Colin Doody Limited

The Dental Practice at Dronfield Woodhouse

Inspection Report

41 Pentland Road,
Dronfield Woodhouse
Dronfield,
Derbyshire
S18 8ZQ
Tel: 01246418979
Website: www.dental-dw.co.uk

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Overall summary

We carried out an announced comprehensive inspection on 8 September 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

The Dental Practice at Dronfield Woodhouse was registered with the Care Quality Commission (CQC) in December 2013 to provide dental services to patients in Dronfield Woodhouse and the surrounding areas. The practice provides private dental treatment. Services provided include general dentistry, dental hygiene, teeth whitening, crowns and bridges, root canal treatment and conscious sedation. The practice is situated in a building in Dronfield Woodhouse in north Derbyshire. All of the clinical and treatment rooms are located on the ground floor. The practice is open 09:00 am to 1:00 pm & 2:00 pm to 6:00 pm on Mondays; 09:00 am to 1:00 pm & 2:00 pm to 5:00 pm on Tuesdays, Wednesdays and Thursdays; 09:00 am to 12:30 pm & 1:00 pm to 3:30 pm on Fridays.

Access for urgent treatment outside of opening hours is usually through the emergency dental NHS direct telephone line.

The practice has two dentists, two dental hygienists/ therapists, and two dental nurses. There is a practice manager, a receptionist and a cleaner.

Summary of findings

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

We received feedback from 57 patients about the services provided. Feedback was wholly positive. Several patients said they had been coming to the practice for over 20 years. All of the feedback identified patients were extremely happy with the dental service provided.

Our key findings were:

- The practice had systems for recording accidents, significant events and complaints.
- Learning from any complaints and significant incidents were recorded and learning was shared at staff meetings.
- The dental practice was located on the ground floor and allowed easy access to patients with restricted mobility.
- The practice was visibly clean.
- The practice had provided training in safeguarding and whistle blowing for all staff, and staff were aware of these procedures and the actions required.
- Patients said they were very satisfied with the service they received.
- Patients said they were treated with dignity and respect, our observations confirmed this.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Staff had been trained to deal with medical emergencies.
- Emergency medicines and oxygen were readily available.
- The practice was carrying out sedation services for nervous patients using nitrous oxide (laughing gas).
- Following the inspection the practice purchased an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.
- The principal dentist was contacting patients after their treatment to ensure they had no on going issues with pain or discomfort, and to offer reassurance. Thereby demonstrating a caring and compassionate approach.
- The practice followed the relevant guidance (Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control.
- Patients' care and treatment was planned and delivered in line with National Institute for Health and Care Excellence (NICE) guidelines.
- Patients were involved in making decisions about their treatment, and options were identified and explored with them.
- Patients' confidentiality was maintained.

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

- Check staff personnel files to be assured they are up-to-date with all required information.
- Introduce weekly testing of the ultrasonic cleaner, with records demonstrating the tests had been completed.
- Consider staff training for all staff involved in the operation of X-ray machines.
- Review patients' notes when consent is an issue, so that the patient's notes fully identify the discussion and decision making process.
- Introduce a system for producing an action plan when patient surveys are analysed, and there are areas where a score of less than 100% is recorded, or there are negative comments.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

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

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts and information was shared with staff.

Staff had been trained in safeguarding vulnerable adults and children. There were clear guidelines for reporting concerns and the practice had a lead member of staff to offer support and guidance over safeguarding matters. There had been no safeguarding issues recorded in the previous 12 months.

The practice purchased an automated external defibrillator (AED) following the inspection.

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

Infection control procedures 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. However, the ultrasonic cleaner used as a back-up was not being routinely checked.

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

Are services effective?

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

Patients were assessed before treatment began. This included completing a health questionnaire or updating one for returning patients who had previously completed a health questionnaire.

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

Patients were advised of the potential health risks posed by alcohol and tobacco.

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 worked to maintain patients' confidentiality.

Feedback from patients was very positive, with particular reference to the friendliness and approachability of staff.

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

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

Summary of findings

Patients said they felt involved in their care, and were able to express their views and opinions.

Are services responsive to people's needs?

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

The appointments system was accessible and met patients' needs. The practice made every effort to see patients who were in pain or in need of urgent treatment the same day.

