Miss Kehinde O. A. Gbolade

Hathersage Dental Surgery

Inspection Report

Unit 4B
Heather Lane,
Hathersage,
Hope Valley,
Derbyshire
S32 1DP
Tel: 01433 650044
Website: www.hathersagedental.co.uk

Date of inspection visit: To Be Confirmed
Date of publication: 10/12/2015

Overall summary

We carried out an announced comprehensive inspection on 15 September 2015 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

Hathersage Dental Surgery was registered with the Care Quality Commission (CQC) in June 2013. The practice provides regulated dental services to patients in Hathersage and the surrounding areas. The practice provides mostly (approximately 99%) NHS dental treatment. Services provided include general dentistry, dental hygiene, teeth whitening, crowns and bridges, and root canal treatment. The practice also offers laser dentistry using a Biolase Waterlase laser.

The practice is a small single handed dental practice, with three dental nurses/ receptionists.

The practice is open: Monday: from 8:00 am to 5:00 pm; Tuesday: from 8:30 am to 5:30 pm; Wednesday: from 8:00 am to 5:00 pm; Thursday: from 9:00 to 6:00 pm and Friday: from 9:00 am to 5:00 pm. Access for urgent treatment outside of opening hours is through a dedicated telephone number for the emergency dental service at Scarsdale Hospital in Chesterfield. This information is available on both the practice leaflet and website.

We received feedback from eight patients, about the services provided. We saw that all eight provided positive comments. Patients said they were happy with the service provided. Patients also provided positive

Summary of findings

feedback about the dentist, the treatment and the whole staff team. Patients said they were able to ask questions, and the dentist explained the treatment options and costs.

Our key findings were:

- The practice had a system for recording accidents, significant events and complaints.
- There were systems and processes for staff to learn from any complaints and significant incidents.
- All staff had received whistle blowing training and were aware of these procedures and the actions required.
- Feedback from patients was very positive.
- Patients said they were happy with, and satisfied with the dental service they received.
- Patients said they were treated with dignity and respect, and our observations supported this.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Staff had been trained to deal with medical emergencies.
- Emergency medicines, an automated external defibrillator (AED) and oxygen were readily available. 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.
- Regular audits were not being completed at the practice to identify improvements required.
- The practice mostly followed the relevant guidance (Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control. However, we were not assured that six monthly audits were being completed as outlined in the guidance.
- Patients' care and treatment was planned and delivered in line with National Institute for Health and Care Excellence (NICE) guidelines.
- Patients were involved in making decisions about their treatment
- Options for treatment were identified and explored and discussed with patients.
- Patients' confidentiality was maintained.

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

- Review the access arrangements for patients with restricted mobility under the Equality Act 2010.
- Consider the arrangements for regular update and review of the practice policies, procedures and risk assessments.
- Record the temperature of any refrigerator used to store temperature sensitive medicines, and review the use so that medicines and foodstuffs were not stored in the same refrigerator.
- Review the systems and processes in place to assess, monitor and improve the quality and safety of the service. This should include regular audits of the service provided.

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 had systems for recording accidents and significant events. Learning points were shared with the staff team.

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

All staff had been trained in safeguarding vulnerable adults and children. There were clear guidelines for reporting concerns and the practice had 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 new members of staff. This was to ensure staff were suitable and appropriately qualified and experienced to carry out their role. New members of staff were given an induction programme to follow.

Infection control procedures mostly followed published guidance to ensure that patients were protected from potential risks.

Equipment used in the decontamination process was maintained by a reputable 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 before any treatment began. This included completing a health questionnaire or updating one for returning patients who had previously completed a health questionnaire.

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.

The practice provided information about risks, and ways of promoting better oral health.

When relevant the dentist discussed the use of alcohol and tobacco to help improve patients' oral health.

The practice had sufficient numbers of qualified and experienced staff to meet patients' needs.

There were clear procedures for referring patients to secondary care (hospital or other dental professionals).

Patients aged under 18 years were routinely offered a fluoride varnish.

Staff were aware of the need for valid consent, and patient care records reflected this.

Are services caring?

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

Summary of findings

Patients were treated with courtesy, dignity and respect.

Staff were open and welcoming to patients at the dental practice.

Patients' confidentiality was maintained.

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 about their dental treatment.

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 was accessible to patients and met their needs. Patients who were in pain or in need of urgent treatment were usually seen the same day.

The practice had taken steps to meet the needs of patients with restricted mobility, with the provision of a chair lift. However, a full Equality Act 2010 access audit had not been completed.

