Oswald House Dental Practice

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Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 12 August 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

Oswald House Dental Practice was registered with the Care Quality Commission (CQC) in November 2013 to provide dental services to patients in Ashbourne and the surrounding areas in the county of Derbyshire. The practice provides both NHS and private dental treatment, with approximately 60% being NHS patients. Services provided include general dentistry, dental hygiene, teeth whitening, crowns and bridges, and root canal treatment. The practice is situated in a Grade II listed building in the centre of Ashbourne, with treatment rooms on the ground and first floors. The practice is open Monday to Friday 8:45 am to 12:45 pm and 1:45 pm to 5:30 pm. Access for urgent treatment outside of opening hours is usually through the NHS 111 telephone line. In addition a private out-of-hours service is available for a £95 call out fee plus the cost of treatment. The practice is considering whether a relocation to new purpose built premises would be in the practices and patients' best interests.

The practice has four dentists, two hygienists/ therapists, and seven dental nurses. There is a practice manager, a reception manager and three receptionists.

The practice manager is the registered manager. A registered manager is a person who is registered with the

Summary of findings

Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

We viewed nine Care Quality Commission (CQC) comment cards that had been completed by patients, about the services provided. We saw that all nine comment cards had wholly positive comments. Patients said they were extremely happy with the service provided. In addition, we spoke with two patients who spoke positively about the dental service they were receiving. Patients said they were treated well at the practice. Patients said they were able to ask questions, and the dentist explained the treatment options and costs.

Our key findings were:

- The practice had systems for recording accidents, significant events and complaints.
- Learning from any complaints and significant incidents were recorded and learning was shared with staff.
- The practice was visibly clean.
- The practice had provided training in safeguarding and whistle blowing for all staff, and staff were aware of these procedures and the actions required.
- Patients said they were satisfied with the service they received, and several said they were very happy.
- Patients said they were treated with dignity and respect.
- 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 and oxygen were readily available.
- The practice had ordered 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.
- The practice followed the relevant guidance (Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control.
- 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, and options were identified and explored with them.
- Patients' confidentiality was maintained.

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

- Ensure staff training records identify that all staff had received up-to-date fire training. This posed a risk to patients and staff, as the dental practice was located in an older building over several floors.
- Ensure the infection control policy gives full guidance to staff regarding infection control risks and management of those risks.
- Ensure sharps boxes have guidance on display beside the box, as identified in health and safety executive (HSE) guidance: 'Health and safety (sharp instruments in healthcare) regulations 2013.
- Ensure the clinical waste bin in the decontamination room has a lid, to reduce the infection control risk.
- Ensure records of measures taken to reduce the risk of patients and staff developing Legionnaires' disease are complete and up-to-date.
- Ensure information on how to make a complaint is clearly displayed in the practice leaflet.

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 procedures for reporting accidents and significant events and learning points were shared with staff in team meetings.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts and information was shared 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 ordered an automated external defibrillator (AED) as they did not have one.

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

Infection control procedures were being amended to follow 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 assessed before 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 use of alcohol and tobacco together with dietary advice was given to patients to help improve their 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).

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

Are services caring?

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

Staff were aware of the need for confidentiality and worked in a way that protected patients.

Patients were treated with dignity and respect, and staff were open and welcoming to patients at the dental practice.

Patients said they were happy with the dental care they received, and had confidence in the staff to meet their needs.

Summary of findings

Patients said they felt involved in their care, and 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 appointments system was accessible and met patients' 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 level access, and a ground floor treatment room.

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 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 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.

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

Oswald House 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 12 August 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 the management team.

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, one hygienist, the practice manager, two dental nurses and two receptionists. We reviewed policies, procedures and other documents. We reviewed nine Care Quality Commission (CQC) comment cards that we had left prior to the inspection, for patients to complete, about the services provided at the practice. We also spoke with two patients.

We informed stakeholders, for example NHS England area team and Healthwatch that we were inspecting the practice; however we did not receive any information of concern from them.

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 introduced procedures for investigating, responding to and learning from accidents, significant events and complaints. Documentation showed the last recorded accident had occurred in November 2014, with two accidents recorded in the last year. These had both been injuries to members of staff, including a needle stick injury. This had prompted the practice to raise awareness among the staff about needle stick injuries and how to avoid them.

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. We saw the minutes of staff meetings which showed that health and safety matters had been discussed, and learning points shared.

In respect of significant incidents these were recorded on specific forms. Learning outcomes had been identified and learning was shared with staff. We saw a specific example of a breakdown in communication between the practice and a laboratory carrying out technical work for the practice. This had been identified and the issue resolved by the practice manager.

