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Noble Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 5 December 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

Noble Dental Practice has two dentists, (the principal dentist and an associate dentist), two part time dental hygienists, one of whom is a newly qualified foundation hygienist (The practice has been approved by the regional postgraduate deanery to provide education and supervision to foundation hygienists/therapists), a qualified dental nurse who is registered with the General Dental Council (GDC), two trainee dental nurses and two receptionists.

The practice's opening hours are 8am to 5pm on Monday and Tuesday, 9am to 5.30pm on Wednesday and Thursday and 9am to 1pm on Friday. The practice is closed for lunch each day between 1pm to 2pm.

Noble Dental Practice is a general dental practice offering treatment to adults and children funded by the NHS or privately. The practice has two dental treatment rooms on the ground floor and a reception and waiting area. There is a separate decontamination room for cleaning, sterilising and packing dental instruments.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. 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 comments from 18 patients by way of comment cards which were available at the practice for the two weeks prior to our inspection.

Our key findings were

Summary of findings

- The practice had not developed systems for the recording and learning from significant events and there was no policy available to guide staff although they did have an accident book.
- Staff had received training regarding safeguarding vulnerable adults and child protection and were aware of the procedure for reporting any suspicions of abuse although contact details were out of date on some information seen.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Patients were treated with dignity and respect.
- The practice was visibly clean and well maintained.
- Oral health advice and treatment were provided in-line with the 'Delivering Better Oral Health' toolkit (DBOH).
- Infection control procedures were in place with infection prevention and control audits being undertaken on a six monthly basis. Staff had access to personal protective equipment such as gloves and aprons.
- The provider had emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- Staff had been trained to deal with medical emergencies.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- Policies and procedures were available to guide staff, although not all contained a date of implementation or review.
- The practice was well-led and staff felt involved and worked as a team.

There were areas where the provider could make improvements and should

- Review the systems in place to record, investigate and learn from incidents that occur in the practice.
- Review the practice's policies, procedures and risk assessments; to ensure that a date of implementation and review is recorded, out of date information removed to avoid confusion for staff, reference is made to the Mental Capacity Act in the practice's consent policy and the practice's sharps procedure should be reviewed to ensure that due regard is given to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Review the systems in place for checking equipment to be used in a medical emergency to ensure the practice are giving due regarding to the guidelines provided by the Resuscitation Council (UK).
- Review the storage of dental care products and medicines requiring refrigeration to ensure they are stored in line with the manufacturer's guidance and the fridge temperature is monitored and recorded.
- Review the practice's audit protocols at regular intervals to help improve the quality of service. For example radiography and dental care records audits and ensure that all audits have documented learning points which are shared with relevant staff and the resulting improvements can be demonstrated.

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.

Systems were in place for recording significant events and accidents. Staff were aware of the procedure to follow to report incidents, accidents and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Medicines for use in an emergency were available on the premises as detailed in the Guidance on Emergency Medicines set out in the British National Formulary (BNF). Emergency medical equipment was also available and documentation was available to demonstrate that checks were being made to ensure equipment was in good working order and medicines were within their expiry date. Staff had received training in responding to a medical emergency. There were sufficient numbers of suitably qualified staff working at the practice. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults. The practice followed procedures for the safe recruitment of staff, this included carrying out disclosure and barring service (DBS) checks, and obtaining references.

Infection control audits were being undertaken on a six monthly basis which is in line with the recommendations of HTM 01-05. The practice had systems in place for waste disposal and on the day of inspection the practice was visibly clean and clutter free.

Are services effective?

No action

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

The dentist made accurate, detailed and contemporaneous notes in patient dental records. They used national guidance in the care and treatment of patients.

The practice followed best practice guidelines when delivering dental care. These included Faculty of General Dental Practice (FGDP) and National Institute for Health and Care Excellence (NICE).

The practice had developed a consent policy although this did not reference the Mental Capacity Act 2005 (MCA). However, the practice displayed guidance on the principles of the MCA and staff spoken with were aware of the MCA and its relevance in obtaining consent for patients who may lack capacity to consent for themselves.

Staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

Are services caring?

