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Green Dental Care

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 2 February 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

Green Dental Care is situated over two floors of a health centre just outside Nottingham city centre. The practice was registered with the Care Quality Commission (CQC) in June 2011. The practice provides regulated dental services to patients from a wide area of Nottingham and the surrounding area. This was because the practice's location on a main road into the city centre made it relatively easy for patients to attend who were not from the local area. The practice provides mostly NHS dental treatment. Services provided include general dentistry, dental hygiene, crowns and bridges, and root canal treatment.

The practice is open: Mondays to Thursdays: 8:30 am to 5:30 pm, and Fridays: 8:30 am to 1:30 pm. The practice is closed at the weekend. Access for urgent treatment outside of opening hours is by ringing the practice and following the instructions on the answerphone message. Alternatively NHS patients should ring the 111 telephone number.

The practice has two dentists, one of whom was the principal dentist and owner of the business. There were five dental nurses who also worked on reception, one of whom was on maternity leave. There was one practice manager, an assistant manager and there was one further receptionist and an administrator in charge of training.

Summary of findings

We received positive feedback from 17 patients about the services provided. This was through CQC comment cards left at the practice prior to the inspection and by speaking with patients in the practice.

Our key findings were:

- There were systems in place to record accidents, significant events and complaints, and any learning points from them were identified and shared with staff.
- The records showed that apologies had been given for any concerns or upset that patients had experienced.
- There was a whistleblowing policy and procedures and staff were aware of these procedures and how to use them. All staff had access to the whistleblowing policy.
- Patients spoke positively about the dental service they received.
- Patients said they were treated with dignity and respect.
- Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.
- There was the necessary equipment for staff to deal with medical emergencies, and staff had been trained how to use that equipment. .
- The practice followed the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control.
- Patients' were involved in discussions about the planning and delivery of care and treatment. Patient recall intervalswere in line with National Institute for Health and Care Excellence (NICE) guidance.
- Treatment options were identified, explored and discussed with patients.
- Patients' confidentiality was maintained.

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

- Consider installing a hearing loop as a reasonable addition as identified in the Equality Act (2010).

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.

Accidents and significant events were recorded and learning points were shared with staff.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts and took appropriate action including sharing information with staff.

All staff had received up-to-date training in safeguarding vulnerable adults and children. There were clear guidelines for reporting concerns and the practice had a lead member of staff to offer support and guidance over safeguarding matters.

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

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

The practice had infection control procedures to ensure that patients were protected from potential risks. Regular audits of the decontamination process were as recommended by the current guidance. Equipment used in the decontamination process was maintained by a specialist company and regular checks were carried out to ensure equipment was working properly and safely.

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

Are services effective?

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

All patients were clinically assessed by a dental professional before any treatment began. This included completing a health questionnaire or updating one for returning patients. The practice used a recognised assessment process to identify any potential areas of concern in patients' mouths, jaws and neck, including their soft tissues (gums, cheeks and tongue). Additional assessments were completed on children to ensure preventative measures for tooth decay were effective.

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 prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart).

There were clear procedures for referring patients to secondary care (hospital or other dental professionals). Staff were able to demonstrate that referrals had been made in a timely way when necessary.

The consent policy required an update to ensure that it clearly referenced the relevant legislation and guidance.

Are services caring?

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

Staff were able to demonstrate their understanding of the need for patient confidentiality. Staff took steps to ensure patients' that confidentiality was maintained in all areas of the practice.

Summary of findings

Patients were treated in a polite caring manner and with dignity and respect.

Staff at the practice were friendly and welcoming to patients and made efforts to help anxious patients relax.

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

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

Are services responsive to people's needs?

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

Patients said it was easy to get an appointment. Patients who were in pain or in need of urgent treatment could usually get an appointment the same day.

The practice had ground floor treatment rooms, so that patients with restricted mobility could access the practice and receive treatment.

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

There were systems for patients to make formal complaints, and these were acted upon, and apologies given when necessary.

Are services well-led?

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

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

The practice was carrying out regular 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, and the practice listened to those views and acted upon them.