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

Are services well-led?

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

The practice was not always 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 make comments.

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

Hathersage Dental Surgery

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 8 September 2015. The inspection team consisted of one 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 seven members of staff, including members of the management team.

We informed the NHS England area team and local Healthwatch that we were inspecting the practice; we did not receive any information of concern from NHS England, and Healthwatch informed us they had received one positive comment about the practice.

Prior to 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 one dentist and two dental nurses. We reviewed policies, procedures and other documents. Eight patients provided feedback 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 had procedures for investigating, responding to and learning from accidents, significant events and complaints. During the last 12 months there had been four recorded accidents. These were all minor injuries to staff with the last one occurring in February 2015. Documentation showed that each accident had been analysed and steps put in place to reduce the risk of them occurring again.

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 practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts. These were sent out centrally by a government agency (MHRA) and informed health care establishments of any problems with medicines or healthcare equipment. The principal dentist received the alerts by e mail and shared them with other members of staff.

Reliable safety systems and processes (including safeguarding)

The practice had a safeguarding vulnerable adults and children policy. The policies were dated 2 January 2014 and 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 principal dentist was the identified lead for safeguarding in the practice who 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 having completed the training in June 2014. There had been no recorded safeguarding incidents at the practice on file.

The practice had a policy to assess the 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. The practice had 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. However, we found there was not an up to date audit of COSHH materials to ensure the risk assessment was current and complete.

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 1June 2016. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

Guidelines from the British Endodontic Society say that dentists should be using rubber dams when completing root canal treatments. A rubber dam is a thin rubber sheet that isolates selected teeth and protects the rest of the patient's mouth during treatment. However, discussions with the dentist and examination of patients' record cards identified the dentist did not always use a rubber dam when completing root canal treatments. This was because of patient choice, or there was not enough tooth structure to engage the rubber dam. Where a rubber dam was not used the dentist isolated the tooth with cotton wool rolls. The dentist also made sure the dental nurse had the aspirator in the patient's mouth throughout the procedure. This was to protect the patient's airway and to aspirate any debris.

Medical emergencies

The dental practice had emergency medicines and oxygen to deal with any medical emergencies that might occur. These were located in a central location, and all staff members knew where to find them. The medicines were as recommended by the 'British National Formulary' (BNF). We checked the medicines and found them all to be 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 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 2014. We saw evidence that refresher training had been booked for October 2015 for all staff.

Resuscitation Council UK guidelines suggest the minimum equipment required includes an AED and oxygen which should be immediately available.

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

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

There were sufficient numbers of suitably qualified and skilled staff working at the practice to meet the needs of the patients.

Monitoring health & safety and responding to risks

The practice had a health and safety policy which was dated 18 December 2013. Risks to staff and patients had been identified and assessed, and the practice had introduced measures to reduce those risks. For example: there was a legionella risk assessment, and weekly tests of the fire alarm were being completed.

The practice had other specific policies and procedures to manage other identified risks. For example: A waste management contract and policy for handling clinical waste; fire safety policies and procedures and COSHH procedures. Records showed the fire extinguishers had last been serviced in October 2014.

The practice had a health and safety law poster on display in the decontamination 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.

Staff training records identified that staff had received up-to-date training in health and safety matters, including fire training which took place on 22 March 2015.

Infection control

Infection control within 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.' 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. Following HTM 01-05 would comply with best practice.

The practice had an infection control policy which had been updated in April 2013. The policy 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 staff had completed training in infection control.

An infection control audit had been completed, however this was not dated, so we were unable to assess if this was a current infection control audit, or if audits were being completed on a six monthly basis in line with the published guidance (HTM 01-05)

The practice used sharps bins (secure bins for the disposal of needles, blades or any other instrument that posed a risk of injury through cutting or pricking.) The bins were located out of reach of small children. The health and safety executive (HSE) had issued guidance: 'Health and safety (sharp instruments in healthcare) regulations 2013', and the practice were following the guidance.

Are services safe?

We saw the dentist used disposable safe sharps syringes and needle blocks for removing needles from syringes in accordance with the sharps regulations 2013. Only the dentist handled contaminated sharps as a practice policy. This lowered the risks and avoided two handed re-sheathing of needles.

