Trinity Terrace Dental Practice Partnership

IDH Derby

Inspection Report

113 London Road
Derby
Derbyshire
DE1 2QS
Tel: 01332 344810
Website:

Date of inspection visit: 4 February 2016
Date of publication: 22/03/2016

Overall summary

We carried out an announced comprehensive inspection on 4 February 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

Mydentist in Derby is situated over three floors of a building located just of the inner ring road in central Derby. The practice is part of a larger organisation with a corporate dental provider. The practice was registered with the Care Quality Commission (CQC) in January 2014. The practice provides regulated dental services to patients from a wide area of Derbyshire. This was because the practice's location close to the centre of Derby and near the ring road made it relatively easy for patients to attend who were not from the immediate area. The practice provides mostly NHS dental treatment. Services provided include general dentistry, dental hygiene, crowns and bridges, and root canal treatment.

The practice is open: Monday to Thursday: 8:45 am to 5:30 pm, and Friday: 8:45 am to 5 pm. Access for urgent treatment outside of opening hours is by telephoning the practice and following the instructions on the answerphone message. Alternatively patients should ring the 111 telephone number.

The practice has six dentists, one orthodontist, two dental hygienists, seven dental nurses, three of whom also worked on reception, one receptionist, two trainee dental nurses and one practice manager.

We received positive feedback from 37 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.

Summary of findings

Our key findings were:

- There were systems in place to record accidents, significant events and complaints. There was a system to identify any learning points from them and these were shared with staff.
- The records showed that apologies had been given for any concerns or upset that patients had experienced.
- There was a whistleblowing policy and procedures which staff were aware of, and knew how to use them. All staff had access to the whistleblowing policy.
- Feedback from patients about the dental services they received was positive.
- 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.
- There were a sufficient supply of the necessary equipment for staff to deal with medical emergencies, and staff had been trained how to use that equipment. .
- The practice followed the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control.
- Patients' were involved in discussions about the planning and delivery of care and treatment. Patient recall intervals were in line with National Institute for Health and Care Excellence (NICE) guidance.
- Treatment options were identified, explored and discussed with patients.
- Patients' confidentiality was maintained.

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

- Replace the broken hearing loop as a reasonable addition as identified in the Equality Act (2010).
- Review the Control of Substances Hazardous to Health (COSHH) file and ensure that this is up-to-date to comply with the COSHH Regulations 2002.
- Review the usage of rubber dams to follow the guidelines from the British Endodontic Society. This would include recording in the patients' care records when rubber dams have been used, and if not why not.

Review how feedback was given to patients on a regular basis following the Family & Friends test and the practice's own survey.

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.

Accidents and significant events were recorded and monitored. Learning points from any accidents or significant events were shared with staff.

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

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.

The practice had the necessary emergency equipment including an automated external defibrillator (AED) and oxygen. Regular checks were being completed to ensure the equipment was in good working order.

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

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

X-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.

All patients were clinically assessed by a dentist before any treatment began. This included completing or updating a health questionnaire. There was a recognised assessment process to identify any potential areas of concern in patients' mouths, jaws and neck, including their soft tissues (gums, cheeks and tongue).

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

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

Are services caring?

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

Staff maintained patient confidentiality.

Patients were treated in a polite caring manner and with dignity and respect.

Staff at the practice were friendly and welcoming to patients.

Summary of findings

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.

Are services responsive to people's needs?

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

Patients said they could easily get an appointment. Patients who were in pain or in need of urgent treatment were usually seen the same day.

The practice did not have ground floor treatment rooms. Therefore patients who could not manage the stairs were referred to a different dental practice.

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 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.

The practice was part of a larger corporate provider. 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.

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

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

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

IDH Derby

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

Before the inspection we asked the 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 spoke with six members of staff during the inspection.