The practice was able to meet the needs of patients with restricted mobility, as there was level access, and all treatment rooms were on the ground floor.

There were arrangements for emergency dental treatment outside of normal working hours, including weekends and public holidays which were clearly displayed in the waiting room, on the practice website and the practice leaflet.

Are services well-led?

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

The practice held regular staff meetings to share information and discuss making improvements.

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

Patients were able to express their views and comments.

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

The Dental Practice at Dronfield Woodhouse

Detailed findings

Background to this inspection

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

We carried out an announced, comprehensive inspection on 8 September 2015. The inspection team consisted of two Care Quality Commission (CQC) inspectors 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 six members of staff, including the management team.

Prior to the inspection we asked the practice to send us information which we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, the details of the staff members, their qualifications and proof of registration with their professional bodies.

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

During the inspection we spoke with two dentists, one dental hygienist, the practice manager, two dental nurses and one receptionist. We reviewed policies, procedures and other documents. We received feedback from 57 patients about the 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 dental practice had a policy for recording accidents to both staff and patients. Records showed the last accident had occurred in June 2014, with no accidents recorded in the last year. Documentation showed that learning had been shared following accidents in the past. The practice had policies for complaints and critical incidents. The minutes of a staff meeting dated 29 September 2014 showed complaints had been discussed and the policy updated and reviewed. In addition the minutes identified that safety issues had been prominent in the discussions, for example safeguarding, needle stick injuries and fire safety were all discussed.

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 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. We saw an example of an alert which identified a problem with window blinds. The practice manager demonstrated how following the alert all window blinds in the practice had been checked and action taken to make them safe.

Reliable safety systems and processes (including safeguarding)

The practice had a policy for both safeguarding vulnerable adults and children. The policies were in date and had been reviewed. Information on how to raise concerns and who to contact at the local authority was available to all staff. The practice had an identified lead member of staff for safeguarding and they had been trained to an appropriate level to be able to take the lead. Staff training records showed that all staff had been trained in safeguarding vulnerable adults and children in February 2015. The practice manager said there had been no recorded safeguarding incidents at the practice.

The practice had a policy to assess the risks associated with the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. The practice had identified potentially hazardous substances in use at the dental practice. Each substance was identified and risk assessed. Steps to reduce the risks included the use of personal protective equipment for staff and patients and safe and secure storage of hazardous materials. The practice had data sheets from the manufacturer on file to inform staff what action to take if an accident occurred for example in the event of any spillage. Following the inspection COSHH materials were moved to a more secure area.

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

Discussions with dentists and examination of patients' notes identified the dentists were using rubber dams when completing all endodontic treatments. Endodontic treatments are those which deal with the inner pulp of the tooth and include root canal treatments. This was in line with guidelines from the British Endodontic Society. A rubber dam is a thin rubber sheet that isolates selected teeth and protects the rest of the patient's mouth during treatment.

Medical emergencies

The dental practice had emergency medicines and oxygen to deal with any potential medical emergencies.

The medicines were as recommended by the 'British National Formulary' (BNF). We checked the medicines and found them all to be in date. There was a system for checking and recording expiry dates of medicines, and replacing them when necessary.

The practice purchased an automated external defibrillator (AED) following the inspection. 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. Previously the practice had accessed an AED from

Are services safe?

the GP surgery which was located next door to the dental practice. All emergency equipment and medicines were stored centrally with all staff being able to access them if required. Records showed all staff had completed basic life support and resuscitation training and this was up-to-date. The training included the use of an AED. The practice manager said this training was updated annually for all staff.

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

Discussions with staff identified they understood what action to take in a medical emergency. They were able to describe those actions in relation to various medical emergencies including a cardiac arrest (heart attack).

Staff recruitment

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

We found that for most staff the practice recruitment policy and the regulations had been followed. However, we saw one member of staff who did not have the required documentation. We discussed this with the practice manager who said that the necessary documentation was available, but had not been put in the file. This was for a new member of staff who had just started working at the practice. We saw the evidence during the inspection.

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

Monitoring health & safety and responding to risks

The practice had a health and safety policy and environmental risk assessments. Risks to staff and patients had been identified and assessed, and the practice had introduced measures to reduce those risks. For example: a needle stick injury policy and discussion in staff meetings to reduce the risk.

