringes and needles in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, and practice policy. We discussed this with the dentist, who outlined the steps taken to reduce the risks of sharps injuries. We were assured that the practice had considered the risks and taken suitable steps to reduce those risks.

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

Medical emergencies

The dental practice had emergency medicines and oxygen to deal with any medical emergencies that might occur. These were located in a secure central location, and all

Are services safe?

staff members knew where to find them. We checked the medicines and found they were all in date. We saw the practice had a system in place for checking and recording expiry dates of medicines, and replacing when necessary.

The practice had a first aid box, and we saw the contents were being checked regularly.

The practice had an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. Records showed all staff had completed basic life support and resuscitation training in February 2015. Resuscitation Council UK guidelines suggest the minimum equipment required includes an AED and oxygen which should be immediately available. The practice also had portable suction and manual resuscitation equipment (a big valve mask) for use in an emergency.

Discussions with staff identified they understood what action to take in a medical emergency. Staff said they had received training in medical emergencies. We spoke with one member of staff who was able to describe the actions to take in relation to various medical emergencies including a cardiac arrest (heart attack).

Staff recruitment

We looked at the staff recruitment files for six staff members to check that the recruitment procedures had been followed. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all staff personnel files. This includes: proof of identity; checking the prospective staff members' skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed). DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

We found that all members of staff had received a DBS check, and in the records we sampled all had been completed within the last five years. We discussed the records that should be held in the personnel files with the principal dentist, and saw the practice recruitment policy and the regulations had been followed.

Monitoring health & safety and responding to risks

The practice had both a health and safety policy and environmental risk assessments, which had been reviewed and updated in November 2015. Risks to staff and patients had been identified and assessed, and the practice had measures in place to reduce those risks. For example, the practice had trained staff in manual handling, and had undertaken a fire risk assessment to identify and minimise the risks.

Records showed that fire detection and fire fighting equipment such as fire alarms and emergency lighting were regularly tested. The fire risk assessment had been updated in November 2015. The fire extinguishers were also last serviced in November 2015.

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

Staff training records identified that staff had received up-to-date training in health and safety matters, including fire safety training.

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 described how cleaning should be completed at the premises including the treatment rooms and the general areas of the practice. Dental nurses had set responsibilities for cleaning and infection control in each individual treatment room. The practice had systems for testing and auditing the infection control procedures. Records showed all staff had received training in infection control.

Records showed that an infection control audit had been completed, an action plan produced, and action taken. We saw that six monthly infection control audits were being completed as recommended in HTM 01-05

Are services safe?

The practice had a sharps policy which had been reviewed in May 2015. There were sharps bins (secure bins for the disposal of needles, blades or any other instrument that posed a risk of injury through cutting or pricking.) We saw the bins in the decontamination room and treatment rooms were located off the floor. The guidance says sharps bins should not be located on the floor, and should be out of reach of small children. The Health and Safety Executive (HSE) guidance: 'Health and safety (sharp instruments in healthcare) regulations 2013', was being followed.

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

The practice had a dedicated decontamination room that had been organised in line with HTM 01-05. The decontamination room had been organised with a dirty and clean areas, and there was a clear flow in between to reduce the risk of cross contamination and infection. In addition there was an area in the clean side for bagging clean and sterilised dental instruments and date stamping them. Staff wore personal protective equipment during the process to protect themselves from injury. These included gloves, aprons and protective eye wear.

We found that instruments were being cleaned and sterilised in line with the published guidance (HTM 01-05). A dental nurse demonstrated the decontamination process, and we saw the procedures used followed the practice policy.

The practice had a washer disinfector (a machine for cleaning dental instruments similar to a domestic dish washer). After the washer disinfector instruments were rinsed and examined using an illuminated magnifying glass. Finally the instruments were sterilised in the practice's autoclave (a device for sterilising dental and medical instruments). The practice had one vacuum autoclave. This was designed to sterilise hollow and wrapped dental instruments. At the completion of the sterilising process, instruments were dried, packaged, sealed, stored and dated with an expiry date.

We checked the equipment used for cleaning and sterilising was maintained and serviced regularly in accordance with the manufacturers' instructions. There were daily, weekly and monthly records to demonstrate the decontamination processes to ensure that equipment was functioning correctly. Records showed that the equipment was in good working order and being effectively maintained.