No action

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

Summary of findings

We observed the staff to be welcoming and caring towards the patients. Privacy and confidentiality were maintained for patients using the service on the day of the inspection. Staff were aware of the importance of confidentiality. Feedback from patients was positive. Patients praised the staff and the service and treatment received. Patients commented that staff were professional, friendly and helpful.

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 could access routine treatment and urgent or emergency care when required. The practice offered dedicated emergency appointments each day enabling effective and efficient treatment of patients with dental pain.

The practice had developed a complaints procedure and information about how to make a complaint was available for patients to reference.

The practice had made reasonable adjustments to enable patients in a wheelchair or with limited mobility to access treatment.

Are services well-led?

No action 

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

There were good governance arrangements and an effective management structure in place. Regular staff meetings were held although these were not formal documented meetings. Staff said that they felt well supported and could raise any issues or concerns with the principal dentist.

Annual appraisal meetings took place and staff said that they were encouraged to undertake training to maintain their professional development skills. Staff told us the provider was very approachable and supportive and the culture within the practice was open and transparent. Staff told us they enjoyed working at the practice and felt part of a team.

Noble Dental Practice

Detailed findings

Background to this inspection

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

This inspection took place on 5 December 2016 and was led by a CQC inspector and supported by a specialist dental advisor. Prior to the inspection, we reviewed information we held about the provider. We asked the practice to send us some information that we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, and the details of their staff members including proof of registration with their professional bodies.

During our inspection we toured the premises; we reviewed policy documents and staff records and spoke with four members of staff, including the principal dentist. We looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the computer system that supported the dental care records.

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.

No action

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Systems were in place to enable staff to report accidents. We saw that accident reporting books were available. There had been one accident reported within the last 12 months. We were told that accidents would be discussed with staff as and when they occurred.

The practice had not reported any significant events within the last 12 months. We saw that the practice had developed separate incident policies regarding child protection and information security. However the practice did not have a significant events policy and there was no documentation available to record incidents, action taken, outcomes or learning.

All staff we spoke with understood the Reporting of Injuries, Diseases and Dangerous Occurrences regulations (RIDDOR) and who to report incidents to. We were told that there had been no events at the practice that required reporting under RIDDOR.

We discussed national patient safety and medicines alerts with the principal dentist. We were told that practice had not received any of these alerts recently. During our discussions we identified that the practice had not subscribed to receive Medicines and Healthcare products Regulatory Agency (MHRA) alerts via email. These were sent out centrally by a government agency (MHRA) to inform health care establishments of any problems with medicines or healthcare equipment. During the inspection the principal dentist provided evidence to demonstrate that they had registered to receive MHRA alerts.

The practice's complaint policy recorded information regarding Duty of Candour. Duty of Candour is a legislative requirement for providers of health and social care services to set out requirements that must be followed when things go wrong with care and treatment. For example informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The principal dentist confirmed that the ethos of the practice was open and honest and staff always apologised when things went wrong or when a complaint was received.

Reliable safety systems and processes (including safeguarding)

The practice had developed policies regarding child protection and safeguarding vulnerable adults.

Details of how to report suspected abuse to the local organisations responsible for investigation were available although some documentation contained out of date contact details. There was no date of implementation or review recorded on these policies and it therefore might be difficult for staff to identify the most up to date information. Various other pieces of information regarding child protection and safeguarding vulnerable adults were available to guide staff. For example child protection roles and responsibilities, child protection flow chart

Policies seen did not identify the safeguarding lead; however staff spoken with said that they would speak with the principal dentist if they needed to report suspicions of abuse. We were told that this dentist was always available for help and advice if needed.

There had been no safeguarding issues to report at this practice. We saw evidence that all staff had completed the appropriate level of safeguarding training.

We discussed the prevention of needle stick injuries with the principal dentist. They explained that the treatment of sharps and sharps waste was in accordance with the current EU Directive with respect to safe sharp guidelines, thus protecting staff against blood borne diseases. The practice used a system whereby needles were not manually re-sheathed using the hands following administration of a local anaesthetic to a patient. The dentists were responsible for ensuring safe recapping using a 'scoop' method, a recognised way of recapping a used needle using one hand. They were also responsible for disposing of the used needles into the appropriate sharps' bin.

We were told that there had been no sharps injuries. Accident records shown to us confirmed this.

Sharps information was on display in treatment rooms and other locations where sharps bins were located.