The practice had specific policies and procedures to manage other identified risks. For example: A Control of Substances Hazardous to Health (COSHH) policy and risk assessments; fire safety policies and procedures and an infection control policy. Staff told us that fire detection and fire fighting equipment such as fire alarms and emergency lighting were regularly tested, and we saw records in respect of these checks had been completed. The fire risk assessment was dated 25 September 2014, and the fire extinguishers had been serviced and checked on March 2015.

Staff training records identified that all staff had received up-to-date fire training. The last fire evacuation drill was recorded on 29 September 2014.

Infection control

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

The practice had an infection control policy, 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.

An infection control audit had been completed on 2 September 2015. There were no action points arising from this audit, as the practice scored 100%.

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

Are services safe?

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' ad the practice was following that guidance.

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

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

A dental nurse demonstrated the decontamination process, and we saw the procedures used followed the practice policy. Guidance and instructions were on display for staff reference. The instruments were cleaned manually, rinsed and examined using an illuminated magnifying glass. Finally the instruments were sterilised in an autoclave (a device for sterilising dental and medical instruments).

At the completion of the sterilising process, instruments were dried, packaged, sealed, stored and dated with an expiry date.

We checked the records to see 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 this and to ensure that equipment was functioning correctly. Records showed that the equipment was in good working order and being effectively maintained. The practice also had an ultrasonic cleaner. An ultrasonic bath is a piece of equipment specifically designed to clean dental instruments through the use of ultrasound and water. This was used as a backup should the washer disinfector fail. However, the ultrasonic cleaner was not being routinely tested so that should it be needed, the staff could not have confidence that it was in good working order. The provider agreed to start testing the ultrasonic cleaner weekly and recording the results of the test.

Staff files showed that staff had received inoculations against Hepatitis B and received regular blood tests to check the effectiveness of that inoculation. People (staff) who are likely to come into contact with blood products, or are at increased risk of needle stick injuries should receive these vaccinations to minimise the risk of contracting blood borne infections. A needle stick injury is a puncture wound similar to one received by pricking with a needle.

The practice had completed a risk assessment for assessing the risks of Legionella. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. Regular temperature checks and flushing would significantly reduce the risk of Legionella developing. 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. This was in line with national guidance.

Equipment and medicines

Records showed that equipment at the practice was maintained and serviced in line with manufacturer's guidelines. Portable appliance testing (PAT) had taken place on electrical equipment, and was due for renewal in March 2016. 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, with the last service having been in March 2015.

Medicines used at the practice were stored and disposed of in line with published guidance. There were sufficient stocks available for use. Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities.

Emergency medicines and oxygen were available, and located centrally and securely for use in an emergency.

Radiography (X-rays)

The practice had two intra oral X-ray machines for X-raying individual teeth, or parts of the mouth, one located in each

treatment room. There was also one extra-oral X-ray machine (an orthopantomogram known as an OPG) for taking X-rays of the entire jaw and lower skull, this was located in the corridor. X-rays were carried out in line with local rules that were relevant to the practice and specific equipment. The local rules for the use of each X-ray machine were available in each area where X-rays were carried out. The practice had started using digital X-rays which were developed electronically. This had removed the need for staff to develop the X-rays using chemicals in the practice.

The practice had a radiation protection file which contained documentation to demonstrate the X-ray equipment had been maintained at the intervals recommended by the manufacturer. Records showed that the dates X-ray equipment was tested and serviced.

The local rules identified the practice had a radiation protection supervisor (the principal dentist) and a radiation protection advisor, as identified in the Ionising Radiation Regulations 1999 (IRR 99). Their role was to ensure the equipment was operated safely and by qualified staff only. Staff members authorised to carry out X-ray procedures were clearly identified. However, the dental nurses did not have radiography qualifications, but were observed being involved in the process. The dentists were supervising, although it would be safer if all staff involved in the X-ray processes were qualified to do so.

The OPG machine had been installed on 14 August 2015. When asked staff members were unsure where the emergency cut-off switch for the OPG machine was located. It is important to identify these switches quickly in an emergency. We found that emergency cut-off switches for all of the X-ray machines were not clearly labelled. Following discussion with the practice manager and the principal dentist assurances were given that the switches would be labelled. This was confirmed the day after the inspection.