The practice had a clinical waste contract, and waste matter was collected on a regular monthly basis. Clinical waste was stored while awaiting collection. We identified the bin used to store contaminated waste outside the practice was not secure. The provider sent us photographic evidence after the inspection that this issue had been addressed. The clinical waste contract also covered the collection of amalgam (dental fillings) which contained mercury and was therefore considered a hazardous material. The practice had spillage kits for both mercury and bodily fluids.

The practice had a room in which there was a decontamination area that had been organised in line with HTM 01-05. The decontamination area had defined dirty and clean areas to reduce the risk of cross contamination and infection. In addition there was an area for bagging clean and sterilised dental instruments and date stamping them. There was a clear flow of instruments through the dirty to the clean area. 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). The practice had a washer disinfector (a machine for cleaning dental instruments similar to a domestic dish washer). A dental nurse demonstrated the decontamination process, and we saw the procedures used followed the practice policy. Guidance and instructions were on display within the decontamination room for staff reference. The instruments were cleaned rinsed and examined using an illuminated magnifying glass. Finally the instruments were sterilised in an autoclave (a device for sterilising dental and medical instruments).

The practice had one steam autoclave. This was designed to sterilise non wrapped or solid 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 manufacturer's instructions. There were daily, weekly and monthly records to demonstrate the decontamination processes to ensure that equipment was functioning correctly. The provider sent us copies of records after the inspection showing the autoclaves had been serviced to demonstrate the equipment was in good working order and being effectively maintained.

Staff files showed that staff had received inoculations against Hepatitis B and received regular blood tests to check the effectiveness of that inoculation. People (staff) who are likely to come into contact with blood products, or are at increased risk of needle stick injuries should receive these vaccinations to minimise the risk of contracting blood borne infections. A needle stick injury is a puncture wound similar to one received by pricking with a needle. The practice had a needle stick injury policy on display; this was dated 27 June 2013.

The practice had a policy for assessing the risks of Legionella. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. This was to ensure the risks of Legionella bacteria developing in water systems had been identified and measures taken to reduce the risk of patients and staff developing Legionnaires' disease. Records showed that the practice was had completed a risk assessment on 14 September 2015. This identified that the practice was a low risk of developing legionella.

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 with the last testing recorded in April 2014. 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.

Medicines used at the practice were stored and disposed of in line with published guidance. Medicines were stored securely and there were sufficient stocks available for use. Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities. However, the refrigerator was being used to store both

temperature sensitive medicines and non-clinical items. We also saw the temperature of the refrigerator was not being recorded. Following discussion the provider said that temperatures would be taken and recorded going forward. Following the inspection the provider sent photographic evidence to show this was happening.

Emergency medicines and oxygen were available, and located centrally and securely ready for use if needed.

Radiography (X-rays)

The dental practice had one intraoral X-ray machine (intraoral X-rays concentrate on one tooth or area of the mouth). X-ray equipment was located in the 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 practice had a radiation protection file which contained documentation to demonstrate the X-ray equipment had been maintained at the intervals recommended by the manufacturer.

The local rules identified the practice had a radiation protection supervisor (RPS) (the provider) and a radiation protection advisor (RPA) (a company specialising in servicing and maintaining X-ray equipment). The Ionising Radiation Regulations 1999 (IRR 99) required that an RPA and an RPS be appointed and identified in the local rules. Their role was to ensure the equipment was operated safely and by qualified staff only. Staff members authorised to carry out X-ray procedures were clearly identified. The measures in place protected people who required X-rays to be taken as part of their treatment.

Emergency cut-off switches for the X-ray machines were located away from the machines and were clearly labelled.

We discussed the use of X-rays with the dentist. This identified the practice monitored the quality of its X-ray images and had records to demonstrate this. The practice was using digital X-ray images. Digital X-rays rely on lower doses of radiation, and did not require the potentially hazardous chemicals to develop the images required with conventional X-rays. 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' notes showed that information related to X-rays was recorded in line with current guidance from the Faculty of General Dental Practice (UK) (FGDP-UK). This included grading of the X-ray, views taken, justification for taking the X-ray and the clinical findings.

Documentation at the practice showed that radiography (X-rays) had been audited to gain an insight into the safety of the X-ray equipment and that the procedures for the use of the X-ray machines had been followed correctly.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Information about the assessment, diagnosis and treatment of patients plus any advice given by dental professionals was recorded in individual patient notes. We reviewed the dental care records for four patients, we found that an up to date medical history had been taken on each occasion.

Patients' medical histories including any health conditions, current medicines being taken and whether the patient had any allergies were taken for every patient attending the practice for treatment. If the dentist wanted to take an X-ray and the patient was of child bearing age, the possibility of being pregnant was also discussed. For returning patients the medical history focussed on any changes to their medical status.

