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Clowne Dental Surgery

Inspection Report

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Date of inspection visit: 8 November 2016
Date of publication: 23/12/2016

Overall summary

We carried out an announced comprehensive inspection on 8 November 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

Clowne Dental Surgery is located on two floors of premises situated in the centre of the village of Clowne in north Derbyshire. There are two treatment rooms, one on each floor. The practice provides mostly NHS dental treatments (60%). There is a car park to the side of the dental practice for patient parking.

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

The practice's opening hours are – Monday to Friday: 9 am to 6 pm. The practice is also open on alternate Saturdays: 9 am to 1 pm.

Access for urgent treatment outside of opening hours is by telephoning the practice and following the instructions on the answerphone message. Alternatively patients can telephone the NHS 111 telephone number.

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

Summary of findings

The practice is registered with the Care Quality Commission (CQC) as a partnership.

The practice has two dentists; one qualified dental nurse; two trainee nurses and one part time receptionist. Dental nurses also work on reception.

Before the inspection we sent CQC comments cards to the practice for patients to complete to tell us about their experience of the practice and during the inspection we spoke with patients. We received responses from 39 patients who provided positive feedback about the services the practice provides.

Our key findings were:

- The premises were visibly clean and there were systems and processes in place to maintain the cleanliness.
- The systems to record accidents, significant events and complaints were not robust.
- Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.
- There were not effective systems at the practice related to the Control of Substance Hazardous to Health (COSHH) Regulations 2002.
- Staff at the practice had a limited understanding of consent, particularly in relation to the Mental Capacity Act 2005 and Gillick competency, a legal precedent where a child may give their own consent to treatment.
- Patients said they had no problem getting an appointment that suited their needs.
- Patients were able to access emergency treatment when they were in pain.
- Patients provided positive feedback about their experiences at the practice. Patients said they were treated with dignity and respect; and the dentist involved them in discussions about treatment options and answered their questions.
- Patients' confidentiality was protected.
- The records showed that apologies had been given for any concerns or upset that patients had experienced at the practice.
- The practice followed the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control with regard to cleaning and sterilizing dental instruments.
- There was a whistleblowing policy accessible to all staff, who were aware of procedures to follow if they had any concerns about a colleague's practice.
- The practice had the necessary equipment for staff to deal with medical emergencies, and staff had been trained how to use that equipment. This included an automated external defibrillator, oxygen and emergency medicines.

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

- Review the practice's system for the recording, investigating and reviewing incidents or significant events with a view to preventing further occurrences and ensuring that improvements are made as a result.
- Review its responsibilities as regards to the Control of Substance Hazardous to Health (COSHH) Regulations 2002 and, ensure all documentation is up to date and staff understand how to minimise risks associated with the use of and handling of these substances.
- Review the security of prescription pads in the practice and ensure there are systems in place to monitor and track their use.
- Review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.
- Review staff awareness of Gillick competency and ensure all staff are aware of their responsibilities.
- Review its responsibilities to the needs of people with a disability and the requirements of the Equality Act 2010 and consider installing a hearing induction loop to assist patients and visitors who used a hearing aid.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

The practice was visibly clean.

The systems for recording accidents, incidents and complaints were not robust.

All staff had received up-to-date training in safeguarding vulnerable adults and children. There were clear guidelines for reporting concerns and the practice had a lead member of staff to offer support and guidance over safeguarding matters. Staff knew how to recognise the signs of abuse, and how to raise concerns when necessary.

There were not effective systems at the practice related to the Control of Substance Hazardous to Health (COSHH) Regulations 2002.

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

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

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

X-ray equipment was regularly serviced to make sure it was safe for use.

Are services effective?

No action

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

All patients were clinically assessed by a dentist before any treatment began. The practice used a recognised assessment process to identify any potential areas of concern in a patient's mouth including their soft tissues (gums, cheeks and tongue).

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 patient recalls, lower wisdom tooth removal and the prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart).

Staff had not received training in the Mental Capacity Act 2005 and therefore their understanding of how this impacted on consent was limited.

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

Summary of findings

Are services caring?

No action

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

Patient confidentiality was maintained and electronic dental care records were password protected.

Feedback from patients identified staff were friendly, and treated patients with care and concern. Patients also said they were treated with dignity and respect.

There were systems for patients to be able to express their views and opinions.

Are services responsive to people's needs?