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

Green Dental Care

Detailed findings

Background to this inspection

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

We carried out an announced, comprehensive inspection on 2 February 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

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

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, including the principal dentist and three dental nurses, who also worked as receptionists, and the practice manager. We reviewed policies, procedures and other documents. We received feedback from 17 patients about the dental service

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There were procedures for recording, investigating, responding to and learning from accidents, significant events and complaints. Documentation showed the last recorded accident had occurred in May 2013, this being a minor injury to a member of staff. The cause had been identified and steps taken to ensure this was not repeated. Accident records went back over several years to demonstrate the practice had recorded and addressed issues relating to safety at the practice.

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. The accident policy had details of how to make a RIDDOR report together with a flow chart for ease of reference.

The practice kept a log of significant events. The records showed there had been no significant events recorded in the last year. The most recent incident related to a patient collapsing in the practice. This had occurred almost two years previously. The records showed that appropriate action had been taken by the practice staff, and the medical emergencies procedures had worked effectively.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts. These were sent out centrally by a government agency (MHRA) to inform health care establishments of any problems with medicines or healthcare equipment. Alerts were received by the practice manager or principal dentist by e mail and were analysed and information shared with staff if and when relevant. The practice manager said there had not been any for some time, with the most recent relating to the dangers posed by e cigarettes, and information about the Ebola virus.

Reliable safety systems and processes (including safeguarding)

The practice had separate policies for safeguarding vulnerable adults and children. These policies had been reviewed and updated in January 2016. The policies identified how to respond to any concerns and how to escalate those concerns. Discussions with staff showed that they were aware of the safeguarding policies, knew who to contact and how to refer concerns to agencies outside of the practice when necessary. A flow chart and the relevant contact phone numbers were on display in staff areas of the practice.

The practice had an identified lead for safeguarding in the practice and this was the administrator responsible for staff training. The lead had received enhanced training in child protection to support them in fulfilling that role. We saw the practice had detailed files for both safeguarding vulnerable adults and children. Both files contained training information and teaching plans. Both showed a comprehensive level of information delivered in a format that was easy for staff to understand. Staff training records showed that all staff at the practice had undertaken training in safeguarding adults and children, with an update fro the safeguarding lead to all staff in January 2016.

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

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 2 January 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

The practice had a sharps policy which identified how to handle sharps (particularly needles and sharp dental instruments) safely. We saw the practice used a recognised system for handling sharps safely in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, and practice policy. We discussed this

with a dentist, who outlined the steps taken to reduce the risks of sharps injuries. There were sharps bins (secure bins for the disposal of needles, blades or any other instrument that posed a risk of injury through cutting or pricking.) We saw the bins in the decontamination room and treatment rooms were located off the floor. The guidance says sharps bins should not be located on the floor, and should be out of reach of small children. The Health and safety Executive (HSE) guidance: 'Health and safety (sharp instruments in healthcare) regulations 2013', was being followed.

Discussions with dentists and review of patients' dental care records identified the dentists were not always using rubber dams when completing root canal treatments. Guidelines from the British Endodontic Society say that dentists should be using rubber dams. A rubber dam is a thin rubber sheet that isolates selected teeth and protects the rest of the patient's mouth and airway during treatment. We were told the reason for not using a rubber dam was a clinical decision or on occasions the patients' choice. The principal dentist said the practice did not carry out many root canal treatments, so this was not a regular occurrence. As an alternative dentists were using high speed suction and cotton wool padding.

Medical emergencies

The dental practice had emergency medicines and oxygen to deal with any medical emergencies that might occur. These were located in a secure location, and all staff members knew where to find them. We checked the medicines and found they were all in date. We saw the practice had a system in place for checking and recording expiry dates of medicines, and replacing when necessary.

The practice had a first aid box, and we saw the contents were being checked regularly. The practice was located in a health centre, and were working in partnership with the GPs who shared the building. As a result a named nurse from the GP practice was the designated first aider for the dental practice.

The practice had an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. Records showed all staff had completed basic life support and resuscitation training and an update was booked for 6 February 2016. Resuscitation Council UK guidelines suggest the minimum equipment required and includes an AED and oxygen which should be immediately available. The practice also had airways to support breathing, portable suction and manual resuscitation equipment (a bag valve mask) for use in an emergency. The practice also had a sphygmomanometer for measuring blood pressure should the need arise.