We discussed the use of X-rays with the principal dentist. This showed the practice was monitoring the quality of its X-ray images and there were records to demonstrate this. This ensured the X-rays were of the required standard and therefore reduced the risk of patients being subjected to further unnecessary X-rays. All patients completed medical history forms and the dentist considered each patient's individual circumstances to ensure it was safe for them to receive X-rays. This included identifying where patients might be pregnant. Patients' notes showed that information related to X-rays was recorded in line with current guidance from the Faculty of General Dental Practice (UK) (FGDP-UK). This included grading of the X-ray, views taken, justification for taking the X-ray and the clinical findings.

Sedation services

The practice used relative analgesia, a mild form of sedation. This method of conscious sedation used nitrous oxide, commonly known as 'laughing gas'. The practice referred to this when treating children as 'a magic carpet ride'. Conscious sedation services were provided in order to assist the treatment of nervous patients or those with a phobia about coming to the dentist. One dentist was trained to perform conscious sedation and during the inspection we spoke with this dentist. During conscious sedation practice the dentist was supported by a conscious sedation trained dental nurse. Systems and processes were in line with current guidelines and equipment and medicines in accordance with the Resuscitation Council Guidelines were readily available. These included a reversal agent should it be required. The conscious sedation medicines were secured when not in use.

We saw that consent processes were robust and that this was reflected in the clinical notes. Assessment for suitability for conscious sedation was conducted at a separate visit in advance of the treatment. This allowed time for the patient to understand information and withdraw consent if they so wished.

Detailed information on the conscious sedation process was available on the practice website. It was the sedationist's responsibility to monitor and discharge the patient when recovery was complete. This occurred in a separate recovery room. All staff were appropriately trained and maintained continuous professional development (CPD) in accordance with current guidelines. All staff involved in conscious sedation had received training in dealing with emergencies.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Documentation showed that at the start of any consultation, the dentist carried out an assessment and diagnosis of the patient's oral condition. Advice on lifestyle choices, such as the use of alcohol and tobacco on oral health was also given. Options for treatment were also discussed and recorded in the patients' dental notes. We reviewed three dental records, and found that an up to date medical history had been taken on each occasion.

Medical histories included any health conditions, current medicines being taken and whether the patient had any allergies. If an X-ray was to be taken and the patient was of child bearing age, the possibility of being pregnant was also discussed. For returning patients the medical history focussed on any changes to their medical status.

Discussions with dentists and records showed comprehensive assessment of the periodontal tissues (the gums and soft tissues of the mouth) had been undertaken. These had been recorded using the basic periodontal examination (BPE) screening tool. BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to a patient's gums.

We saw that the dentists used nationally recognised guidelines to base treatments and develop longer term plans for managing oral health. Records showed that treatments had been relevant to the symptoms or findings, treatment options were explained and that adequate follow up had been arranged.

We spoke with dentists, and a dental nurse who said that each individual patient had their diagnosis discussed with them. Treatment options and costs were explained before treatment started. Discussions with two patients reflected this, as both patients said their treatment was discussed with them, and costs were explained and identified. In addition several of the Care Quality Commission (CQC) comment cards, supported the view that treatment was discussed and costs explained. Where relevant, information about preventing dental decay was given to improve the outcome for the patient. The patient notes were updated with the proposed treatment after discussing the options. Patients were monitored through follow-up appointments in line with National Institute for Health and Care Excellence (NICE) guidelines.

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

We received feedback from 57 patients about the service. Patients said they were happy with the care and treatment they received, and they trusted and had confidence in the dentist and the staff.

Health promotion & prevention

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

The practice had a room where clinical staff could speak with patients and review notes, X-rays or treatment plans. This room could also be used as a recovery room after sedation, and had been the health promotion room particularly aimed at children.

We saw examples in patients' notes that advice on smoking cessation, alcohol and diet had been discussed. We saw leaflets related to stopping smoking in the waiting areas. These leaflets also identified the negative effects of smoking on patients' health. In the waiting room the practice had a television which played positive messages with regard to dental health and hygiene.

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 document and had used it in their practice.