The practice had not completed a sharps injury risk assessment. This important document should inform staff of the equipment which could cause a needle stick injury and any actions required to reduce the risk of injury.

We asked about the instruments which were used during root canal treatment. We were told that root canal treatment was carried out where practically possible using

a rubber dam. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work).

Medical emergencies

The dental practice had medicines and equipment in place to manage medical emergencies. Emergency medicines seen were as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice and all were in date.

Emergency equipment including oxygen and an automated external defibrillator (AED) (a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm), were available. Records shown to us demonstrated that the AED was checked on a monthly basis and oxygen was checked on a weekly basis to ensure that they were in good working order. Guidelines provided by the Resuscitation Council (UK) suggest that checks should be undertaken on at least a weekly basis.

Staff had all received annual training in basic life support with the date of the last training of 1 June 2016.

We saw that a first aid kit was available which contained equipment for use in treating minor injuries. Staff were aware of the location of the first aid kit. We discussed first aid training with the principal dentist and were told that none of the staff had received training but this would be addressed as soon as possible.

Staff recruitment

The practice had a recruitment and human resources file which contained information and guidance regarding the recruitment process. We discussed the recruitment of staff and were told that the hygienist and the three dental nurses had been employed during 2016. We looked at these recruitment files in order to check that recruitment procedures had been followed.

Recruitment files contained information such as proof of identity, contracts of employment, details of registration with professional bodies and training certificates. We saw that a written reference was available in one file but not in other files seen. There was also a pre-employment medical questionnaire in one file. The principal dentist told us that potential employees were asked verbally during interview if they had any medical conditions that may impact upon their work. A questionnaire would then be completed as necessary. We were also told that references had not been obtained for those staff who were training at the practice, for example the dental nurses or foundation hygienist but references would be sought for other employees.

Disclosure and barring service checks (DBS) were in place or had been applied for and we were told that these had been completed for all staff. 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.

The practice planned for staff absences to ensure the service was uninterrupted. We were told that dental nurses provided cover for each other during times of annual leave or unexpected sick leave. The practice had arrangements with another local practice to provide emergency cover at times of annual leave or unexpected sick leave of the dentist. There were enough staff to support dentists during patient treatment. We were told that all dentists worked with a dental nurse. The dental hygienists also worked with a dental nurse.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice had developed a health and safety policy and a health and safety poster was on display in the staff room. One health and safety policy seen did not record a date of implementation or review. However a health and safety policy statement seen in a different file recorded a review date of November 2016. The principal dentist was the named lead regarding health and safety. All staff spoken with said that they could speak with the principal dentist for health and safety advice if required.

Risk assessments had been completed relating to fire, radiation, lone working and a general practice risk assessment. Not all of the risk assessments seen recorded a date for review. An internal health and safety inspection was completed on an annual basis.

We discussed fire safety with principal dentist and looked at the practice's fire safety risk assessment and associated documentation. We saw that a fire risk assessment had been completed on 20 July 2014, and a further risk

assessment completed on 20 May 2016 which identified a low level of risk. The principal dentist was responsible for fire safety and a receptionist had been identified as the deputy.

Records seen confirmed that fire extinguishers were subject to routine maintenance by external professionals with the date of last service being 29 November 2016. We were told that the landlord of the premises was responsible for service of emergency lighting and the fire alarm. There was no documentary evidence available to demonstrate when this equipment was last serviced. The principle dentist confirmed that they would obtain this information from the landlord.

We saw that weekly fire alarm checks were completed and records showed that a fire drill took place in July 2014 and a review, "fire drill what to do" was completed in July 2016.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. Details of all substances used at the practice which may pose a risk to health were recorded in a COSHH file and actions described to minimise their risk to patients, staff and visitors were recorded. An itemised list was available which had been reviewed and updated when new products were used and when products were no longer used at the practice.

Infection control

As part of our inspection we conducted a tour of the practice we saw that the dental treatment room, waiting area and reception were visibly clean, tidy and uncluttered. Dental nurses who worked at the practice were responsible for undertaking all environmental cleaning of both clinical and non-clinical areas. Cleaning logs were available for both clinical and non-clinical areas to demonstrate cleaning undertaken. The practice followed the national colour coding scheme for cleaning materials and equipment in dental premises and signage was in place to identify which colour of cleaning equipment was specific for use in that area.