Discussions with staff identified they understood what action to take in a medical emergency. Staff said they had received training in medical emergencies. We spoke with two members of staff who was able to describe the actions to take in relation to various medical emergencies including a patient collapsing in the practice. The most recent significant event recorded at the practice showed that when a patient collapsed in the practice staff had responded appropriately.

Staff recruitment

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

We found that all members of staff had received a DBS check. We discussed the records that should be held in the recruitment files with the principal dentist, and saw the practice recruitment policy and the regulations had been followed.

Monitoring health & safety and responding to risks

The practice had both a health and safety policy and environmental risk assessments. Risks to staff and patients had been identified and assessed, and the practice had measures in place to reduce those risks. For example: risk assessments for pregnant and nursing mothers; slips, trips and falls; and manual handling.

Are services safe?

Records showed that fire detection and fire fighting equipment such as fire alarms and emergency lighting were regularly tested. The fire risk assessment had been updated in October 2015. The fire extinguishers were last serviced in June 2015, with staff fire training at a staff meeting in November 2015.

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

Infection control

Dental practices should be working towards compliance with the Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' in respect of infection control and decontamination of equipment. This document sets out clear guidance on the procedures that should be followed, records that should be kept, staff training, and equipment that should be available.

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

Records showed that regular six monthly infection control audits had been completed as identified in the guidance HTM 01-05. The last audit in December 2015 scored 100%, so no action plan was necessary on that occasion.

The practice had a clinical waste contract, and waste matter was collected regularly. Clinical waste was stored in the treatment rooms while awaiting collection. This was because the waste bins had a large capacity, and the principal dentist said the bins were never full before they were due to be emptied. The clinical waste contract also covered the collection of amalgam, a type of dental filling which contains mercury and is therefore considered a hazardous material. The practice had spillage kits for both mercury and bodily fluids, which were in date.

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

We found that instruments were being cleaned and sterilised in line with the published guidance (HTM 01-05). A dental nurse demonstrated the decontamination process, and we saw the procedures used followed the practice policy.

The practice had a washer disinfector (a machine for cleaning dental instruments similar to a domestic dish washer). After the washer disinfector instruments were rinsed and examined using an illuminated magnifying glass. Finally the instruments were sterilised in the practice's autoclave (a device for sterilising dental and medical instruments). The practice had one vacuum autoclave in use (with a second available as a back up). This was designed to sterilise wrapped dental instruments. At the completion of the sterilising process, instruments were dried, packaged, sealed, stored and dated with an expiry date.

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

We examined a sample of dental instruments that had been cleaned and sterilised using the illuminated magnifying glass. We found the instruments to be clean and undamaged.

Information in the practice showed that staff had received inoculations against Hepatitis B and received regular blood tests to check the effectiveness of that inoculation. Health professionals who are likely to come into contact with blood products, or are at increased risk of sharps injuries

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

The practice had a policy for assessing the risks of Legionella and a Legionella risk assessment. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. Records showed the practice was aware of the risks associated with Legionella and had taken steps to reduce them with regular water tests, which were recorded.

The practice was flushing the dental unit water lines used in the treatment rooms. This was done for two minutes at the start of the day, and for 30 seconds between patients, and again at the end of the day. A concentrated chemical was used for the continuous decontamination of dental unit water lines to reduce the risk of Legionella bacterium developing in the dental unit water lines.

Equipment and medicines

The practice kept records which showed that equipment was maintained and serviced in line with manufacturer's guidelines and instructions. Portable appliance testing (PAT) had taken place on electrical equipment at the practice on 6 October 2015. Fire extinguishers were checked and serviced by an external company and staff had been trained in the use of equipment and evacuation procedures.

The practice had all of the medicines needed for an emergency situation, as identified in the current guidance. Medicines were stored securely and there were sufficient stocks available for use. Medicines used at the practice were stored and disposed of in line with published guidance.

Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities.

Prescription pads at the practice were available and managed effectively. Numbered prescription pads were allocated to each dentist, and the practice was able to track their movement. The prescription pads were stored securely when not in use.