No action

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

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

Patient areas including treatment rooms were all located on the ground floor which allowed easy access for patients with restricted mobility. A disabled access audit in line with the Equality Act (2010) had been completed to consider the needs of patients with restricted mobility. The practice did not have an induction hearing loop to assist patients who used a hearing aid.

There were systems and processes to support patients to make formal complaints. Where complaints had been made these were acted upon, and apologies given when necessary.

Are services well-led?

No action

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

There was a clear management structure at the practice. Staff were aware of their roles and responsibilities within the dental team, and knew who to speak with if they had any concerns.

The practice had a system for carrying out regular audits of both clinical and non-clinical areas to assess the safety and effectiveness of the services provided. Policies and procedures had been kept under review.

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

Clowne Dental Surgery

Detailed findings

Background to this inspection

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

We carried out an announced, comprehensive inspection on 8 November 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

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

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

We reviewed policies, procedures and other documents. We received feedback from 39 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

The practice had systems for recording and investigating accidents, significant events and complaints. However, those systems were not robust as the practice had not analysed those accidents and incidents that had occurred. Therefore any learning points had not been shared with the staff. Documentation showed the last recorded accident had occurred in April 2016 this being a minor injury to a member of staff. We saw no evidence the accident had been analysed or learning points recorded.

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

Discussions with the principal dentist showed there had been no significant events in the twelve months leading up to this inspection. There were forms in the practice for recording any significant events and reporting to NHS England area team if appropriate.

The practice did not receive 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. Following the inspection the practice sent evidence they had signed up for these alerts.

A review of the complaints log showed that patients had been informed when they were affected by something that went wrong, given an apology and informed of any actions taken as a result. Discussions with the principal dentist identified they knew when and how to notify CQC of incidents which caused harm.

Reliable safety systems and processes (including safeguarding)

The practice had a policy for safeguarding vulnerable adults and children. The policy identified how to respond to and escalate any safeguarding concerns. The relevant contact telephone numbers for protection agencies were available for staff both within the policy and behind reception. Discussions with staff showed that they were aware of the safeguarding policies, knew who to contact and how to refer concerns to agencies outside of the practice when necessary. The principal dentist said there had been one safeguarding referral made by the practice. The reason for the referral was clearly documented in the patient's dental care record.

The principal dentist was the identified lead for safeguarding in the practice. They had received training in child protection to level two in October 2013 with annual updates to support them in fulfilling that role. We saw evidence that all staff had completed safeguarding training to level two in December 2015.

The practice had limited guidance for staff on the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. There were risk assessments for certain products such as mercury but not for all products. We also saw that there were very few copies of manufacturers' product data sheets. Data sheets provided information on how to deal will spillages or accidental contact with chemicals and advised what protective clothing to wear.

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 5 March 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

The practice had a policy for dealing with needlestick injuries which was on display in decontamination room. However, there was not a policy for recapping needles to inform staff how to handle sharps (particularly needles and sharp dental instruments) safely. We saw the practice did not use a recognised system for handling sharps safely in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Discussions with the principal dentist identified there were no devices in clinical areas for the safe removal and disposal of needles and sharps. The principal dentist said they were unaware of these devices, but would make arrangements to purchase them for the treatment rooms. Practice policy was that only dentists handled sharp instruments.

There were sharps bins (secure bins for the disposal of needles, blades or any other instrument that posed a risk of injury through cutting or pricking.) We saw the sharps bin in the upstairs treatment room was located on the floor. The 2013 regulations indicated sharps bins should not be located on the floor and should be out of reach of small children. Sharps bins were also not signed and dated. The National Institute for Healthcare Excellence (NICE) guidelines: 'Healthcare-associated infections: prevention

and control in primary and community care' advise – sharps boxes should be replaced every three months even if not full. Signing and dating would allow the three month expiry date to be identified.

Discussions with dentists identified they were using rubber dams when providing root canal treatment to patients. Guidance from the British Endodontic Society is that rubber dams should be used whenever possible. A rubber dam is a thin, square sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment (treatment involving the root canal of the tooth) is being provided. On the rare occasions when it is not possible to use rubber dams, the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured. We saw the practice had a supply of rubber dam kits available.

Medical emergencies

The dental practice had equipment in preparation for any medical emergencies that might occur. This included emergency medicines and oxygen which were located in a secure central location. We checked the medicines and found they were all in date. There were systems in place to check expiry dates and monitor that equipment was safe and working correctly.