The practice had developed an infection control folder. All of the contents of this folder were reviewed on an annual basis with the date of last review being 5 may 2016. This folder contained various infection prevention and control related policies, for example decontamination processes, infection prevention and control, hand hygiene, cleaning, legionella, equipment testing protocols and a sharps and blood spillage policy.

A general infection prevention and control policy statement was on display in the decontamination room. This recorded the name of the principal dentist as the infection control lead. The principal dentist was responsible for ensuring infection prevention and control measures were followed.

We discussed infection prevention and control audits with the principal dentist. We were shown a copy of an audit completed on 28 November 2016 which the practice achieved an assessment score of 94%. We were told that in the future these audits would be completed on a six monthly basis.

Staff were immunised against blood borne viruses (Hepatitis B) to ensure the safety of patients and staff and records were available to demonstrate this.

Records demonstrated that all qualified clinical staff had undertaken training on an annual basis regarding the principles of infection control. Trainee dental nurses were undertaking this as part of their training course.

Staff had access to supplies of personal protective equipment (PPE) for themselves and for patients. Staff uniforms ensured that staff member's arms were bare below the elbow. Bare below the elbow working aims to improve the effectiveness of hand hygiene performed by health care workers.

We looked at the procedures in place for the decontamination of used dental instruments. A dental nurse demonstrated the decontamination process and we found that instruments were being cleaned and sterilised in line with the published guidance (HTM 01-05).

A dental nurse showed us the procedures involved in disinfecting, inspecting and sterilising dirty instruments; packaging and storing clean instruments. The practice routinely used an ultrasonic bath to clean the used instruments. A visual inspection was undertaken using an illuminated magnifying glass and then instruments were sterilised in an autoclave (a device for sterilising dental and medical instruments). There was a clear flow of instruments through the dirty zone to the clean area. Staff wore personal protective equipment during the process to protect themselves from injury which included gloves,

aprons and protective eye wear. Clean instruments were packaged; date stamped with a use by date one year from the day of sterilisation. and stored in accordance with current HTM 01-05 guidelines.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria legionella is a term for particular bacteria which can contaminate water systems in buildings) they described the method they used which was in line with current HTM 01 05 guidelines.

A risk assessment regarding Legionella had been carried out by an external agency on 2 December 2016. We saw records to confirm that routine temperature monitoring checks and waterline test strips were being completed on a monthly basis.

We discussed clinical waste and looked at waste transfer notices. We saw that the practice had a contract in place regarding the disposal of clinical and municipal waste. We were told that the practice telephoned the waste contractor to arrange collection. Clinical waste was securely stored in an area of the practice where members of the public could not access it. The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health.

Equipment and medicines

We saw that maintenance contracts were in place for essential equipment such as X-ray sets which were serviced on 25 November 2016, the autoclave was serviced on 6 September 2016 and

fire safety equipment which was serviced on 29 November 2016.

We were not shown records to demonstrate the dates of service for the compressor or the ultra-sonic cleaner as we were told that these had been newly purchased and were not due for service. We were not shown any records to demonstrate the date of purchase or date that the next service was due. However following this inspection we received a copy of documentation demonstrating that the compressor had been serviced following this inspection.

All portable electrical appliances at the practice had received an annual portable appliance test (PAT) on 7 September 2016.

We saw that one of the emergency medicines (Glucagon) was being stored in the fridge. Glucagon is used to treat diabetics with low blood sugar. This medicine could be stored at room temperature with a shortened expiry date; however it was the practice's preference to store this medicine in the fridge. Records were not kept to demonstrate that medicines were stored in the fridge at the required temperature of between two and eight degrees Celsius.

Dental treatment records showed that the batch numbers and expiry dates for local anaesthetics were recorded when these medicines were administered. Prescription pads were kept locked away, and a log was kept of their use.

Radiography (X-rays)

The principal dentist told us that a Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure equipment was operated safely and by qualified staff only. Records seen confirmed that the principal dentist was the RPS and an external company the RPA. A contract was in place to ensure that the company provided this service.