Radiography (X-rays)

The dental practice had three intraoral X-ray machines (intraoral X-rays concentrate on one tooth or area of the mouth). There was also one extra-oral X-ray machine (an orthopantomogram known as an OPG) for taking X-rays of the whole mouth including the teeth and jaws. 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 local rules identified the practice had radiation protection supervisors (RPS) this was the principal dentist, and a radiation protection advisor (RPA). This was a company specialising in servicing and maintaining X-ray equipment. The Ionising Radiation Regulations 1999 (IRR 99) requires that an RPA and an RPS be appointed and identified in the local rules. Their role is to ensure the equipment is operated safely and by qualified staff only.

Emergency cut-off switches for the X-ray machines were located away from the machines and were easily accessible for staff.

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

We discussed the use of radiographs (X-rays) with a dentist to confirm the practice was monitoring the quality of the radiograph images. We saw records to demonstrate that this was happening.

The three intraoral X-ray machines had been fitted with rectangular collimation. The Ionising Radiation Regulations (Medical Exposure) Regulations 2000 recommend the use of rectangular collimation to limit the radiation dose a patient receives during routine dental X-rays. Rectangular collimation is a specialised metal barrier attached to the head of the X-ray machine. The barrier has a hole in the middle used to reduce the size and shape of the X-ray beam, thereby reducing the amount of radiation the patient received and the size of the area affected.

All patients were required to complete medical history forms and the dentist considered each patient's individual circumstances to ensure it was safe for them to receive X-rays. This included identifying where patients might be pregnant. There were risk assessments in place for pregnant & nursing mothers.

Patients' dental care records showed that information related to X-rays was recorded in line with guidance from

Are services safe?

the Ionising Radiation (Medical Exposure) Regulations 2000. This included grading of the X-ray, views taken, justification for taking the X-ray and the clinical findings.

Discussions with the principal dentist identified that grading of the radiographs occurred every time an X-ray was taken, to judge if the equipment was working correctly. We saw examples of this in practice.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept dental care records for each patient. We saw a small number of patient care records to confirm what the dentists had told us during the inspection. These records included all information about the assessment, diagnosis, treatment and advice given to patients by dental healthcare professionals. The care records showed a thorough examination had been completed, and included examination of the soft tissues including the tongue and the jaw and neck. The practice used specific forms to help with the diagnosis of its patients' oral health. There was a separate form for adults and children.

The practice used a form to record the patients' medical histories. The patients' medical histories form included any health conditions, medicines being taken and whether the patient had any allergies. The medical history form also included a smile evaluation which focussed on specific oral health issues such as: bad breath, sensitivity, bleeding gums and food traps between the teeth. These were taken for every patient attending the practice for treatment. For returning patients the medical history focussed on any changes to their medical status.

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

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

Health promotion & prevention

There was a range of literature in the waiting room and reception area about the services offered at the practice. In addition there were posters giving general health advice, and information about other local services in the community. There were also posters and leaflets providing information about improving patients' oral health; much of this was aimed at children. For example: Avoiding tooth decay and acid erosion. For adults there was information about the risks associated with smoking, and information about helplines and support with stopping smoking.

The principal dentist explained that many of the children seen at the practice were at risk of dental decay due to poor diet or too much sugar in their diet. As a result the practice routinely provided fluoride application varnish and fluoride toothpaste to all children identified as being at risk.

The principal dentist and a dental nurse had visited local schools to carry out dental health promotion sessions. The practice had access to number of resoursces such as a set of slides to help with the presentation. The practice was located in an area with high social and economic needs, and the dental practice took an active stance in preventing tooth decay through providing information, advice and support to patients.

We saw examples in patients' dental care records that dentists had provided advice on smoking cessation, and alcohol and diet had been discussed. With regard to smoking dentists had highlighted the risk of dental disease and oral cancer. In respect of children we saw evidence that fizzy drinks, chewey sweets and chocolate biscuits had ben discussed and recorded.

Staffing

The practice had two dentists, one of whom was the principal dentist and owner of the business. There were five dental nurses who also worked on reception, one of whom was on maternity leave. There was one practice manager, an assistant manager and there was a further receptionist and an administrator in charge of training. Before 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 saw the staff training records and these identified that staff were maintaining their continuing professional development (CPD). CPD is a compulsory requirement of registration with the General Dental Council (GDC). The training records showed how many hours training staff had

Are services effective?

