Ayem Ltd

Mickleover Square Dental Care

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 24 November 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

Mickelover Square Dental Care is situated on the first floor above a parade of shops in Mickelover on the outskirts of Derby. The practice was registered with the Care Quality Commission (CQC) in May 2014. The practice provides regulated dental services to patients in the Mickelover area of Derby and the surrounding areas. The practice provides both NHS and private dental treatment, with approximately 90% being private patients. Services provided include general dentistry, dental hygiene, teeth whitening, crowns and bridges, and root canal treatment. The practice is open Mondays to Fridays 9:00 am to 5:30 pm apart from Wednesdays when the opening times are 9:00 am to 7:30 pm. Access for urgent treatment outside of opening hours is by ringing the practice and following the instructions on the recorded message.

The practice has four dentists and eight dental nurses who also work on reception.

The principal dentist is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) to manage the service.

Summary of findings

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 received feedback from 45 patients about the services provided. We saw that most of the feedback was positive, with only one negative comment. This related to the difficulty with sometimes getting an appointment. This person also said that once they had an appointment the treatment was very good, and they had no other problems. Patients said they were extremely happy with the service provided, and spoke positively about their experience at this dentist and with the whole staff team. Patients said they were treated well at the practice, and that staff were friendly and approachable, they were able to ask questions, and the dentist explained the treatment options and costs.

Our key findings were:

- The practice had systems and processes to record accidents, significant events and complaints.
- Learning from any complaints and significant incidents were recorded and learning was shared with staff.
- All staff had received whistle blowing training and were aware of these procedures and the actions required.
- Patients spoke positively about the dental service they received, and several said they were very happy.
- Patients said they were treated with dignity and respect.
- Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Staff had been trained to deal with medical emergencies.
- Emergency medicines, an automated external defibrillator (AED) and oxygen were readily available. An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.
- The practice followed the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control.
- Patients' care and treatment was planned and delivered in line with National Institute for Health and Care Excellence (NICE) guidelines.
- Patients were involved in making decisions about their treatment
- Options for treatment were identified and explored and discussed with patients.
- Patients' confidentiality was maintained.

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

- Review the storage of environmental cleaning equipment and materials to eliminate the risk of cross infection.
- Change all waste bins in clinical areas to a hands free, foot pedal design to reduce the infection control risks.
- Carry out a record keeping audit to address inconsistencies across the practice.

Update the information on the NHS Choices website to ensure patients and prospective patients had access to up-to-date information.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice recorded 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 took appropriate action including sharing information with staff.

Staff had been trained in safeguarding vulnerable adults and children. There were clear guidelines for reporting concerns and the practice had a lead member of staff to offer support and guidance over safeguarding matters.

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

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

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

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

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

Are services effective?

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

Patients were clinically assessed by a dental professional before any treatment began. This included completing a health questionnaire or updating one for returning patients who had previously completed a health questionnaire. In addition the practice used a recognised assessment tool to identify any potential areas of concern in patients' mouths.

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

The practice 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).

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 took steps to ensure patients' confidentiality was not compromised.

Patients were treated with dignity and respect.

Staff at the practice were open and welcoming to patients and made efforts to help patients relax, and not be nervous about their dental treatment.

Summary of findings

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

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

Are services responsive to people's needs?

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

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

There were arrangements for patients with restricted mobility who had difficulty accessing the practice to be seen elsewhere at another dental practice.

There were arrangements for emergency dental treatment outside of normal working hours, including weekends and public holidays which were clearly displayed in the waiting room, and 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 friendly place to work, and they could speak with the practice manager or a dentist if they had any concerns.

Mickleover Square Dental Care

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 24 November 2015. The inspection team consisted of one Care Quality Commission (CQC) inspector and a dental specialist advisor. Before the inspection we reviewed information we held about the provider together with information that we asked them to send to us in advance of the inspection. During our inspection visit, we reviewed a range of policies and procedures and other documents including dental care records. We spoke with seven members of staff, including members of the management team.

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 two dentists and three dental nurses. We reviewed policies, procedures and other documents. We received feedback from 45 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 procedures for recording, investigating, responding to and learning from accidents, significant events and complaints. Documentation showed the last recorded accident had occurred in October 2015, this being a minor sharps injury to a member of staff. The cause had been identified and steps taken to ensure this was not repeated.

We saw documentation that showed the practice was aware of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). RIDDOR is managed by the Health and Safety Executive, although since 2015 any RIDDORs related to healthcare have been passed to the Care Quality Commission (CQC). The 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.