Records showed comprehensive assessment of the periodontal tissues (the gums and soft tissues of the mouth) had been undertaken. These had been recorded using 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 the dentist used nationally recognised guidelines on which to base treatments and develop longer term plans for managing patients' oral health. Records showed that treatments had been relevant to the symptoms or findings, treatment options were explained and that adequate follow up had been arranged.

We spoke with the dentist, 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. Feedback from patients identified that patients were involved in discussions about treatment options. This included treatment options and explanations given. Where relevant, information about preventing dental decay was given to improve the outcome for the patient. The patient notes 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.

Discussions with the dentist showed they were aware of NICE guidelines, particularly in respect of recalls of patients, anti-biotic prescribing and wisdom tooth removal. A review of the records identified that the dentist followed NICE guidelines in their treatment of patients.

We received feedback from eight patients who said they were happy with the care and treatment they received. Feedback indicated that dental staff were pleasant, and took their time to explain treatments and reassure patients.

Health promotion & prevention

We saw a range of literature in the waiting room area about the services offered at the practice. There were also leaflets about ways to improve patients' overall oral health. These included posters and leaflets about a 'smile makeover', root canal treatment and gum disease.

We saw examples in patients' notes that advice on smoking cessation had been discussed. With regard to smoking the dentist had highlighted the risk of periodontal disease and oral cancer.

Public Health England had produced an updated document in 2014: 'Delivering better oral health: an evidence based toolkit for prevention'. Following the guidance within this document would be evidence of up to date thinking in relation to oral healthcare. Discussions with the dentist and dental nurses showed they were aware of the Department of Health 'Delivering better oral health' document and used it in their practice.

We saw evidence the practice provided fluoride varnish for children. The dentist said the practice takes this very seriously, and all patients under the age of 18 were assessed and offered a fluoride varnish.

Staffing

The practice had one dentist and three dental nurses/ receptionists. Prior to 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

Are services effective?

(for example, treatment is effective)

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 basic life support, which took place on 5 February 2014. This had been booked for the annual update on 26 October 2015. Safeguarding children training which had been completed on 12 June 2014.

The practice appraised the performance of its staff with annual appraisals. We saw evidence in two staff personal files that appraisals had taken place. We also saw evidence of new members of staff having an induction programme.

Staff said there was a good albeit small team, and there was good support from the dentist.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment. For example referral for treatment at the dental hospital if the problem required more specialist attention. This would usually be the dental hospital in Sheffield. Following treatment by the 'other' dental professional(s) the practice monitored patients to ensure they had received satisfactory treatment and had the necessary after care after treatment at the practice.

The practice did not provide a conscious sedation service, and patients who required this service usually because they were very nervous or had a phobia about coming to the dentist were referred to other practices that provided that service.

Consent to care and treatment

We saw evidence that patients were given treatment options and consent forms which they signed to signify their consent with the agreed treatment. For NHS patients this was through the standard FP17 DC form. This being the form all NHS patients' sign, being both the 'personal dental treatment plan' and the consent to treatment form.

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

The practice's consent policy had a description of competence or capacity and how this affected consent. The policy linked this to the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

During the inspection we observed how staff spoke with patients and whether they treated patients with dignity and respect. Our observations were that patients were treated in a polite courteous manner. Feedback from patients identified the staff treated patients with dignity and respect.

Reception staff told us that they were aware of the need for confidentiality when conversations were held in the reception area, particularly when other patients were present. Therefore all confidential discussions with patients were conducted in the treatment room with the dentist.

We observed a number of patients being spoken with by staff and found that confidentiality was being maintained. We saw that patient records, both paper and electronic were held securely either under lock and key or password protected on the computer.

Involvement in decisions about care and treatment

Patients we spoke with on the day of the inspection spoke positively about the dental practice. They said all of the staff treated them with kindness and the dentist let them ask questions and explained treatment options. This included any particular treatment being clearly explained including the cost. Patients also said they felt involved in the decisions taken, and were able to ask questions and discuss with the dentists the treatment options.

The practice website clearly described the range of services offered to patients. The practice offered both private and NHS treatments and both sets of costs were clearly displayed in the practice and on the website.