There was a first aid box which was located behind reception. We saw evidence the contents were being checked regularly. We saw a certificate demonstrating one member of staff had completed a first aid at work course in March 2016. A poster in the waiting room informed patients of the first aid arrangements.

There was an automated external defibrillator (AED) at the practice. 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 AED was being checked regularly to ensure it was working correctly. This complied with the Resuscitation Council UK guidelines.

All staff at the practice had completed basic life support and resuscitation training in February 2016. We saw certificates that had been issued to staff following this training.

Additional emergency equipment available at the practice included: airways to support breathing, a bag valve mask for manual resuscitation, oxygen masks for adults and children and portable suction.

Discussions with staff identified they understood what action to take in a medical emergency. Staff said they had received training in medical emergencies.

Staff recruitment

We looked at the staff recruitment 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 recruitment files. This includes: proof of identity; checking the person's 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 saw that every member of staff had received a DBS check. We discussed the records that should be held in the recruitment files with the principal dentist.

Monitoring health & safety and responding to risks

The practice had a health and safety policy which had been reviewed in March 2016. The policy identified the principal dentist as the lead person who had responsibility within the practice for different areas of health and safety. As part of this policy each area of the practice had been risk assessed to identify potential hazards and identify the measures taken to reduce or remove them.

Records showed that fire extinguishers had been serviced in February 2016. The practice had a fire risk assessment which identified the steps to take to reduce the risk of fire. The risk assessment had been reviewed in March 2016. We saw there were standalone battery operated smoke alarms throughout the practice and hard wired emergency lighting installed within the premises. Records showed the practice held a fire drill monthly with the last one completed on 4 November 2016.

Are services safe?

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

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

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 available to staff in the decontamination room and behind reception. 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 that regular six monthly infection control audits had been completed. This was as recommended in the guidance HTM 01-05. The last two audits were completed in January 2016 and July 2016. The latest audit had one action point related to the use of personal protective equipment (PPE). We saw this action point had been addressed.

The practice had a clinical waste contract, and waste matter was collected regularly. Clinical waste was stored securely away from patient areas while awaiting collection. The clinical waste contract also covered the collection of amalgam, a type of dental filling which contains mercury and is therefore considered a hazardous material. The practice had a spillage kit for mercury which was within its use by date. The practice also had an antiseptic spray and wipes for dealing with spillages of bodily fluids.

There was one decontamination room where dental instruments were cleaned and sterilised and then bagged, date stamped and stored. Staff wore personal protective equipment during the process to protect themselves from injury. This included the use of heavy duty gloves, aprons and protective eye wear. The practice had latex free gloves available to avoid any risk to staff or patients who might have a latex allergy.

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

The practice had two washer disinfectors; these are machines for cleaning dental instruments similar to a domestic dish washer. After cleaning, instruments were rinsed and examined using an illuminated magnifying glass. Finally the instruments were sterilised in one of the practice's autoclaves (a device for sterilising dental and medical instruments). The practice had two vacuum autoclaves which were designed to sterilise wrapped instruments. At the completion of the sterilising process, all instruments were dried, placed in pouches and dated with a use by date.

We checked the equipment used for cleaning and sterilising the dental instruments was maintained and serviced regularly in accordance with the manufacturers' instructions. There were records to demonstrate this and that equipment was functioning correctly. Records showed that the equipment was in good working order and being effectively maintained.

The practice had a policy for dealing with blood borne viruses. There were records to demonstrate that clinical staff had received inoculations against Hepatitis B and had received boosters when required. Records showed that blood tests to check the effectiveness of the inoculation had been taken. Health professionals who are likely to come into contact with blood products, or who are at increased risk of sharps injuries should receive these vaccinations to minimise the risk of contracting blood borne infections.

The risks associated with Legionella had been assessed. This assessment had been completed by an external contractor in November 2016. Recommendations to reduce the risk at the premises had been made. We saw that the practice had implemented the recommendations and were taking steps to reduce the risks. Legionella is a bacterium found in the environment which can contaminate water

systems in buildings. The practice had taken steps to reduce the risks associated with Legionella with regular flushing of dental water lines as identified in the relevant guidance.

Equipment and medicines

The practice kept records to demonstrate that equipment was maintained and serviced in line with manufacturer's guidelines and instructions. Portable appliance testing had been completed on electrical equipment at the practice in January 2016. There was a landlord's gas safety certificate dated 15 March 2016. The pressure vessel checks on the compressor which produced the compressed air for the dental drills had been completed in October 2016. This was in accordance with the Pressure Systems Safety Regulations (2000). Records showed the autoclaves and the washer disinfectors had also been serviced and validated in October 2016.