The practice had a policy for recording and dealing with significant incidents. The policy was dated October 2015. The practice had no recorded significant event in the last year.

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. Alerts were received by the principal dentist who then shared the information with staff if and when relevant. The practice had not received any relevant alerts during the past year which required action.

Reliable safety systems and processes (including safeguarding)

The practice had a joint safeguarding vulnerable adults and children policy. The policies identified how to respond to any concerns and how to escalate those concerns. Discussions with staff showed that they were aware of the safeguarding policies, knew who to contact and how to refer concerns to agencies outside of the practice when necessary. Posters with a flow chart and the relevant contact phone numbers were on display in staff areas of the practice. A patient folder in the waiting room contained information about safeguarding and who to contact with any concerns.

The principal dentist was the identified lead for safeguarding in the practice and had received enhanced training in child protection to support them in fulfilling that role. Staff training records showed that all staff at the practice had undertaken training in safeguarding adults and children. There had been no recorded safeguarding incidents at the practice on file.

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

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

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

Medical emergencies

There was a medical emergencies policy which gave guidance to staff in the event of a medical emergency. This had been reviewed in September 2015, and we saw evidence this had been discussed in a team meeting.

The dental practice had emergency medicines and oxygen to deal with any medical emergencies that might occur. These were located in a secure central location, and all staff members knew where to find them. The medicines were as recommended by the 'British National Formulary'

Are services safe?

(BNF). We checked the medicines and found them all to be in date. We saw the practice had a system in place for checking and recording expiry dates of medicines, and replacing when necessary.

The practice had a first aid box which was located in the decontamination room. A dental nurse said the contents were not being checked on a regular basis. Two members of staff had attended first aid at work training, and were identified as trained first aiders within the practice.

The practice had an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. Records showed all staff had completed basic life support and resuscitation training in December 2014.

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

Discussions with staff identified they understood what action to take in a medical emergency. Staff said they had received training, and medical emergencies had been discussed in team meetings. Staff were able to describe the actions to take in relation to various medical emergencies including a cardiac arrest (heart attack).

Staff recruitment

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

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

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

Monitoring health & safety and responding to risks

The practice had both a health and safety policy and environmental risk assessments, which had been reviewed and updated in September 2015. Risks to staff and patients had been identified and assessed, and the practice had introduced measures to reduce those risks. For example: Having a first aid box, and two staff members trained in first aid at work.

The practice had other specific policies and procedures to manage other identified risks. For example: A waste management contract and policy for handling clinical waste; fire safety policies and procedures and COSHH procedures. Risks associated with Latex, manual handling and asbestos had also been identified and assessed. Records showed that fire detection and fire fighting equipment such as fire alarms and emergency lighting were regularly tested. The fire extinguishers had last been serviced in February 2015.

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

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

Infection control

Infection control within dental practices should be working towards compliance with the Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' This document sets out clear guidance on the procedures that should be followed; records that should be kept; staff training; and equipment that should be available. Following HTM 01-05 would comply with best practice.

Are services safe?

The practice had an infection control policy which had been updated in September 2015. The policy described how cleaning should be completed at the premises including the treatment rooms and the general areas of the practice. Dental nurses had set responsibilities for cleaning and infection control in each individual treatment room. The practice had systems for testing and auditing the infection control procedures. Records showed all staff had received training in infection control.

An infection control audit had been completed on 10 November 2015. There were no action points arising from this audit. Records showed that six monthly audits were happening routinely.

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

We saw two dentists were using a safe system for syringes and needles in accordance with the sharps regulations 2013.

We saw that the cleaning cupboard was not organised in a way that would prevent cross infection. Cleaning mops were not stored upright, and were leaning against each other. This would allow cross infection from mop head to mop head. We brought this to the attention of the principal dentist who said that the cleaning cupboard and the arrangements for storing mops would be reviewed.

The practice had a clinical waste contract, and waste matter was collected on a regular two weekly basis. Clinical waste was stored securely while awaiting collection. The clinical waste contract also covered the collection of amalgam (dental fillings) which contains mercury and is therefore considered a hazardous material. The practice had spillage kits for both mercury and bodily fluids.

We saw that bins in the clinical areas were not foot pedal operated, but swing bins. This type of bin is a known risk of cross infection. We discussed this with the principal dentist who said arrangements would be made to replace the bins in the clinical areas.