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

During the inspection we spoke with three dentists, two dental nurses and the practice manager. We reviewed policies, procedures and other documents. We received feedback from 37 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 February 2015, this being when a patient slipped on the wet step outside the practice. As a result a hand rail had been fitted to assist patients and reduce the likelihood of the accident recurring. There had been three recorded accidents in the 12 months prior to this inspection. Accident records went back over several years to demonstrate the practice had recorded and addressed issues relating to safety at the practice.

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 practice manager 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 kept a log of significant events. The records showed there had been one significant event recorded in the last year. This related to the theft of a workman's laptop from the practice. The practice had informed both the police and the Care Quality Commission (CQC). The records showed that appropriate action had been taken by the practice staff to increase security within the practice.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts. These were sent out centrally by a government agency (MHRA) to inform health care establishments of any problems with medicines or healthcare equipment. Alerts were received by the practice manager by e mail and were analysed and information shared with staff if and when relevant. The practice manager said the last alert had been received in October 2015, which related to the storage of medicines in syringes, which had been found to be affecting the potency of the medicine.

Reliable safety systems and processes (including safeguarding)

The practice had separate policies for safeguarding vulnerable adults and children. These policies had been reviewed and updated in February 2016. 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 practice manager was the lead for safeguarding in the practice. They had received appropriate training in child protection to support them in fulfilling that role. We saw the practice had detailed files for both safeguarding vulnerable adults and children. Staff training records showed that staff at the practice had undertaken training in safeguarding adults and children. This training had been in various formats from attending a formal safeguarding course through to safeguarding updates through on line training. The most recent training had been delivered in January 2016.

We saw that there were no leaflets or posters relating to safeguarding vulnerable adults and children in the public areas of the practice. The practice manager said they would make arrangements to have posters and leaflets available for patients.

The practice had a policy and procedure and attendant risk assessment 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. During the inspection we saw identified a number of items which were not covered in the COSHH file, which should have been. The practice manager said the COSHH file was due for review, and would inform CQC when this had been completed.

Are services safe?

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

The practice had a sharps policy which identified how to handle sharps (particularly needles and sharp dental instruments) safely. We saw the practice used a recognised system for handling sharps safely in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, and practice policy. We discussed this with a dentist who demonstrated how the system worked and the steps taken to reduce the risks of sharps injuries.

There were sharps bins (secure bins for the disposal of needles, blades or any other instrument that posed a risk of injury through cutting or pricking.) We saw the bins 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.

Dentists told us they were using rubber dams when completing root canal treatments. However we looked at several patients' dental care records and found no evidence to support this. In addition we found a shortage of rubber dam kits (the equipment necessary to use a rubber dam) which suggested that dentists were not always using rubber dams 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. The practice manager said the use of rubber dams would be reviewed, and discussed at a forthcoming staff meeting.

Medical emergencies

The practice had a medical emergencies policy which had been updated in April 2015. There were emergency medicines and oxygen available to deal with any medical emergencies that might occur. These were located in a secure location, and all 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.

There was a first aid box which was located in the decontamination room. Two members of staff had attended a first aid at work course and were the designated first aiders at the practice. There were posters in the practice identifying who the first aiders were for the benefit of the patients.

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 and an update was booked for 12 February 2016. Resuscitation Council UK guidelines suggest the minimum equipment required includes an AED and oxygen which should be immediately available. The practice also had airways to support breathing, 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 three members of staff who was able to describe the actions to take in relation to various medical emergencies including a patient collapsing in the practice.

Staff recruitment

We looked at the staff recruitment files for seven members of staff 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.

Are services safe?

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

Monitoring health & safety and responding to risks

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

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 April 2014.

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

Infection control

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

The practice had an infection control policy which was readily available to staff working in the practice. The policy described how cleaning should be completed at the practice 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 regular six monthly infection control audits had been completed as identified in the guidance HTM 01-05. The last audit in January 2016 scored 97%, the results of the audit were being analysed at the time of our inspection. The previous infection control audit had been completed in August 2015.

The practice had a clinical waste contract, and waste matter was collected regularly. Clinical waste was stored securely 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, which were in date.