The practice had all of the medicines needed for an emergency situation, as recommended in the British National Formulary (BNF).

Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities. However, the practice was not keeping a log of prescription numbers to monitor the security of the prescription pads and maintain an audit trail.

Radiography (X-rays)

There was a Radiation Protection file which contained the relevant information and records relating to the X-ray machines and their safe use on the premises.

The practice had two intraoral X-ray machines (intraoral X-rays concentrate on one tooth or area of the mouth).

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 Radiation Protection file identified the practice had a radiation protection supervisor (RPS) this being the dentists at the practice. The provider had appointed an external radiation protection advisor (RPA). This was a company specialising in servicing and maintaining X-ray equipment, who were available for technical advice regarding the machinery. 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.

The practice had critical examination documentation for the X-ray machines. Critical examinations are completed when X-ray machines are installed to document they have been installed and are working correctly.

Records showed the X-ray equipment had been inspected in April and October 2016. The Ionising Radiation Regulations 1999 (IRR 99) require that X-ray equipment is inspected at least once every three years. The regulations also required providers to inform the Health and Safety Executive (HSE) that X-rays were being carried out on the premises. Documentary evidence dated 16 April 2014 confirmed this had been completed.

Both X-ray machines were fitted with rectangular collimation therefore guidance from The Ionising Radiation Regulations (Medical Exposure) Regulations 2000 (Regulation 7) and the Department of Health's: National Radiological Protection Board (NRPB) 'Guidance notes for Dental Practitioners on the safe use of X-ray equipment' recommending its use, was being followed. 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 receives and the size of the area affected.

The practice used digital X-rays, which allowed the image to be viewed almost immediately, and relied on lower doses of radiation. This therefore reduced the risks to both the patients and staff.

All patients were required to complete a medical history form 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. There were risk assessments in place for pregnant and nursing mothers.

Patients' dental care records showed that information related to X-rays was mostly recorded in line with guidance from the Ionising Radiation (Medical Exposure) Regulations 2000. This included grading of the X-ray, views taken,

Are services safe?

justification for taking the X-ray and the clinical findings. However, there were some examples where this had not been recorded, and this information had not always been identified within the X-ray audits.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice held electronic dental care records for each patient. Dental care records contained information about the assessment, diagnosis, and treatment and also recorded the discussion and advice given to patients by dental healthcare professionals. The care records showed a thorough examination had been completed, and identified any risk factors such as smoking and diet for each patient.

New patients at the practice completed a medical history form which was scanned into their electronic dental records. Returning patients updated their information which was reviewed with the dentist in the treatment room. The patients' medical histories included any health conditions, medicines being taken and whether the patient had any allergies.

The dental care records showed that dentists assessed the patients' periodontal tissues (the gums) and soft tissues of the mouth. The dentists used the basic periodontal examination (BPE) screening tool. BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to a patient's gums. The dentists were using BPE for all patients other than children.

We saw the dentist used national guidelines on which to base treatments and develop treatment plans for managing patients' oral health. Discussions with the dentist showed they were aware of National Institute for Health and Care Excellence (NICE) guidelines, particularly in respect of recalls of patients, prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart) and lower wisdom tooth removal. A review of the records identified that the dentists were following NICE guidelines in their treatment of patients.

Health promotion & prevention

The practice had one waiting room for patients. There were posters and a few leaflets relating to good oral health and hygiene on display. There were free samples of toothpaste for patients available in treatment rooms and at reception and a range of oral health products such as mouthwash and tepee brushes available to buy.

Children seen at the practice were offered fluoride varnish application and fluoride toothpaste if they were identified as being at risk. This was in accordance with the government document: 'Delivering better oral health: an evidence based toolkit for prevention.' This has been produced to support dental teams in improving patients' oral and general health. Discussions with the dentist showed they had a good knowledge and understanding of 'delivering better oral health' toolkit.

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

Staffing

The practice had two dentists; one qualified dental nurse; two trainee nurses and one part time receptionist. Dental nurses also worked on reception. After 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.

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

We looked at staff training records for clinical staff to identify that they were maintaining their continuing professional development (CPD). CPD is a compulsory requirement of registration with the GDC. The training records showed how many hours training staff had undertaken together with training certificates for courses attended. This was to ensure staff remained up-to-date and continued to develop their dental skills and knowledge. Training records for clinical staff were not all clear and we were sent copies of training certificates and CPD details after the inspection. Examples of training completed included: radiography (X-rays), medical emergencies, infection control, and safeguarding.