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 practice manager demonstrated how the alerts were received and information was shared with staff if and when relevant.

Reliable safety systems and processes (including safeguarding)

The practice had a safeguarding vulnerable adults and children policy. The policies included details of 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. There was an identified lead for safeguarding in the practice who had received enhanced training in child protection to support them in fulfilling that role. All staff at the practice had undertaken training in safeguarding adults and children having completed the training during July 2015.

The practice had a policy and procedure to assess risks associated with the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. The policy and procedure had seen the practice identify potentially hazardous substances in use at the premises. Each substance was identified and risk assessed. Steps to reduce the risks included the use of personal protective equipment for staff and patients and 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 swallowed.

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 6 November 2015. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

Discussions with dentists and examination of patients' notes identified the dentists were using rubber dams when completing root canal treatments in line with best practice guidelines from the British Endodontic Society. A rubber dam is a thin rubber sheet that isolates selected teeth and protects the rest of the patient's mouth during treatment.

Medical emergencies

The dental practice had emergency medicines and oxygen to deal with any medical emergencies that might occur. 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.

The practice did not have 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. Staff said the nearest AED was located at WH Smiths shop opposite. However, during

the inspection the practice manager ordered an AED so that the practice had their own. All emergency equipment and medicines were stored centrally with all staff being able to access them if required. Records showed all staff had completed basic life support and resuscitation training on 17 July 2015. The training included the use of an AED, despite the practice not having their own at that time. The practice manager said this training was updated annually 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. They were able to describe those actions in relation to various medical emergencies including a cardiac arrest (heart attack).

Staff recruitment

The practice had a recruitment procedure for appointing new staff. We looked at the personnel files for five 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 the practice recruitment policy and the regulations had been followed.

There were sufficient numbers of suitably qualified and skilled staff working at the practice. A system was in place to ensure that where absences occurred they could be covered, usually by colleagues.

Monitoring health & safety and responding to risks

The practice had both a health and safety policy and environmental risk assessments. Risks to staff and patients had been identified and assessed, and the practice had introduced measures to reduce those risks. For example: local rules for the use of X-ray machines and a legionella risk assessment.

The practice also had other specific policies and procedures to manage other identified risks. For example: A Control of Substances Hazardous to Health (COSHH) policy and risk assessments; fire safety policies and procedures and an infection control policy. Staff told us that fire detection and fire fighting equipment such as fire alarms and emergency lighting were regularly tested, and we saw records in respect of these checks had been completed.

Staff training records identified that not all staff had received up-to-date fire training. This posed a risk to patients and staff, as the dental practice was located in an older building over several floors. The practice manager gave assurances that fire training would be booked for all staff.

Infection control

Infection control within dental practices must follow 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 dated January 2015. The policy described how cleaning should be completed at the premises including the treatment rooms and the general areas of the practice. However, we found the infection control policy to be quite limited, and it did not give full guidance to staff regarding risks and management of those risks. 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.

An infection control audit had been completed on 10 August 2015. There were no action points arising from this audit.

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.' These regulations identified that guidance for staff with regard to sharps should be displayed beside each sharps box. We found that not every sharps box in the practice had the necessary guidance on display.

The practice had a clinical waste contract, and waste matter was collected on a regular basis. Clinical waste was stored securely while awaiting collection. 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 clinical waste bin in the decontamination room did not have a lid, which therefore posed an infection control risk. The bin should be replaced with a covered bin operated by a foot pedal to reduce the risk of cross contamination.

The practice had a dedicated decontamination room that had been organised in line with HTM 01-05. The decontamination room had defined dirty and clean areas to reduce the risk of cross contamination and infection. In addition there was a separate area for bagging clean and sterilised dental instruments 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 not being cleaned and sterilised in line with the published guidance (HTM 01-05). The practice had both a washer disinfector (a machine for cleaning dental instruments similar to a domestic dish washer). It also had an ultrasonic cleaner, this is a piece of equipment specifically designed to clean dental instruments through the use of ultrasound and water. Neither machine was in use, as the staff were cleaning dental instruments by hand. This method of cleaning is acceptable, however HTM 01 - 05 advises the use of a washer disinfector or an ultrasonic cleaner. Cleaning by either machine would allow the staff to run tests and audits to demonstrate the cleaning process was robust. This could not be demonstrated by manual cleaning. Following discussion with the practice manager the practice decided to reintroduce cleaning of dental instruments using one of the machines.

A dental nurse demonstrated the decontamination process, and we saw the procedures used followed the practice policy. Guidance and instructions were on display for reference. The instruments were cleaned manually, 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 two steam autoclaves in use. These were 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. Records showed that 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 needle stick injury policy was displayed in the decontamination room. A member of staff was able to describe what action they would take if they had a needle stick injury and this reflected the practice policy.