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

Staff files showed that staff had received inoculations against Hepatitis B and received regular blood tests to check the effectiveness of that inoculation. Health professionals who are likely to come into contact with blood products, or are at increased risk of sharps injuries should receive these vaccinations to minimise the risk of contracting blood borne infections. A sharps injury is a puncture wound similar to one received by pricking with a needle.

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

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

Equipment and medicines

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

Are services safe?

Medicines used at the practice were stored securely and disposed of in line with published guidance. There were sufficient stocks available for use.

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

Prescription pads at the practice were available and managed effectively. Numbered prescription pads were allocated to each dentist, and the prescription pads were stored securely when not in use.

Radiography (X-rays)

The dental practice had two intraoral X-ray machines (intraoral X-rays concentrate on one tooth or area of the mouth). X-ray equipment was located in each treatment room. X-rays were carried out in line with local rules that were relevant to the practice and specific equipment. The local rules for the use of each X-ray machine were available in each area where X-rays were carried out.

The local rules identified the practice had radiation protection supervisors (RPS) this was the principal dentist, and a radiation protection advisor (RPA). This was a company specialising in servicing and maintaining X-ray equipment. The Ionising Radiation Regulations 1999 (IRR 99) requires that an RPA and an RPS be appointed and identified in the local rules. Their role is to ensure the equipment is operated safely and by qualified staff only.

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

Records showed the X-ray equipment had last been serviced in February 2014. The Ionising Radiation Regulations 1999 (IRR 99) require that X-ray equipment is serviced at least once every three years.

We discussed the use of radiographs (X-rays) with a dentist to confirm the practice was monitoring the quality of the radiograph images and that there were records to demonstrate this. The practice was not using conventional radiograph images, but was considering swopping to digital radiographs which rely on lower doses of radiation, and do not require the chemicals to develop the images required with conventional radiographs.

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

All patients were required to complete medical history forms and the dentist considered each patient's individual circumstances to ensure it was safe for them to receive X-rays. This included identifying where patients might be pregnant. Patients' dental care records showed that information related to X-rays was recorded in line with current guidance from the Faculty of General Dental Practice (UK) (FGDP-UK). This included quality grading of the X-ray, views taken, justification for taking the X-ray and the clinical findings. Discussions with the principal dentist identified that grading of the radiographs occurred every time an X-ray was taken, to judge if the equipment was working correctly. We saw examples of this in practice.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept dental care records for each patient. We reviewed the care records for eight patients during the inspection. These records included all information about the assessment, diagnosis, treatment and advice given to patients by dental healthcare professionals. The care records showed a thorough examination had been completed, and included examination of the jaw and neck.

The practice used two forms to record patients' medical histories, an initial assessment form and an update form to record any changes. The initial patients' medical histories form included any health conditions, medicines being taken and whether the patient had any allergies. These were taken for every patient attending the practice for treatment. For returning patients the medical history focussed on any changes to their medical status.

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

We saw that dentists used nationally recognised guidelines on which to base treatments and develop longer term plans for managing patients' oral health. Discussions with dentists showed they were aware of NICE guidelines, particularly in respect of recalls of patients, antibiotic prescribing and wisdom tooth removal. We asked the dentists to show us a sample of dental care records which reflected that they were following NICE guidelines in their treatment of patients.

Health promotion & prevention

There was literature in the waiting room and reception area about the services offered at the practice. There was also information about how to improve patients' oral health; much of this was aimed at children. For example: Avoiding tooth decay and acid erosion. For adults there was information about the risks associated with smoking, and information about helplines and support with stopping smoking.

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

Discussions with the principal dentist identified that the practice was in a low risk area for child tooth decay. As a result the practice did not routinely provide fluoride application varnish to all children. A risk based approach was taken instead, and each child was risk assessed and treated accordingly.

Staffing

The practice had two dentists, one part time dental hygienist, five dental nurses, and one trainee dental nurse. Before the inspection we checked the registrations of all dental care professionals with the General Dental Council (GDC) register. We found all staff were up to date with their professional registration with the GDC.

We reviewed staff training records and saw staff were maintaining their continuing professional development (CPD). CPD is a compulsory requirement of registration with the General Dental Council (GDC). The training records showed how many hours training staff had undertaken together with training certificates for courses attended. This was to ensure staff remained up-to-date and continued to develop their dental skills and knowledge. Examples of training completed included: safeguarding, infection control and manual handling.