Staffing

The practice had two dentists, two dental hygienists/ therapists, and two dental nurses. There was a practice manager, one receptionist and a cleaner. Prior to the inspection we checked the registrations of all dental care professionals with the General Dental Council (GDC) register. We found all staff were up to date with their professional registration with the GDC.

We reviewed staff training records at the practice and saw staff were maintaining their continuing professional development (CPD). This was to ensure they remained up-to-date with changes in dental practice and developed

Are services effective?

(for example, treatment is effective)

their skills. CPD is a compulsory requirement of registration with the General Dental Council (GDC). The training records showed how many hours training staff had undertaken together with training certificates for courses attended.

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

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment. For example referral for treatment at the dental hospital if the problem required more specialist attention. The practice then monitored patients after their treatment to ensure they had received satisfactory treatment and had the necessary after care after treatment at the practice.

Patients being referred for oral surgery in hospital would usually be referred to the Charles Clifford Hospital in Sheffield. We saw examples of urgent two week referrals for suspected oral cancer for example. This was in line with the National Institute for Health and Care Excellence (NICE) guidelines.

Consent to care and treatment

We saw evidence that patients were given treatment options and consent forms which they signed to signify their consent with the agreed treatment. Discussions with dentists showed they were aware of and understood the use of Gillick competency for young persons. Gillick competence is used to decide whether a child (16 years or younger) is able to consent to their own medical or dental treatment without the need for parental permission or knowledge. The practice consent policy provided information about Gillick competencies. The principal dentist said he was aware of Gillick competencies, but could not recall any instances when it had been necessary to use them.

The practice had a policy for adults who lacked capacity. This would be for example patients with a learning disability or dementia. These patients could not give valid consent because they did not understand what they were consenting to. The policy 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 staff identified an example where capacity had been an issue for a particular patient. A review of the patient's notes identified that there was no record of the discussion or rationale for the decisions that were made.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

During the inspection we observed how the staff spoke with patients and whether they treated patients with dignity and respect. Our observations showed a friendly approach by staff which was to help patients relax. We saw several examples of staff talking to patients in a manner which showed both dignity and respect.

The reception staff told us that they were aware of the need for confidentiality when conversations were held in the reception area, particularly when other patients were present. They said that a private area was available for use, with either the 'recovery room or an unused treatment room available for this purpose.

We observed a number of patients being spoken with at the reception desk and found that confidentiality was being maintained. We saw that patient records, both paper and electronic were held securely either under lock and key or password protected on the computer.

We received feedback from 57 patients about the service. Patients said they were happy with the care and treatment they received, and they trusted and had confidence in the dentist and the staff. Several patients spoke about the friendliness of the staff, and how they were made to feel at ease. There were also comments from patients saying they had been treated with compassion and empathy. Several patients identified the reception staff as being particularly good in these areas.

The principal dentist showed us records that identified patients had been contacted by telephone a few days after treatment. This allowed the dentist to check that the treatment had gone well, and the patient was well, and not suffering any pain or discomfort. The records showed that this was routine for the dentist.

There were murals on the wall throughout the practice, which were aimed at helping children see the dentist as a fun place to visit. Feedback from adult patients about the décor had been mostly positive, with older patients also saying they found the murals relaxing and a distraction.

Involvement in decisions about care and treatment

Patients we spoke with on the day of the inspection were positive about the dental treatment they received and the dentist they saw. They told us treatment was explained clearly to them including the cost, that they felt involved in the decisions taken, and were able to ask questions and discuss with the dentists the treatment options.

CQC comment cards completed by patients included comments about how treatment was always explained in a way the patients could understand. Patients on 12 comment cards said they had been patients at the practice for over 20 years. Eight comment cards made specific reference to treatment being explained and patients feeling involved in the treatment decisions taken. Six comment cards said the patients were particularly nervous and were involved in discussions with the dentist in ways to overcome their anxieties.

The practice information leaflet and the practice website clearly described the range of services offered to patients. The costs were clearly displayed and fee information was available on the practice website. This included ten different options for payment plans and dental insurances.

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Patients told us the practice had an appointment system which met their needs. When patients were in pain or where treatment was urgent efforts would be made to see the patient the same day. Nine CQC comment cards made reference to the appointment system and the patient's satisfaction with 'always' being seen in an emergency. The patients we spoke with said it was easy to get an appointment, and said they had no complaints.