The practice had a dedicated decontamination room that had been organised in line with HTM 01-05. The decontamination room had dirty and clean areas, and there was a clear flow between to reduce the risk of cross contamination and infection. The clean and sterilised dental instruments were then pouched and date stamped. Staff wore personal protective equipment during the process to protect themselves from injury. These included heavy duty 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 an ultrasonic cleaner, which is a piece of equipment specifically designed to clean dental instruments through the use of ultrasound and water. After being in the ultrasonic cleaner, the 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 two steam autoclaves. These were designed to sterilise solid or non-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 the dental instruments was maintained and serviced regularly in accordance with the manufacturers' instructions. There was a mixture of daily, weekly and monthly records to demonstrate the decontamination processes and ensure that equipment was functioning correctly. Records showed that the equipment was in good working order and being effectively maintained.

Are services safe?

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

Information in the practice 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 certification to demonstrate the risks of Legionella had been assessed and steps taken to reduce those risks. The assessment was dated 29 January 2014 and was valid until 31 August 2016. 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 with regular recorded water tests.

The practice flushed the dental water unit lines 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 those dental water lines.

Equipment and medicines

All items of portable electrical equipment at the practice had been tested to ensure they were safe and working correctly. This type of test is known as a PAT test (Portable Appliance Test) and the most recent PAT test had been on 1 February 2016. There were comprehensive records within the practice to demonstrate PAT testing had been completed. Fire extinguishers were checked and serviced by an external company and staff had been trained in the use of equipment and fire evacuation procedures.

The practice had all of the medicines identified by the latest guidance for use in an emergency situation. This included oxygen. Medicines were stored securely and there were sufficient stocks available for use.

Radiography (X-rays)

The dental practice had five intraoral X-ray machines (intraoral X-rays concentrate on one tooth or area of the mouth). These were located in the treatment rooms. There was also one extra-oral X-ray machine (an orthopantomogram known as an OPG) for taking X-rays of the whole mouth including the teeth and jaws. 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 more than one and a half metres away from the X-ray machine heads. This was a requirement of IRR 99.

Records showed the X-ray equipment had last been serviced in October 2015. The IRR 99 requires 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. We saw records to demonstrate that this was happening.

The five intraoral X-ray machines 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 having an X-ray at the dental practice had completed a medical history form. This provided information so the dentist could consider if it was safe for the patient to receive X-rays. This included identifying where patients might be pregnant. There were risk assessments in place for pregnant & nursing mothers.

Are services safe?

Patients' dental care records showed that information related to X-rays was recorded in line with guidance from the Ionising Radiation (Medical Exposure) Regulations 2000. This included 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 held dental care records for each patient. We saw a small number of patient care records to confirm what the dental staff had told us 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 soft tissues including the tongue and the jaw and neck.

The practice asked patients to complete a form to record the patients' medical histories. These 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 followed nationally recognised guidelines on which to base any treatment 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, prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart) and wisdom tooth removal.

Health promotion & prevention

There was a range of literature in the waiting room and reception area about different treatments offered at the practice. In addition there were posters and leaflets giving advice about different aspects of oral health such as gum disease and tooth decay. 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 dentists had provided advice on stopping smoking, and the poor effects of alcohol and diet on oral health had been discussed. With regard to smoking dentists had highlighted the risk of dental disease and oral cancer.

Staffing

The practice has six dentists, one orthodontist, two dental hygienists, seven dental nurses, three of whom also worked on reception, one receptionist, two trainee dental nurses and one practice manager. Before the inspection we checked the registrations of all dental care professionals with the General Dental Council (GDC) register. We found all staff were up to date with their professional registration with the GDC.

We looked at staff training records and these showed that 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: Radiography (X-rays) and medical emergencies.

The practice carried out annual appraisals for all staff. The records showed that appraisals had been completed during 2015. We saw evidence in four staff files that appraisals had taken 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.

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 a difficult extraction. The practice also referred patients who required sedation, usually as a result of the patient being very nervous or having a phobia about visiting the dentist. The practice had a log of other dental practices and services where referrals could be made. We saw copies of referral forms for use in making referrals to the various other dental practices and services.