The practice appraised the performance of its staff with annual appraisals. We saw evidence in three staff files that appraisals had been taking place. We also saw evidence of new members of staff having an induction programme. We spoke with two members of staff who said they had received an annual appraisal with the principal dentist.

Working with other services

The practice made referrals to other dental professionals when it was clinically indicated that a referral should be made. For example referral for treatment at the dental hospital if there was suspected cancer or the patient required advanced oral surgery. Records within the practice identified that for suspected oral cancer referrals had been made within the two week window for urgent referrals. The practice kept a record of other practices and services who accepted referrals, and the reason why that referral would

Are services effective?

(for example, treatment is effective)

be made. The practice also kept a log of referrals that had been made, and used this to monitor that patients had been seen in a timely manner, and the necessary documentation had been sent.

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

Consent to care and treatment

The practice had a consent policy which had been reviewed in November 2015. The policy made reference to the Mental Capacity Act 2005 (MCA) and best interest decisions. The MCA provided a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make particular decisions for themselves. Discussions with two members of staff identified their awareness and understanding of the MCA.

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

Discussions with the principal dentist showed they were aware of and understood the use of Gillick competency to assess and record competency for young persons. Gillick competence is used to decide whether a child (16 years or younger) is able to consent to their own medical or dental treatment without the need for parental permission or knowledge.

The principal dentist gave an example of a patient who had lost their capacity to consent. After seeing the patient and talking with them it became clear they were not able to understand the implications of the proposed treatment plan. A referral to secondary care (the community dental service) was made, as they were more experienced to meet this patient's needs.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

During the inspection we observed staff speaking with patients. We saw that staff were friendly and polite, and took time and trouble to put patients at ease. Our observations showed that patients were treated with dignity and respect.

The reception desk was located in the waiting room and was open plan. We discussed the need for confidentiality with reception staff who told us that the practice took positive steps with regard to confidentiality. Treatment was discussed with patients in the privacy of the treatment room. There was a radio playing in the waiting room to help mask conversations at the reception desk. As a result the practice had a Performing Rights Licence (PPL). Staff said that if a confidential or sensitive conversation was needed; either the office or an unused treatment room was available for privacy.

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

We received feedback from five patients, this was both in the practice and through Care Quality Commission (CQC) comment cards we had left at the practice prior to our inspection. Comments from patients were positive, with two patients making specific reference to being treated with dignity and respect.

Involvement in decisions about care and treatment

We received feedback from five patients on the day of the inspection. Patients said the dentists involved them in decisions about their care and treatment. Two patients when asked said that dentists explained things clearly and gave the opportunity to ask questions.

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

We spoke with dentists, and a dental nurse who said that each patient had their dental treatment and diagnosis discussed with them. Treatment options and costs were explained before treatment started, and patients were given a written treatment plan including costs. Where necessary information about preventing dental disease was given to improve patients' oral health. This included discussions about smoking and diet, and the effects of carbonated drinks on the patient's teeth, gums and mouth. The dental care records were updated with the proposed treatment after discussing the options. Patients were monitored through follow-up appointments in line with National Institute for Health and Care Excellence (NICE) guidelines.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We spoke with two patients during the inspection. Both patients said that getting an appointment was not difficult. Both patients had been able to make appointments that were convenient for them, and in a timely manner. When patients were in pain or where treatment was urgent the practice made efforts to see the patient the same day. One patient said they had previously lost a filling, on ringing the practice they were offered an appointment that day, and received the necessary treatment.

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

New patients were asked to complete a medical and dental health questionnaire. This allowed the practice to gather important information about the patient's previous and current dental and medical history. For returning patients the medical history was updated so the dentists had the best available information available to them to meet patients' needs safely. The practice used two different forms, one for collecting information from new patients, and one for updating the patients' medical history details.

The treatment rooms were spacious and well equipped. We saw there was a good supply of dental instruments, and there were sufficient instruments to meet the needs of the practice.

Tackling inequity and promoting equality

The practice was situated in a single story building close to centre of Ruddington village. The ground floor location allowed patients who may have difficulty accessing services due to mobility or physical issues to be seen. The practice had an equality and diversity policy to direct staff in meeting needs and promoting equality. Training records showed that staff had completed equality and diversity training on the 4 August 2015.