The practice had two intra-oral X-ray machines which can take an image of a few teeth at a time, and one orthopantomogram (OPG) machine which can take a panoramic X-ray of the jaws. Digital X-rays were used which do not require chemical processing. In addition they are available to view almost instantly, and use a lower effective dose of radiation than traditional films.

We saw evidence that all of the dentists were up to date with the required continuing professional development on radiation safety.

We saw that the practice had notified the Health and Safety Executive that they were planning to carry out work with ionising radiation on 29 June 2005.Local rules were available in the rooms were X-ray machines were located for all staff to reference if needed.

Copies of the critical examination packs for each of the X-ray sets along with the maintenance logs were available for review. The maintenance logs were within the current recommended interval of three years.

Dental care records where X-rays had been taken showed that dental X-rays were justified and reported on every time.

We discussed radiography audits with the principal dentist. We were told that the practice had not completed a

No action

Are services safe?

radiography audit within the last few years. Audits would help to ensure that best practice was being followed and highlight improvements needed to address shortfalls in the delivery of care.

No action

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Wediscussed patient care with the dentist and checked dental care records to confirm the findings. The practice kept up to date dental care records. They contained information about the patient's current dental needs and past treatment. We were told that an examination of the patient's teeth, gums and soft tissues was completed in line with recognised guidance from the Faculty of General Dental Practice (FGDP). During this assessment dentists looked for any signs of mouth cancer. Detailed records were kept which included details of the condition of the teeth and the gums using the basic periodontal examination (BPE) scores. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). We saw that patients were requested to complete or update medical history records at every appointment.

The dentists used NICE guidance to determine a suitable recall interval for the patients. This takes into account risk factors such as diet, oral cancer, tooth wear, dental decay, gum disease and patient motivation to maintain oral health into consideration to determine the likelihood of patients experiencing dental disease. Patients could be referred to the dental hygienist if required.

Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained in detail. Patients were given written treatment plans and were given the option to go away and think about treatment before any agreement was reached to continue.

The decision to take an X-ray was made according to clinical need and in line with recognised general professional guidelines. Patient dental care records that we saw demonstrated that all of the dentists were following the guidance from the Faculty of General Dental Practice (FGDP) regarding record keeping.

Health promotion & prevention

We discussed oral health and preventative care with the principal dentist and staff. We saw that some staff had received training regarding 'Delivering better oral health: an evidence-based toolkit for prevention'. This is a toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

We found a good application of guidance issued in the DH publication when providing preventive oral health care and advice to patients. We were shown entries in dental care records that detailed patients' oral health, discussions that had taken place with patients regarding improving oral health. We were told that the dentist explained tooth brushing and interdental cleaning techniques to patients in a way they understood. Patients were also referred to the dental hygienist if needed who would also give detailed information about oral health and hygiene.

The practice had a display in the waiting room informing patients of the amount of hidden sugar in different types of foods and leaflets regarding oral hygiene were available in the waiting room. Free samples of toothpaste were available on the reception desk and the practice had a selection of dental products on sale in the reception area to assist patients with their oral health.

Staffing

Practice staff included two dentists, (the principal dentist and an associate dentist), two part time dental hygienists, one of whom is a newly qualified foundation hygienist, a qualified dental nurse who is registered with the General Dental Council (GDC), two trainee dental nurses and two receptionists.

We discussed staff training with the principal dentist. We also looked at some staff training certificates; these demonstrated that staff were meeting their CPD requirements. CPD is a compulsory requirement of registration as a general dental professional. Clinical staff were up to date with their recommended CPD as detailed by the GDC including medical emergencies, infection control and safeguarding training. Staff had access to on-line training courses and staff confirmed that they were encouraged to attend training courses and supported to develop their skills.

Records shown to us demonstrated that professional registration with the GDC was up to date for all relevant staff.

No action

Are services effective?

(for example, treatment is effective)

Appraisal systems were in place. Staff said that these were held on an annual basis. We saw that personal development plans were available for staff. However information recorded in appraisal documentation and personal development plans was brief.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves. For example referrals were made for patients who required sedation, oral surgery or community services.

A computerised referral log was set up for each patient, a copy of the referral letter was kept and patients were offered a copy. Systems were in place to ensure referrals were received in a timely manner, referrals would be sent by fax, NHS mail and post.