(for example, treatment is effective)

undertaken together with training certificates for courses attended. This was to ensure staff remained up-to-date and continued to develop their dental skills and knowledge. Examples of training completed included: Radiography (X-rays), Medical emergencies and Legal and ethical issues.

The practice carried out annual appraisals for all staff. The records showed that appraisals had been completed during 2015. We saw evidence in three staff files that appraisals had taken place. We also saw evidence of new members of staff having an induction programme. We spoke with two members of staff who said they had received an annual appraisal with the principal dentist.

Working with other services

The practice made referrals to other dental professionals when it was clinically indicated that a referral should be made. For example referral for treatment at the dental hospital if there was suspected cancer or the patient required a difficult extraction. The practice usually referred to the Intermediate Minor Oral Surgery Management Centre (IMOS). This being an NHS service providing community based specialist advice and treatment in Nottingham.

Records within the practice identified that for patients with suspected oral cancer, referrals had been made within the two week window for urgent referrals, and these were tracked to ensure they had been received and the patient seen.

Patients' care records showed that referrals had been made, and that patients' had been involved in discussions about the referral and the reasons why it was necessary.

Consent to care and treatment

The practice had a consent policy which had been reviewed and updated in April 2015. The policy made reference to the Mental Capacity Act 2005 (MCA) and best interest decisions. The MCA provided a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make particular decisions for themselves.

The practice used the standard NHS treatment plan and consent form (FP17DC) for NHS patients. These forms allowed the practice to record consent, and also identified the cost of the treatment for the patient. The practice also had a range of consent forms to be usedin specific situations. These included: for children and adults who are unable to consent to investigation or treatment. All of these consent forms came with detailed guidance notes for their use.

Discussions with the principal dentist showed they were aware of and understood the use of Gillick to record 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.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

During our inspection we carried out a number of observations of staff speaking with patients. We saw that staff were friendly, polite and professional. Our observations showed that patients were treated with dignity and respect.

The reception desk was located in the waiting room. We discussed the need for confidentiality with reception staff who explained how this was achieved. The reception desk was away from the main body of the waiting room, and screens provided a degree of confidentiality. Should it be necessary to discuss a confidential matter, there were areas of the practice where this could happen, such as the office or an unused treatment room. Staff said that all details of patients' individual treatment was discussed in the privacy of the treatment room.

We observed several patients being spoken with by staff throughout the day, and found that confidentiality was being maintained both at the reception desk and in the treatment room. We saw that patient dental care records were held securely and where computers were used they were password protected. Paper records were stored securely at the practice.

Involvement in decisions about care and treatment

We received feedback from 17 patients on the day of the inspection. Patients said the staff were caring, helpful and polite. Care Quality Commission (CQC) comment cards identified dentists took the time and trouble to involve patients in decisions about care and treatment. Three patients made specific reference to dental staff being professional, approachable, and the patients being able to ask questions or raise any worries or concerns.

The practice offered mostly NHS dental treatments and costs for both NHS and private treatments were clearly displayed in the practice.

We spoke with two dentists, and two dental nurses who explained that each patient had their diagnosis and dental treatment discussed with them. The treatment options and costs involved were explained before treatment started. Patients were given a written treatment plan which included the costs.

Where necessary information about preventing dental decay was given to improve patients' oral health. This included discussions about smoking and diet, and the effects of carbonated drinks on the patient's teeth, gums and mouth. The dental care records were updated with the proposed treatment after discussing the options. Patients were monitored through follow-up appointments in line with National Institute for Health and Care Excellence (NICE) guidelines.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice was situated in a health centre. As a result thought and planning had been put into the layout of the practice, and it was well suited to meeting patients' needs. There were separate staff and patient areas, which helped with confidentiality and security. The treatment rooms were accessible to patients in wheelchairs or with restricted mobility and were well equipped.