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. However the records showed no temperature information had been recorded since March 2015. Regular temperature checks and flushing would significantly reduce the risk of Legionella developing.

Equipment and medicines

Are services safe?

Records showed that equipment at the practice was maintained and serviced in line with manufacturer's guidelines. Portable appliance testing (PAT) had taken place on electrical equipment. 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. 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 for use in an emergency. However, the room where the oxygen was stored did not have a medical gasses sign on the door. The practice manager ordered a sign from the supplier during the inspection.

Radiography (X-rays)

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 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. Records showed that the dates X-ray equipment was tested, serviced and if necessary repaired.

The local rules identified the practice had a radiation protection supervisor (the principal dentist) and a radiation protection advisor, as identified in the Ionising Radiation Regulations 1999 (IRR 99). 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.

We discussed the use of X-rays with a dentist. This identified the practice monitored the quality of its X-ray images and had records to demonstrate this. This ensured the X-rays were of the required standard and reduced the risk of patients being subjected to further unnecessary 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.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice stored information about the assessment, diagnosis, treatment and advice of dental healthcare professionals provided to patients. We reviewed five dental records, we found that an up to date medical history had been taken on each occasion.

Medical histories included any health conditions, current medicines being taken and whether the patient had any allergies. If an X-ray was to be taken 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 that the dentists used nationally recognised guidelines to base treatments and develop longer term plans for managing 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 dentists, and a dental nurse who said that each individual patient had their diagnosis discussed with them. Treatment options and costs were explained before treatment started. This was supported by several of the Care Quality Commission (CQC) comment cards, and in face to face discussions with patients. 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 dentists showed they were aware of NICE guidelines, particularly in respect of recalls of patients, anti-biotic prescribing and wisdom tooth removal. These being the most current guidelines being followed. A review of the records identified that the dentist were following NICE guidelines in their treatment of patients.

We reviewed nine Care Quality Commission (CQC) comment cards completed by patients at the practice. All nine contained positive comments. Patients said they were very happy with the care and treatment they received. Dental staff kept patients informed, and they were able to ask questions.

Health promotion & prevention

We saw a range of literature in the waiting room and reception area about the services offered at the practice.

The practice had a consultation room where clinical staff could speak with patients and review notes, X-rays or treatment plans. Staff said the consultation room was more comfortable than the treatment room, and provided a relaxing environment to hold discussions. This included health promotion discussions with the computer available to provide visual information.

We saw examples in patients' notes 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. Patients' alcohol consumption was recorded (number of units of alcohol per week) as this could have an effect on dental health.

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 dentists showed they were aware of the Department of Health 'Delivering better oral health' document and used it in their practice.

Staffing

The practice had four dentists, two hygienists/ therapists, and seven dental nurses. There was a practice manager, a reception manager and three 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.

Are services effective?

(for example, treatment is effective)

We reviewed staff training records and saw staff were maintaining their continuing professional development (CPD). This was to ensure they remained up-to-date and developed their skill levels. 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.

The practice appraised the performance of its staff with annual appraisals. We saw evidence in staff personal files that appraisals had been taking place. We spoke with two members of staff who said they had an annual appraisal with the practice manager.

Staff said they felt well supported and that they felt part of the team.

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. The practice then monitored patients after their treatment 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 were also referred to other practices that provided that service. This would particularly apply to nervous patients who required sedation to help them relax.

Patients being referred for oral surgery would usually be referred to the Charles Clifford Hospital in Sheffield, although other options in Derby and Nottingham (Queens Medical Centre) were available to patients. We saw examples of urgent two week referrals for suspected oral cancer for example. This was in line with the National Institute for Health and Care Excellence (NICE) guidelines.

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. Discussions with dentists 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 consent policy provided information about Gillick competencies.

The consent policy also had a description of competence or capacity and how this affected consent. The policy linked this to the Mental Capacity Act 2005 (MCA). Staff training records showed staff had attended training with regard to the MCA 2005. 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 the staff spoke with patients and whether they 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. They said that a private area was available for use, with either the back office or an unused treatment room available.

We observed a number of patients being spoken with at the reception desk 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.

We viewed nine Care quality Commission (CQC) comment cards that had been completed by patients. All nine had positive comments about the staff and the services provided. We spoke with two patients who said they were very happy with the service provided. Several patients using both comment cards and in person spoke about the friendliness of the staff, and how they were made to feel at ease. There were also comments from patients saying they had been treated professionally and had received good dental care.