Are services effective?

(for example, treatment is effective)

Records within the practice identified that for patients with suspected oral cancer, referrals had been made within the two week window for urgent referrals.

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 during 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.

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

Discussions with dentists showed they were aware of and understood the use of Gillick to 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.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

During our inspection we observed staff speaking with patients. We saw that staff at reception were friendly, polite and welcoming. Our observations showed that patients were treated with dignity and respect.

The reception desk was located next to the waiting room. We talked with reception staff about the need for confidentiality. The reception staff explained how that they were aware of the need for confidentiality. Staff said they were careful to protect patients' privacy both at the reception desk and when speaking on the telephone. Staff identified that if it were necessary to discuss a confidential matter, there were areas of the practice where this could happen, such as a staff area behind reception. Staff said that all details of patients' individual treatment was discussed in the privacy of the treatment room.

We observed several patients being spoken with by staff throughout the day, and did not witness any occasion when patients' confidentiality had been breached. We saw that patient dental care records were held securely and where computers were used they were password protected. Paper records were stored securely at the practice.

Involvement in decisions about care and treatment

We received feedback from 37 patients on the day of the inspection. This was both by speaking to patients during the inspection and through Care Quality Commission (CQC) comment cards left at the practice before the inspection. Several CQC comment cards identified dentists took the time and trouble to involve patients in decisions about care and treatment. Two patients made specific reference to dentists and dental nurses being approachable so that patients were able to ask questions about their treatment and care.

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

We spoke with three dentists, and two dental nurses who said that every patient had their dental diagnosis and treatment discussed with them. All of the treatment options and costs involved were explained before treatment started. Every patient was given a written treatment plan which included the costs.

We saw that when necessary information about preventing dental decay was given to improve patients' oral health. This was recorded in the patients' dental care records, and included evidence that discussions about smoking and diet and the effects on patients' teeth, gums and mouth had been discussed. 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

The practice was situated in a large older property close to the centre of Derby. The building dictated the layout of the practice. Treatment rooms were situated on the upper floors, and there was no lift. However there were arrangements in place for patients to be seen elsewhere if they were unable to manage the stairs. There were separate staff and patient areas, which helped with confidentiality and security. The treatment and waiting 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.

We spoke with two patients during the inspection. Both patients said that getting an appointment had been quite easy. One patient said they had needed urgent treatment in the past, and had been seen the same day. They had telephoned for an urgent appointment and been offered one straight away. Staff said that when patients were in pain or where treatment was urgent the practice made efforts to see the patient within 24 hours, and usually the same day.

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

New patients were asked to complete a medical and dental health questionnaire. This allowed the dentists to gather 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.

It was clear that patients were not rushed into making decisions, and were given plenty of time to think about the options and make up their minds before giving their consent to treatment. We saw examples of patients having longer appointments to have time to consider their options.

Tackling inequity and promoting equality

The practice had good access to all forms of public transport with a bus stop located close by. There was street parking available in the local area.

Staff said the practice had a hearing induction loop. The Equality Act (2010) requires where 'reasonably possible' hearing loops to be installed in public spaces, such as dental practices. However, the hearing loop was found to be broken. The practice manager said a replacement would be purchased.

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 six dentists which also made getting an appointment relatively easy.

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 problem the patient usually brought someone to interpret therefore avoiding the need for interpreters.

Access to the service

Information on the practice website identified the practice was open: Mondays to Thursdays: 8:50 am to 5:30 pm; Fridays 8:45 am to 5 pm. The practice was closed for lunch between 1 pm and 2 pm. This information was also available within the practice.

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

Concerns & complaints

The practice had a complaints policy and procedure to explain to patients how they might make a formal complaint. The procedure explained the process, and included the contact details of other agencies to contact if the complaint was not resolved to the patients satisfaction. This included NHS England and the Parliamentary and Health Service Ombudsman.