Records at the practice showed that all staff had received an annual appraisal. This was completed with the principal dentist. We saw evidence of new members of staff having an in-depth induction programme which included a one to one support meeting with the principal dentist every two to three weeks.

Are services effective?

(for example, treatment is effective)

Working with other services

The practice made referrals to other dental professionals based on risks or if a service was required that was not offered at the practice. We saw the practice referred to other local dental services, orthodontic practices and for minor oral surgery. The standard NHS referral documentation was being used.

The practice did not provide a sedation service. Therefore if a patient required sedation they were referred elsewhere. This was usually through a local community dental practice for all patients. If the practice was unable to perform minor oral surgery they referred to the Intermediate minor oral surgery (IMOS) service. Children or patients with special needs who required more specialist dental care were referred to the community dental service.

Referrals were made to the Maxillofacial department at the local hospital for wisdom teeth removal under general anaesthetic, and suspicious lesions (suspected cancer). Referrals for suspected cancer were fast tracked with referrals faxed through to the hospital. The practice also made referrals for NHS orthodontic treatment (where badly positioned teeth are repositioned to give a better appearance and improved function)

Consent to care and treatment

The practice had a patient consent policy however; this made no reference to the Mental Capacity Act 2005 (MCA).

The MCA provides a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make particular decisions for themselves. Discussions with staff showed a limited understanding on the MCA and how it might apply to dentistry.

The consent policy did identify informed consent but this did not include patients' mental capacity or making best interest decisions on their behalf as identified in the MCA. We saw how consent was recorded in the patients' dental care records. The records showed the dentist had discussed the treatment plan with the patients, and this included risks, costs and options. This allowed patients to give their informed consent. As most patients received NHS treatment the practice recorded consent on a computerised copy of the FP17 DC form, the standard NHS consent form. The practice had its own consent form for patients who received private dental treatment.

We talked with dental staff about their awareness of Gillick competency. This refers to the legal precedent set that a child may have adequate knowledge and understanding of a course of action that they are able to consent for themselves without the need for parental permission or knowledge. We saw that staff had a limited understanding of Gillick competency and that further training was required.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

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

The reception desk was located within the waiting room. We asked reception staff how patient confidentiality was maintained at reception. Staff said that details of patients' individual treatment were never discussed at the reception desk. In addition if it was necessary to discuss a confidential matter, there were areas of the practice where this could happen such as the decontamination room or an unused treatment room.

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

Involvement in decisions about care and treatment

We received positive feedback from 39 patients about the services provided. This was through CQC comment cards left at the practice prior to the inspection, and by speaking to patients in the practice during the inspection.

The practice offered mostly NHS treatments (60%) and the costs of NHS and private treatment were clearly displayed in the waiting room.

We spoke with the dentist about how patients had their diagnosis and dental treatment discussed with them. The dentist demonstrated in the patient care records how the treatment options and costs were explained and recorded. Patients were given a written copy of the treatment plan which included the costs. We noted that patients' dental care records identified the diagnosis and treatment options discussed with patients.

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The patient areas of the practice were mostly located on the ground floor. There was parking including disabled parking available next to the dental practice.

The practice had separate staff and patient areas, to assist with confidentiality and security.

We saw there was a good supply of dental instruments, and there were sufficient instruments to meet the needs of the practice.

Staff said that when patients were in pain or where treatment was urgent the practice made efforts to see the patient the same day. To facilitate this, the practice made appointment slots available for patients who came and sat and waited to be seen.

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

Tackling inequity and promoting equality

The practice had an equal opportunities policy which made reference to the Equality Act (2010) and gave staff guidance on treating patients without prejudice or discrimination.

There were two treatment rooms one of which was situated on the ground floor. This allowed patients with restricted mobility easy access to treatment at the practice. The practice was not accessible for patients in a wheelchair due to the size of the front door and turning space within the practice. The ground floor treatment room was not large enough for patients to manoeuvre a wheelchair into the room. A notice in reception informed patients they could not take their pushchair or wheelchair into the treatment room. The principal dentist said this was due to a lack of room and the infection control risk posed by the pushchair.

The practice had one ground floor toilet for patients to use. This was compliant with the Equality Act (2010) in that it was a large room with support bars and an emergency pull cord to summon assistance. The door to the toilet was wider than usual to allow easier access for patients with restricted mobility.