Involvement in decisions about care and treatment

We spoke with two patients on the day of the visit. Both were positive about the dental treatment they received and the dentists they saw. Both patients said that treatment was explained clearly to them including the cost. Both patients also said they felt involved in the decisions taken, and were able to ask questions and discuss with the dentists the treatment options.

Care Quality Commission (CQC) comment cards completed by patients included comments about how treatment was always explained in a way the patients could understand. Three comment cards made specific reference to treatment being explained and patients feeling involved in the treatment decisions taken.

The practice information leaflet and the practice website clearly described the range of services offered to patients. The practice offered private treatments and the costs were clearly displayed and fee information was also available on the practice 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 confirmed this and reported that dental staff always explained things clearly, and in a way that they could understand. Patients received a 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

The practice had an appointment system which patients said both in person and through Care Quality Commission (CQC) comment cards met their needs. When patients were in pain or where treatment was urgent patients efforts would be made to see the patient the same day. One CQC comment card made reference to the appointment system and the patient's satisfaction with the appointments system. Both patients we spoke with said it was easy to get an appointment, and said they had no complaints.

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 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 had considered the needs of patients who may have difficulty accessing services due to mobility or physical issues. The practice had level access to a side door providing step free access into the practice. This was to assist patients with mobility issues, using wheelchairs or mobility scooters and parents with prams or pushchairs. A ground floor treatment room was available for those patients who could not manage the stairs. The practice had a ground floor toilet, which was accessible for patients. However, the toilet was small and would be difficult for a person with restricted mobility. The practice manager said that as the building was a Grade II listed building, making alterations was difficult. This had been a factor in considering a move to new purpose built premises.

The practice had good access by all forms of public transport. Car parking was either street parking or in a pay and display car park. The practice was located in the centre of Ashbourne close to the bus station.

Staff members told us that longer appointment times were available for patients who required extra time or support, such as patients who were particularly nervous or anxious.

Access to the service

The practice was open Monday to Friday 8:45 am to 12:45 pm and 1:45 pm to 5:30 pm.

The arrangements for emergency dental treatment outside of normal working hours, including weekends and public holidays were clearly displayed in the waiting room area and in the practice leaflet. Access for urgent treatment outside of opening hours was usually through the NHS 111 telephone line. In addition a private out-of-hours service is available for a £95 call out fee plus the cost of treatment.

Concerns & complaints

Oswald House had a complaints procedure that explained the process to follow when making a complaint. However, this information was not part of the practice leaflet, although it was available on the practice website. The timescales and the person responsible for handling the complaint were also identified. 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 no formal complaints received in the past twelve months.

Care Quality Commission (CQC) comment cards reflected that patients were satisfied with the dental services provided.

Are services well-led?

Our findings

Governance arrangements

The practice monitored and improved the service provided for patients. For example the practice

reviewed feedback from patients, and held regular staff meetings. The practice manager 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.

The practice had governance arrangements in place. This was demonstrated by several audits which we reviewed. For example: audits of patients' notes and regular review and updates of policies and procedures. However, as already identified the infection control policy was in need of review. Discussions with staff identified they were aware of their roles and responsibilities within the practice.

There were systems for clinical and non-clinical audits taking place within the practice. These included audits of patient records, oral health assessments and X-ray quality. Health and safety related audits and risk assessments were also in place.

Leadership, openness and transparency

We saw minutes of meetings where information was shared and issues discussed.

Staff said there was an open and transparent culture at the practice which encouraged openness and honesty. Staff said they were confident they could raise issues or concerns at any time with the practice management team without fear of discrimination. All staff told us the practice was a relaxed and friendly place to work. Staff told us that they could speak with the practice manager or a dentist if they had any concerns. All staff members we spoke with said they felt part of a team, 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 stated its main aim was: "… To provide dental care and treatment of consistently good quality for all patients and only provide services that meet patients' needs and wishes. We aim to make care and treatment as comfortable and convenient as possible."

We found staff were aware of the practice values and were able to demonstrate that they worked towards these.

Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. Staff told us they had good access to training, to ensure essential training was completed each year.

The practice undertook regular audits of its record keeping, infection control procedures, and the quality of its X-rays to ensure good standards were maintained and to identify any shortfalls.

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

Staff said that patients could give feedback at any time they visited. However, patients preferred not to complete written feedback, instead mostly providing this verbally. The practice manager said that many patients were resistant to change, and were happy with things the way they were.

There was a comments box in the waiting room, and questionnaires for patients, however, the practice rarely received any suggestions. Staff said patients were encouraged to complete these forms and provide feedback.

The patients we spoke with said they were aware of the comment box in the waiting room and the questionnaires. However, neither had ever completed a questionnaire, or provided any formal feedback.