We saw a template that was used in the treatment room to refer patients to hospital if they had a suspected oral cancer. These were comprehensive, and dentists followed Faculty of General Dental Practice (FGDP) guidelines when making notes for these referrals.

Consent to care and treatment

The practice had developed a consent policy although this did not reference the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The practice displayed guidance on the principles of the MCA and staff spoken with were aware of the MCA and best interest decisions.

There were no recent examples of patients where a mental capacity assessment or best interest decision was needed. However there were no capacity assessment forms should these be required.

The practice demonstrated a good understanding of the processes involved in obtaining full, valid and informed consent for an adult. Written consent forms were available for more complex treatments such as root canal treatments, extractions and whitening. The principle dentist confirmed that individual treatment options were discussed with each patient. We were told that patients were given verbal information to support them to make decisions about treatment. We were shown entries in dental care records where treatment options were discussed with patients. There was evidence in records that consent was obtained. In addition a written treatment plan with estimated costs was produced for all patients to consider before starting treatment. Treatment plans were available for patients receiving NHS or private treatment.

We saw that consent was reviewed as part of a recent record card audit.

No action

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We were told that privacy and confidentiality were maintained at all times for patients who used the service. We observed staff to be friendly and helpful to patients when interacting with them. Information we received from patients on comment cards indicated that they were very happy with the level of care they received from the practice, with some commenting that staff were pleasant, respectful and helpful and good at putting nervous patients at ease.

Staff we spoke with explained how they ensured information about patients using the service was kept confidential Patients' clinical records were stored electronically. Computers were password protected and backed up on a daily basis to secure storage. The computer screens at the reception desks were positioned below the level of the counter so that they could not be overlooked by a patients stood at the reception. If computers were ever left unattended then they would be locked to ensure confidential details remained secure.

To help maintain privacy and dignity we saw that the treatment room was situated off the waiting area. Doors were closed at all times when patients were with the dentist. Conversations between patient and dentist could not be heard from outside the treatment rooms which protected patient's privacy.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. A dental nurse told us that patients were shown a large model of the mouth to explain treatment and oral hygiene techniques. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them.

Details of NHS costs were on display in the reception area.

We spoke with the dentist and a trainee dental nurse about the Gillick competency test. The test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions about their care and treatment. These staff demonstrated a good understanding of Gillick principles.

No action

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided NHS treatment with private treatment upgrades available. NHS treatment costs were clearly displayed in the waiting area and private costs were available upon request and would be discussed with patients before agreement was reached to provide any private treatment. Patients would be given a treatment plan which recorded full information about treatments and costs.

We discussed appointment times and scheduling of appointments. We found the practice had an efficient appointment system in place to respond to patients' needs. Patients were given adequate time slots for appointments of varying complexity of treatment. We were told that vacant appointment slots were kept each morning and afternoon to accommodate urgent appointments for patients in dental pain. If the emergency slots had already been taken for the day then the patient was offered to sit and wait for an appointment if they wished.

Tackling inequity and promoting equality

This practice was suitable for wheelchair users, having ground floor treatment rooms which were large enough to accommodate a wheelchair or a pram. Access to the front of the building was via a few small steps, however a stair lift was provided. Level access was provided to the side of the building and an accessible toilet suitable to meet the needs of people with restricted mobility was available.

The practice did not have a hearing induction loop for use by people who were hard of hearing. However staff said that alternative methods were used to communicate with these patients.

We asked about communication with patients for whom English was not a first language. We were told that patients could communicate in English sufficiently to make their needs known.

The practice did not have access to a recognised company to provide interpreters. The principal dentist said that there were very few patients who could not speak English and therefore interpreting was not an issue.

Access to the service

The practice was open from 8am to 5pm on Monday and Tuesday, 9am to 5.30pm on Wednesday and Thursday and 9am to 1pm on Friday. The practice closed for lunch each day between 1pm to 2pm and a telephone answering machine informed patients that the practice was closed at lunchtime. A separate telephone answering machine message gave emergency contact details for patients with dental pain when the practice was closed during the evening, weekends and bank holidays.

Patients were able to make appointments over the telephone or in person. Reception staff told us that patients were usually able to get an appointment to see a dentist within two days of their initial contact unless they were in dental pain in which case they were seen within 24 hours. Emergency appointments were set aside for each dentist every day in the morning and afternoon; this ensured that patients in pain could be seen in a timely manner.