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

We found that instruments were being cleaned and sterilised in line with the published guidance (HTM 01-05). The practice had an ultrasonic bath. An ultrasonic bath is a piece of equipment specifically designed to clean dental instruments through the use of ultrasound and water. After the ultrasonic bath Instruments were rinsed and examined using an illuminated magnifying glass. Finally the instruments were sterilised in an autoclave (a device for sterilising dental and medical instruments).

A dental nurse demonstrated the decontamination process, and we saw the procedures used followed the practice policy. Guidance and instructions were on display within the decontamination room for staff reference. However, when asked a dental nurse said they were not dismantling the amalgam guns before placing them into the ultrasonic cleaner. By not dismantling, effective cleaning could not be assured. An amalgam gun is used to push the amalgam into the cavity. The principal dentist said that procedures would be amended to ensure amalgam guns were dismantled during the cleaning process.

The practice had one vacuum autoclave. This was designed to sterilise wrapped or hollow 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.

Are services safe?

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 sharps injuries should receive these vaccinations to minimise the risk of contracting blood borne infections. A sharps injury is a puncture wound similar to one received by pricking with a needle.

The practice had a policy for assessing the risks of Legionella. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. This was to ensure the risks of Legionella bacteria developing in water systems had been identified and measures taken to reduce the risk of patients and staff developing Legionnaires' disease. Records showed that the practice was recording water temperatures regularly to monitor the risks associated with Legionella. In addition the practice was flushing the water lines used in the treatment rooms. This was done for two minutes at the start of the day, and for 30 seconds between patients, and again at the end of the day. A concentrated chemical was used for the continuous decontamination of dental unit water lines to reduce the risk of Legionella bacterium developing in the water lines.

Equipment and medicines

Records showed that equipment at the practice was maintained and serviced in line with manufacturer's guidelines and instructions. Portable appliance testing (PAT) had taken place on electrical equipment with the last testing recorded as 14 January 2014. Fire extinguishers were checked and serviced by an external company and staff had been trained in the use of equipment and evacuation procedures. Records showed the fire extinguishers had been serviced annually.

Medicines used at the practice were stored and disposed of in line with published guidance. Medicines were stored securely and there were sufficient stocks available for use. A log recording batch numbers was kept for antibiotic and local anaesthetic medicines.

Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities. However, the temperature of the medicines refrigerator was not being recorded. There were temperature sensitive medicines being stored within the refrigerator, including Glucagon (a hormone which promotes the breakdown of glycogen to glucose in the liver). Following discussion, the principal dentist said that temperatures would be taken and recorded starting with immediate effect.

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

Prescription pads at the practice were numbered and a log was kept. Numbered prescription pads were allocated to named individual dentists, and the prescription pads were stored securely when not in use.

Radiography (X-rays)

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

The practice did not have a single radiation protection file containing documentation to demonstrate the X-ray equipment had been maintained at the intervals recommended by the manufacturer. Information was held in several locations within the practice, as a result it took time to locate important information.

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

Emergency cut-off switches for the X-ray machines were located away from the machines and were clearly labelled. Every room in which an X-ray machine was located had appropriate signage on the door, to inform that an X-ray machine was located within.

Records showed the X-ray equipment had last been serviced on 18 January 2013. The Ionising Radiation Regulations 1999 (IRR 99) require that X-ray equipment is serviced at least once every three years.

Are services safe?

We discussed the procedures for taking X-rays with a dentist. This identified the practice monitored the quality of its X-ray images and had records to demonstrate this. The practice used conventional X-ray images not digital. Digital X-rays rely on lower doses of radiation, and do not require the chemicals to develop the images required with conventional X-rays.

All patients were required to complete medical history forms and the dentist considered each patient's individual circumstances to ensure it was safe for them to receive X-rays. This included identifying where patients might be pregnant. Patients' dental care records showed that information related to X-rays was recorded in line with current guidance from the Faculty of General Dental Practice (UK) (FGDP-UK). This included 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 given to patients by dental healthcare professionals. This information was recorded in an individual dental care record for each patient. We reviewed the dental care records for six patients, we found that an up to date medical history had been taken on each occasion. We did note that there were some inconsistencies in the information recorded by different dentists. We brought this to the attention of the principal dentist who said an audit of clinical records was due, and this would be addressed as part of the audit.

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

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 dentists used nationally recognised guidelines on which to base treatments and develop longer term plans for managing patients' oral health. Records showed that treatments had been relevant to the symptoms or findings. We saw that treatment options were usually explained to patients.