Patients who used a wheelchair were directed to other dental practices which were fully accessible for wheelchair users. The practice did not have a hearing induction loop to assist patients who used a hearing aid. The Equality Act requires where 'reasonably possible' hearing loops are to be installed in public spaces, such as dental practices.

Staff in the practice said there had never been a need to use interpreters to help communicate with patients who did not speak English. Staff were aware of a company that would provide this service but the contact details were not available within the practice.

Access to the service

The practice's opening hours were – Monday to Friday: 9 am to 6 pm. The practice was open alternate Saturdays from 9 am to 1 pm.

The practice had a website: www.clownedentalpractice.co.uk. This allowed patients to access the latest information or check opening times or treatment options on-line.

Access for urgent treatment outside of opening hours was by telephoning the practice and following the instructions on the answerphone message. Alternatively patients could telephone the NHS 111 number.

The practice operated a text message reminder service with patients who had appointments with the dentist. Patients received a text or telephone call to their mobile telephone three days before their appointment was due.

Concerns & complaints

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

Information about how to complain was displayed in the waiting room for both private and NHS patients.

From information reviewed in the practice we saw that there had been one formal complaint received in the 12 months prior to our inspection. The documentation showed the complaint had been handled appropriately and an apology and an explanation had been given to the patient.

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Our findings

Governance arrangements

We saw a number of policies and procedures at the practice. There were a number of policies which were not dated however; discussions with the principal dentist indicated all policies were reviewed on an annual basis. The principal dentist said that policies would be dated with review dates in future.

We spoke with staff who said they understood the structure of the practice. Staff said if they had any concerns they would raise these with either the practice owner or one of the dentists. We spoke with two members of staff who said they liked working at the practice.

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

Some policies at the practice were in need of review, such as the consent policy which did not cover all of the areas necessary to give staff comprehensive guidance in relation to consent.

Leadership, openness and transparency

We saw that full staff meetings were scheduled for once a month throughout the year. Staff meetings were minuted and minutes were available to all staff.

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

The practice had guidance relating to the duty of candour which directed staff to be open and to offer apologies when things had gone wrong. This guidance had been produced by the Care Quality Commission (CQC). Documentation showed an example of this had been when a patient had expressed dissatisfaction with the outcome of their treatment and a technical issue with the equipment in the practice had contributed to the problem. The patient had received a written apology and an explanation. Discussions with principal dentist showed they understood the principles behind the duty of candour.

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

Learning and improvement

We saw the practice completed a range of audits throughout the year. This was for clinical and non-clinical areas of the practice. The audits identified both areas for improvement, and where quality had been achieved. The practice schedule identified that planned audits occurred in April and September each year. Examples of completed audits included: Regular six monthly infection control audits with the last two completed in January 2016 and July 2016; We saw that audits of radiography (X-rays) were completed every six months with the last one completed in July 2016. The radiography audits checked the quality of the X-rays including the justification (reason) for taking the X-ray and the clinical findings which had been recorded in the dental care records. The practice had audited their dental care records every six months with the last audit completed in July 2016.

Clinical staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council. Training records at the practice showed that clinical staff were completing their CPD and the hours completed had been recorded. Dentists are required to complete 250 hours of CPD over a five year period, while other dental professionals are required to complete 150 hours over the same period. We saw that key CPD topics such as IRMER (related to X-rays), medical emergencies and safeguarding training had been completed by all relevant staff.

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

The practice had a NHS Friends and Family Test (FFT) comment box which was located in the waiting room. The FFT is a national programme to allow patients to provide feedback on the services provided. The FFT comment box was being used specifically to gather regular feedback from NHS patients, and to satisfy the requirements of NHS England. Information in the practice for October 2016 showed positive feedback with 100% of the 55 patients who responded saying they would recommend the practice

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to family and friends. The practice averaged over 25 responses per month with data showing overwhelmingly that patients would recommend the practice to their family and friends.

There had been four patient reviews recorded on the NHS Choices website including two within the year up to this inspection. Reviews were mixed with two positive and two negative reviews. We noted the practice had not responded to the patient comments on the NHS Choices website.

The practice operated its own satisfaction survey on six monthly basis. There was a suggestion box in the waiting room and patients were invited to provide feedback directly to the practice through this means. The latest results which had been analysed in July 2016 showed 49 patients had responded and results were positive.