The practice had good access to all forms of public transport with a bus stop located directly outside the practice. There was a disabled parking space by the front door, and free patient parking in a small car park to the side of the practice.

Reception staff said the practice had a hearing loop, however discussions showed the staff were not sure how to use the hearing loop, or if it was in working order. The Equity Act (2010) requires where 'reasonably possible' hearing loops to be installed in public spaces. The principal dentist said they would look into the situation with regard to the hearing loop.

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

The practice had access to a recognised company to provide interpreters, and this included the use of sign language. Staff said that there were very few patients who could not speak English, and if language was a potential barrier the patient usually brought someone to interpret therefore avoiding the need for interpreters.

Access to the service

The practice website identified the practice was open: Mondays 9 am to 5:30 pm; Tuesdays 9 am to 6 pm; Wednesdays 9 am to 7 pm; Thursdays 9 am to 5:30 pm and Fridays 9 am to 5 pm. The practice was closed for lunch between 1:00 pm and 2:00 pm.

Access for urgent treatment outside of opening hours was by ringing the practice and following the answerphone message or for NHS patients by calling 111 the NHS out-of-hours service. This information was available in the practice and in the practice leaflet and on the practice website.

The practice operated a text message service to remind patients they had an appointment. This service had been set up following feedback from patients who had requested the service.

Concerns & complaints

The practice had a complaints procedure for patients who wanted to make a complaint. This procedure had been reviewed in December 2015. The procedure explained the process to follow, and included other agencies to contact if the complaint was not resolved to the patients satisfaction. This included the Parliamentary and Health Service Ombudsman and the Dental Complaints Service.

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

Are services responsive to people's needs?

(for example, to feedback?)

From information received before the inspection we saw that there had been two formal complaints received in the past 12 months. Records within the practice showed that complaints had been handled in a timely manner, and there was evidence of investigation into the complaints with the outcomes recorded. The records also showed that apologies had been given when necessary.

Are services well-led?

Our findings

Governance arrangements

There was a clear management structure at the practice. Staff said they understood whom they could speak with if they had any concerns, and understood the management structure. Three staff members said there was good communication within the staff team, and observations during the day, identified positive working relationships.

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

Leadership, openness and transparency

The practice was holding full staff meetings approximately three times a year. However, staff said that there were informal discussions about work related issues on a daily basis. Dental nurses working on reception said that being a small practice team allowed everyone to meet regularly and discuss issues. The minutes of the last full staff meeting were dated 23 December 2015. Full staff meetings were minuted, and those minutes were available to all staff. We saw minutes identified issues such as health and safety, updates to practice policy and staff training.

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

Staff said the practice was a friendly place to work with a good team spirit. Staff told us that they could speak with either dentist if they had any concerns. Staff members said they felt part of a team, were well supported and knew what their role and responsibilities were.

The practice had a whistleblowing policy which was had been reviewed in November 2015. This policy identified how staff could raise any concerns they had about colleagues' conduct or clinical practice. This was both internally and with external agencies. We discussed the whistleblowing policy with one member of staff. They were aware of the policy, and knew the circumstances when it could or would be used. The whistleblowing policy was part of the staff hand book, given to every member of staff, or a copy was available in the office.

Learning and improvement

Discussions with several staff showed they were aware of the practice values, such as promoting good oral health for patients, and providing a patient centred approach to care. Staff showed awareness of national guidelines, as these were discussed at staff meetings. Staff were able to demonstrate that they worked towards the practice values.

The principal dentist had developed a detailed schedule for audits throughout the year. This was for both clinical and non-clinical areas of the practice. The information within the audits identified both areas for improvement, and confirmed that quality was being achieved particularly in respect of clinical areas such as the taking of radiographs (X-rays). The practice was able to demonstrate where improvements had taken place following audits. For example; patient record cards and referrals for both dentists had been audited in August 2015; the recording of medical histories had also been audited in August 2015 and the quality and justification for radiographs had been audited in November 2015.

Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. Training records at the practice showed that training opportunities were available to all staff, and this was encouraged by the management team. Staff said they had good access to training, a mixture of in-house and external training.

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

The practice had a feedback form and box in the waiting room to collect the views of patients. The results were analysed on a regular basis, and results over the period 2014 to 2015 showed 16 patients had provided feedback, which was all positive.

The practice also had the facility on its website for patients to leave messages and provide further feedback, although staff said that so far no patients had used this.