We spoke with dentists, and a dental nurse who said that each patient had their dental treatment and diagnosis discussed with them. Treatment options and costs were explained before treatment started, although not always clearly recorded. Several Care Quality Commission (CQC) comment cards (11) made specific reference to being involved in discussions about treatment options. Both patients we spoke with in the practice said treatment options were discussed and explanations given. Where relevant, information about preventing dental decay was given to improve the outcome for the patient. The dental care records were updated with the proposed treatment after discussing the options. Patients were monitored through follow-up appointments in line with National Institute for Health and Care Excellence (NICE) guidelines.

Discussions with dentists showed they were aware of NICE guidelines, particularly in respect of recalls of patients, antibiotic prescribing and wisdom tooth removal. A review of the records identified that the dentists were following NICE guidelines in their treatment of patients.

Health promotion & prevention

There was literature in the waiting room and reception area about the services offered at the practice. There were also leaflets about how to improve patients' oral health. However, these were limited, and a dental nurse said that the practice had run out of leaflets about smoking cessation. This would suggest there was a demand for such leaflets, and they would contribute to the practice's strategy on health promotion and prevention.

We saw examples in patients' dental care records that advice on smoking cessation, alcohol and diet had been discussed. With regard to smoking dentists had highlighted the risk of periodontal disease and oral cancer. However, we noted that there was inconsistency between dentists on how this information was recorded. Some dentists recorded health promotion advice, some did not. There was also a need to record when health promotion leaflets were given to patients, for example regarding smoking or alcohol.

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 and eight dental nurses who also work on reception. Prior to the inspection we checked

Are services effective?

(for example, treatment is effective)

the registrations of all dental care professionals with the General Dental Council (GDC) register. We found all staff were up to date with their professional registration with the GDC.

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

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

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment in the practice. For example referral for treatment at the dental hospital if the patient required more specialist attention. Following treatment by the 'other' dental professional(s) the practice monitored patients after their treatment. This was to ensure they had received satisfactory treatment and had the necessary after care after treatment at the practice. The practice also referred patients who were no longer physically able to access the dental premises due to the stairs.

The practice did not provide a conscious sedation service. This would be relevant to patients who were very nervous or who had a phobia about coming to the dentist. Patients who required this service were also referred to other practices that did provide conscious sedation.

Consent to care and treatment

The practice had a consent policy which had been reviewed and updated in September 2015. We saw that the practice used hard copy dental care records rather than an electronic system. Every patient's record card was stamped during treatment and signed by the patient onto their record card to show their consent. This was in addition to the patient signing their written treatment plan or estimate to signify their consent.

Discussions with a dentist and a dental nurse 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. We were given an example of a young person who had signed their own consent form at a follow up appointment. Their parent had been present at the initial consultation, and consent had been given then. At the follow up appointment, the parent was not present, but the dentist made sure the young person understood what was going to happen and they were able to give their consent.

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. Discussions with two members of staff identified their awareness and understanding of the MCA.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

During the inspection we took time to observe how the staff spoke with patients and whether they treated patients with dignity and respect. Our observations were of patients being treated politely, and in a professional manner. Care quality Commission (CQC) comment cards completed by patients identified they thought the staff treated patients with dignity and respect.

Reception staff told us that they were aware of the need for confidentiality when conversations were held in the reception area, particularly when other patients were present. They said that a private unused treatment room was usually available if needed, or the practice office.

We observed a number of patients being spoken with by staff and found that confidentiality was being maintained. We saw that patient dental care records were held securely and kept under lock and key.

We received feedback from 45 patients. A third of the patients made specific comments about being treated with dignity and respect. There were also comments about the staff being friendly and approachable and putting patients at ease.

Involvement in decisions about care and treatment

We received positive feedback from patients about the dental practice. This was both from speaking with patients in the practice and through Care Quality Commission (CQC) comment cards we left at the practice prior to our inspection. Patients said they were involved in decisions about their care and treatment, and many spoke positively about the dentists giving time and opportunity to ask questions.

The NHS Choices website did not describe the range of services offered to patients. With no website of their own, the NHS Choices website would be an avenue for patients to find out about the services on offer. Information on the NHS Choices website had not been updated since 15 April 2011, and did not accurately reflect the services and facilities on offer at the practice.

The practice offered both private and NHS treatments and both sets of costs were clearly displayed in the practice.