Information about how to make a complaint was displayed in the practice waiting rooms, 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 the practice recorded any negative comments made on the NHS Choices website as a complaint. Most of the negative comments had been responded to by the corporate provider.

We saw there had also been two direct formal complaints received in the past 12 months. Records within the practice showed the complaints had been handled in a timely manner, and in line with the practice's complaints procedure. Both complaints had been investigated and the outcome had been recorded. The records showed that both complaints had been analysed and steps taken to prevent the situations recurring. We saw that apologies had been given for the concern and upset the patients had experienced.

Are services well-led?

Our findings

Governance arrangements

The practice was part of the mydentist group of dental practices, and there was a corporate provider. As a result policies and procedures had been produced centrally and adapted to reflect the local arrangements in Derby where necessary and appropriate.

There was a clear management structure both within the practice and within the wider organisation. Staff at the practice had set roles and responsibilities. We spoke with four staff members about the management structure, and all four were clear about the structure, roles and responsibilities. Staff said there was good communication within the staff team, and positive working relationships.

We saw several policies and procedures at the practice and identified they had been reviewed and where relevant updated during 2015. The practice manager demonstrated there was a management plan which included the review and updating of policies and procedures.

We looked at a selection of patient dental care records to assess if they were complete, legible, accurate, and secure. Our findings were that dental care records were as they should be.

Leadership, openness and transparency

The practice had a practice manager, who had been newly appointed. They were studying for a

Level four in Practice Management and an NVQ level four in management.

The practice held regular staff meetings throughout the year. Full staff meetings were minuted, and those minutes were available to all staff. We saw the minutes of past meetings which identified topics such as clinical issues and health and safety had been discussed.

We spoke with a number of staff of different grades and responsibilities. Staff said there was an open culture, and those in management or more senior roles were approachable. Staff said they were confident they could raise issues or concerns at any time. Observations showed there was a relaxed and friendly attitude among the staff, with obvious signs of team working across all 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.

The practice had a whistleblowing policy which identified how staff could raise any concerns they had about colleagues' conduct or clinical practice. This was both internally and with identified external agencies. We discussed the whistleblowing policy with a dental nurse who was able demonstrate their understanding of the whistle blowing procedures.

Learning and improvement

We talked with several staff members about the practice values. Staff said the corporate provider made the company values very clear. The practice was due to be redecorated and have some areas upgraded and refurbished. As part of the refurbishment examples of the company values would be on display in each treatment room.

The practice manager demonstrated that there was a schedule of audits completed throughout the year. The audits were a tool to drive improvement and measure quality, and were for both clinical and non-clinical areas of the practice. Examples of audits we saw during the inspection included: Infection control, patients record cards, consent and radiographs (X-rays).

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. This was a mixture of in-house and external training.

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

The practice used the NHS Friends & Family comment box which was located in the waiting room. This was to gather regular feedback from the NHS patients, and to satisfy the requirements of NHS England. The responses within the boxes were analysed on a monthly basis and fed back to the Area team (NHS England). Since the Family & Friends test was introduced in April 2015 the practice has received regular feedback each month. Analysis of the Friends & Family information showed all of the responses were positive. All respondents were either likely or highly likely to recommend the practice to their family and friends.

Are services well-led?

The practice also had its own survey which was managed through the corporate provider. This allowed the provider to gather patient feedback about the performance of the practice, and to analyse both positive and negative feedback. The practice manager said that feedback gathered in this manner in the past had provided positive responses.

We visited the NHS Choices website and reviewed the comments that patients had left about the practice. In the 12 months leading up to the inspection there had been two comments posted on the website. Both comments were positive. The practice had not provided a response to either of the comments. We discussed this with the practice manager, who agreed that it would be in the practice's interests to provide a written response. The practice manager said they would look into doing this.

We noted that the practice did not give feedback to the patients in the practice regarding the comments that had been made. This was through neither the practice's own survey nor the Family & Friends test. We discussed with the practice manager. The practice would be looking to provide feedback to patients each month in the future.