We were told that staff always tried to accommodate patient's wishes regarding appointment times and tried to offer appointments based around patient's working arrangements were necessary. Patients were given a telephone call as a reminder approximately one week prior to their appointment.

Concerns & complaints

The practice had a complaints policy and a procedure that set out how complaints would be addressed, who by, and the timeframes for responding. The policy recorded contact details such as NHS England and the Parliamentary and Health Service Ombudsman and the Dental Complaints service (for private patients). This enabled patients to contact these bodies if they were not satisfied with the outcome of the investigation conducted by the practice. Staff spoken with were knowledgeable about how to handle a complaint.

We were shown the complaint folder and saw that the practice had not received any complaint within the last 12 months. Records regarding previous complaints were shown to us, these demonstrated that complaints were investigated and patients were offered an initial apology and assistance to sort out any problems. The practice's complaints policy records that staff should always offer an apology and try to resolve all issues; information regarding 'Duty of Candour' was also included in the complaint policy.

No action

Are services responsive to people's needs?

(for example, to feedback?)

Patients were given information on how to make a complaint. We saw that a copy of the complaints policy was on display in the waiting area.

No action

Are services well-led?

Our findings

Governance arrangements

The principal dentist was in charge of the day to day running of the service. We noted clear lines of responsibility and accountability across the practice team.

The practice had policies and procedures in place to support the management of the service, and these were readily available for staff to reference. These included health and safety, complaints, safeguarding adults and protecting children, whistle blowing and infection control. A staff handbook was available for staff and all staff had read this during their induction to the practice.

Risk assessments were in place to mitigate risks to staff, patients and visitors to the practice.

These included risk assessments relating to fire, radiation, lone working and a general practice risk assessment. These helped to ensure that risks were identified, understood and managed appropriately. However not all of the risk assessments seen recorded a date for review.

Leadership, openness and transparency

The practice had clear lines of responsibility and accountability. Staff were aware of their roles and responsibilities and were also aware who held lead roles within the practice. The principal dentist was available on a day to day basis to provide advice and support to staff at this practice.

We were told that formally documented staff meetings were not held. Staff confirmed that informal meetings were held on at least a daily basis. For example if necessary staff discussed the day ahead prior to the practice opening to patients or staff met during lunch and at the end of the day. A message book was available and staff were able to leave messages for issues to be discussed with staff during informal meetings. Staff we spoke with reported an open and honest culture across the practice and they felt fully supported to raise concerns with the principal dentist.

Annual appraisal meetings were held and personal development plans available for all staff although documentation available was brief. Staff confirmed that they were encouraged and supported to undertake training.

Learning and improvement

The practice did not have a structured plan in place to audit quality and safety. We were shown one infection control audit which was completed on 28 November 2016. We were told that in the future these audits would be completed on a six monthly basis. We were not shown documentary evidence to demonstrate that infection prevention and control audits had been completed on a six monthly basis in accordance with HTM 01(05) guidance.

We asked to see copies of other audits such as radiography but where told that this audit had not been completed within the last 18 months. We were shown a copy of the record card audit but this was not dated to demonstrate when this audit had been completed.

Staff were supported in achieving the General Dental Council's requirements in continuing professional development (CPD). We saw evidence that all clinical staff were up to date with the recommended CPD requirements of the GDC.

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

The practice had systems in place to seek and act on feedback from patients including those who had cause to complain. We saw that there was a suggestions box in the waiting area and the friends and family test (FFT) was available for patients to complete. The FFT is a national programme to allow patients to provide feedback on the services provided. We looked at the FFT results for 2015 and 2016. Responses received were positive, the NHS Choices website records that 100% of patients would recommend this practice (28 patients responded).

The principal dentist told us that the last in-house patient satisfaction survey was completed in 2015 and we saw the results of this survey which were positive. Since the introduction of the FFT the practice had not carried out their own satisfaction survey. We were told that the results of FFT or comments and complaints received would be discussed with staff during one of their daily meetings.

Staff said that they would speak with the principal dentist if they had any issues they wanted to discuss. We were told that feedback would always be welcomed and the principal dentist was open and approachable and always available to provide advice and guidance.