Dental care records we reviewed demonstrated that staff recorded the information they had provided to patients about their treatment and the options open to them. Patients we spoke with said that dental staff always explained things clearly, and in a way that they could understand. Patients received a written treatment plan which clearly outlined their treatment and the cost involved.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

There was an appointment system which patients said met their needs. When patients were in pain or where treatment was urgent the practice made efforts to see the patient the same day. Feedback from patients about the appointment system was positive, with three patients making positive remarks about getting an appointment.

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 could respond to any changes in health status.

Tackling inequity and promoting equality

The practice was located on the first floor, and the limitations presented by the building made access for people with restricted mobility problematic. There was a chair lift available, and this gave access to the dental practice via the opticians next door. The principal dentist said that there had been discussions with the fire department and builders regarding improving the disabled access to the practice. However, the layout and design of the building was a problem.

The practice had good access to all forms of public transport. Car parking was available in a car park outside the practice. The railway station was a short two minute walk from the practice.

Access to the service

The practice was open on:

Monday from 8:00 am to 5:00 pm; Tuesday from 8:30 am to 5:30 pm; Wednesday from 8:00 am to 5:00 pm; Thursday from 9:00 am to 6:00 pm and Friday from 9:00 am to 5:00 pm

The arrangements for emergency dental treatment outside of normal working hours, including weekends and public holidays were displayed in the waiting room area and in the practice leaflet, and on the practice website. Access for urgent treatment outside of opening hours was through a dedicated telephone number for the emergency dental service at Scarsdale Hospital in Chesterfield.

The practice was located on the first floor of a building close to the train station. There was parking directly outside. Access to the practice for patients with restricted mobility was via a chair lift, and through the opticians next door.

The practice had restricted access for patients with mobility issues, and an Equality Act 2010 access audit had not been completed.

Concerns & complaints

The practice had a complaints procedure that explained the process to follow when making a complaint. This included contacting the practice in the first instance; contacting NHS England (contact details supplied) if the issue remained unresolved; or contacting the Parliamentary and Health Service Ombudsman (contact details supplied) if the issue remained unresolved.

This information was available in the practice and in the practice leaflet, and within the dental practice. Staff said they were aware of the procedure to follow if they received a complaint.

From information received prior to the inspection we saw that there had been two formal complaints received in the past 12 months. Records within the practice showed that the complaints had been handled in a timely manner, and evidence of investigation into the complaints and the outcomes were recorded.

Are services well-led?

Our findings

Governance arrangements

We saw that a several policies had not been reviewed for lengthy periods of time, in some cases years. This included the infection control policy and the health and safety policy. In addition several audits were overdue. For example: the Control of Substances Hazardous to Health (COSHH) audit, the radiography (X-ray) audit, and we could not have confidence in the infection control audit as it was not dated.

Staff said that with a small team the staff met regularly and discussed issues and procedure within the practice. These meetings were not always minuted, although there were minutes of formal staff meetings available.

The practice reviewed feedback from patients, particularly through the Friends and Family test, the results of which were analysed. The provider had responsibility for the day to day running of the practice and was fully supported by the practice team. There were clear lines of responsibility and accountability; staff knew who to report to if they had any issues or concerns.

Leadership, openness and transparency

The practice team was very small, with only four members. As a result we saw that communication between team members was direct. Lines of accountability and the leadership of the practice were clear.

Staff said there was an open and transparent culture at the practice. Staff said they were able to raise issues or concerns at any time with the dentist without fear of discrimination. All staff we spoke with said the practice was a relaxed and friendly place to work. Feedback from patients echoed this view with several commenting on the relaxed and friendly atmosphere. Staff members said they felt part of a team, were well supported and knew what their role and responsibilities were.

Staff were aware of how to raise concerns about their place of work under whistle blowing legislation. We saw that the practice had a whistle blowing policy, and all staff had access to the policy.

Learning and improvement

In their statement of purpose the practice described its aim to be: Provision and maintenance of excellent oral health in a well-managed, caring, safe and clean environment for users of my services. My aim is help people live life with dental function, free of active dental decay and oral disease.

We found staff were aware of the practice values and were able to discuss these when asked. There was a clear focus on patient care throughout the dental team.

Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. Documentation at the practice showed that training opportunities were available to all staff.

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

Staff said that patients could provide feedback at any time they visited. We saw that there was an e mail address to provide feedback via the website. However, staff said patients had not used this feature.

The practice also had the NHS Friends & Family box in the waiting room. There had been nine responses in the last month. Analysis of the friends & family information showed positive comments.

The patients we spoke with said they were aware of the comment box in the waiting room. However, they had never provided any formal feedback.