New patients were asked to complete a medical and dental health questionnaire. This allowed the practice to gather important information about the patient's previous dental and medical history. For returning patients the medical history was updated so the dentists could respond to any changes in health status. We saw examples of both blank and completed forms. Discussions with a dentist showed that information was checked and verified before treatment began.

Tackling inequity and promoting equality

The practice was able to meet the needs of patients who may have difficulty accessing services due to mobility or physical issues. The practice had level step free access from the street to the treatment room. This allowed patients with mobility issues, using wheelchairs or mobility scooters and parents with prams or pushchairs to access the practice. The practice had a toilet, which was accessible for patients. However, the toilet was small and would be difficult for a person with restricted mobility. The practice manager said that the constraints of the building made it difficult to make any changes which would improve the situation.

The practice had good access by all forms of public transport. Car parking was available in a free car park at the side of 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 on Mondays from 9:00 am to 1:00 pm and 2:00 pm to 6:00 pm; on

Tuesdays, Wednesdays and Thursdays from 9:00 am to 1:00 pm and 2:00 pm to 5:00 pm; and on

Fridays from 9:00 am to 12:30 pm and 1:00 pm to 3:30 pm. This information was available in both the practice leaflet and on the practice website.

The arrangements for emergency dental treatment outside of normal working hours, including weekends and public holidays were clearly displayed in the waiting room area, the practice leaflet and o the practice website. Access for urgent treatment outside of opening hours was usually through the NHS Direct telephone line.

The treatment areas of the practice were located at ground level. There was level access from the street to the treatment room, so patients with restricted mobility or using a wheelchair could access services.

Concerns & complaints

Information on raising concerns or complaints was available in the practice leaflet. More detailed information was available on both the practice website and in the practice itself.

Prior to the inspection we asked the practice to provide us with details of any complaints received during the past 12 months. The information supplied showed one complaint had been received in that time period. The complaint had been managed in-house, and resulted in a clear explanation to the complainant and as a result their satisfaction with the outcome. Documentation within the practice showed the practice complaints policy and procedure had been followed.

Minutes of staff meetings showed that complaints had been discussed and learning shared with the staff team.

CQC comment cards reflected that patients were satisfied with the dental services provided.

Are services well-led?

Our findings

Governance arrangements

The practice continually monitored and improved the service provided for patients. For example the practice regularly reviewed feedback from patients, and held regular staff meetings. We saw documentary evidence of patient surveys, analysis of the results and discussions in staff meetings. The practice manager had responsibility for the day to day running of the practice and was fully supported by the practice team. There were clear lines of responsibility and accountability; staff knew who to report to if they had any issues or concerns.

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

Leadership, openness and transparency

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

Staff said there was a culture at the practice which encouraged openness and honesty. Staff said they were confident they could raise issues or concerns at any time with the practice management team without fear of discrimination. Both dental nurses and the receptionist had worked at the practice for many years and said they were able to speak with the dentists and practice manager freely. This included raising any concerns. All staff members we spoke with said they felt part of a team, well supported and knew what their role and responsibilities were.

Staff were aware of how to raise concerns about their place of work under whistle blowing legislation. We saw that the practice had a whistle blowing policy, and all staff had access to the policy.

Learning and improvement

In their statement of purpose the practice stated its main aim was: "… To provide dental care and treatment of consistently good quality for all patients and only provide services that meet patients' needs and wishes. We aim to make care and treatment as comfortable and convenient as possible."

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

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

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

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

The practice supplied data relating to a random selection of 30 patients who had been surveyed during October 2014. Questions had focussed on the patients' satisfaction with a number of areas including the décor of the building, the waiting times and cleanliness. The responses had been analysed and conclusions drawn. The results were shared with staff, and successes had been celebrated. However, there was no action plan to address areas where the practice had scored less than 100%. In most areas the practice had scored in the high 90's or 100%. A score less than 100% showed there was room for improvement. The provider said the practice did act on feedback and scoring 90% or more (even if not 100%) was seen as very good. Some of the lower scores were questions about the décor at the practice, and the provider felt this could be personal preference e.g. not liking the child friendly murals.