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Feedback from patients about appointments was positive. Four patients had made reference to appointments, and being seen quickly in an emergency. Six others had commented that it was easy to get an appointment at a time that suited. When patients were in pain or where treatment was urgent the practice made efforts to see the patient the same day.

New patients were asked to complete a medical and dental health questionnaire. This allowed the practice to gather important information about the patient's previous and current dental and medical history. For returning patients the medical history was updated so the dentists could respond to any changes in health status

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

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 was situated on the first floor of a building with no access apart from a staircase. The principal dentist told us there was an arrangement with another local dentist situated around the corner from the practice. This dentist had ground floor premises and was able to see any patients who could not access the stairs.

The practice had good access to all forms of public transport. Car parking was available either on the street or in a public car park outside the practice.

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 Mondays to Fridays 9:00 am to 5:30 pm apart from Wednesdays when the opening times were 9:00 am to 7:30 pm. Access for urgent treatment outside of opening hours was by ringing the practice and following the instructions on the recorded message. This information was available both in the practice and in the practice leaflet. The practice did not have a website.

We were told that the half hour before and after lunch were available for patients requiring emergency treatment. The allocation of these slots had meant that patients who were in pain could be seen quickly.

The practice had access to an interpreting service, both via the telephone and by booking interpreters in advance. This included interpreters who could communicate using British sign language for deaf patients.

Concerns & complaints

The practice had a complaints procedure that explained the process to follow when making a complaint. Information relating to making a complaint was displayed in the patient information folder in the waiting room. However, this information was not available in the practice leaflet. Staff said they were aware of the procedure to follow if they received a complaint. In addition the complaints procedure did not direct a complainant to contact either NHS England or the Health Ombudsman. This was if they were not satisfied with the practice response. The principal dentist agreed to amend the procedure, and add the contact details for both parties.

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

Are services well-led?

Our findings

Governance arrangements

There was a clear management structure at the practice. Staff said they understood whom they could speak with if they had any concerns. Staff said that the practice held regular staff meetings, and we saw copies of minutes from these meetings.

We reviewed a number of policies and procedures at the practice and saw that they had been reviewed during September or October 2015.

The practice registered with the Care Quality Commission as an organisation in May 2014. The registration status of being an organisation required a registered manager to be in place. The principal dentist was fulfilling this role. A registered manager is a person who is registered with the Care Quality Commission (CQC) to manage the service.

We saw that audits were taking place throughout the year for both clinical and non-clinical areas of the practice. For example both an Infection Prevention Society audit and a record keeping audit had been completed during 2015. Other audits included: consent, X-rays and health and safety and emergency procedures.

Leadership, openness and transparency

We saw minutes of meetings where information was shared and issues discussed with staff. The practice planned audits and staff meetings in advance. In addition we saw the annual training plan which identified how often training should be updated, and where this information was known the dates had been inserted.

Staff said there was an open and transparent culture at the practice which encouraged 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 we spoke with said the practice was a relaxed and friendly place to work. Staff told us that they could speak with the principal dentist if they had any concerns, and staff were aware of whistle blowing legislation and how to use it. Staff members said they felt part of a team, were well supported and knew what their role and responsibilities were.

Learning and improvement

The principal dentist said there had been a dental practice at the location for over 33 years. As a result there were limitations with the building, not least with regard to access for patients with restricted mobility. This was because expectations and legislation was different when the practice had been established. The principal dentist was aware of the limitations imposed by the building and was considering ways to improve the situation.

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. Documentation at the practice showed that training opportunities were available to all staff, and this was encouraged by the management team. Staff said they had good access to training, mostly in-house, but some external training too.

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

The practice had an NHS Friends & Family (F&F) box in the waiting room to collect the views of patients. Analysis of the friends & family information showed positive comments. Information within the practice identified that learning from complaints had been shared with staff, and acted upon.

The patients we spoke with said they were aware of the F & F box in the waiting room. However, none had ever completed a questionnaire, or provided any formal feedback to the practice.

The practice had completed its own patient satisfaction survey for the period 2014-2015. This being an annual process with the 2015-2016 patient survey due to be sent out in the weeks after this inspection. The practice used an external company to analyse the survey information, and we saw that results from the 2014-2015 survey were positive with a high number of patients expressing their satisfaction with the service provided.

The practice reviewed feedback from patients, and held regular staff meetings, which were fully minuted. There were clear lines of responsibility and accountability; staff knew who to report to if they had any issues or concerns.