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

We spoke with two patients during the inspection. Both patients said they had had been able to get an appointment fairly easily. Both patients said they had needed urgent treatment in the past, and had been seen the same day, one patient said they had come and waited, while the other was offered an appointment the same day over the telephone. Staff said that when patients were in pain or where treatment was urgent the practice made efforts to see the patient within 24 hours, and usually the same day. There was a sit and wait service, and dentists allocated one hour a day to see emergencies. The principal dentist said the practice took a risk based approach to the needs of the patients.

We reviewed the appointment book, and saw that patients were allocated sufficient time to receive their treatment and have discussions with the dentist.

Tackling inequity and promoting equality

The practice was situated over two floors of a health centre just outside Nottingham city centre. There were two treatment rooms on the ground floor which provided level access from the street to the treatment room. This allowed patients who may have difficulty accessing services due to mobility or physical issues to be seen.

The practice had good access to all forms of public transport with a bus stop located close by. There was also a disabled parking space in the health centre car park.

Staff said the practice did not have a hearing induction loop. The Equality Act (2010) requires where 'reasonably possible' hearing loops to be installed in public spaces, such as dental practices. One dental nurse at the practice had completed a British sign language (BSL) course.

Patients said that they were usually seen on time, and making an appointment was easy, as the reception staff were both friendly and helpful.

The practice had access to a recognised company to provide interpreters, and this included the use of sign language. Staff said that there were very few patients who could not speak English, and if language was a problem the patient usually brought someone to interpret therefore avoiding the need for interpreters.

Access to the service

The practice leaflet identified the practice was open: Mondays to Thursdays: 8:30 am to 5:30 pm; Fridays 8:30 am to 1:30 pm. The practice was closed for lunch between 1 pm and 2 pm (Mondays to Thursdays). This information was also available within the practice.

Access for urgent treatment outside of opening hours was by calling the 111 the NHS out-of-hours service. This information was available in the practice, in the practice leaflet and on the practice answerphone.

Concerns & complaints

The practice had a complaints procedure for patients who wanted to make a complaint. The procedure explained the process to follow, and included other agencies to contact if the complaint was not resolved to the patients satisfaction. This included NHS England and the Parliamentary and Health Service Ombudsman.

Information about how to make a complaint was displayed in the practice waiting rooms, and in the practice leaflet.

From information received before the inspection we saw that there had been two formal complaints received in the past 12 months. Records within the practice showed the complaints had been handled in a timely manner, and in line with the practice's complaints procedure. Both complaints had been investigated and the outcome had been recorded. The records showed that both complaints had been analysed and steps taken to prevent the situations recurring. We saw that apologies had been given for the concern and upset the patients had experienced.

Are services well-led?

Our findings

Governance arrangements

There was a clear management structure at the practice, with staff having set roles and responsibilities. Staff said they understood they could speak with the principal dentist if they had any concerns, and understood the management structure. We spoke with three members of staff who said there was good communication within the staff team, and observations during the day, identified positive working relationships.

We reviewed a number of policies and procedures at the practice and saw that they had been reviewed and where relevant updated during 2015. The principal dentist had a management plan which included the review and updating of policies and procedures.

We were shown a selection of patient dental care records to assess if they were complete, legible, accurate, and secure. The dental care records we saw were all of these things.

Leadership, openness and transparency

The practice had a management structure for meetings throughout the year. We saw that management meetings were held three monthly to discuss the business side of the practice; full staff meetings were scheduled for every two months; and clinical supervision for the dentists was scheduled six monthly. Full staff meetings were minuted, and those minutes were available to all staff. We saw minutes identified topics such as health and safety and staff training.

We spoke with a variety of staff at the practice and staff said there was an open culture, with all of the dentists readily available to discuss any clinical issues. In addition the principal dentist was approachable, and staff said they were confident they could raise issues or concerns at any time. Observations showed there was a relaxed and friendly albeit professional attitude among the staff. Discussions with different members of the team showed there was a good understanding of how the practice worked, and knowledge of policies and procedures.

The practice had a whistleblowing policy which was had been reviewed in April 2015. This policy identified how staff could raise any concerns they had about colleagues' conduct or clinical practice. This was both internally and with identified external agencies. We discussed the whistleblowing policy with a nurse who was able to give a clear and thorough account of what the procedures were for, and when and how to use them.

Learning and improvement

We talked with several staff about the practice values. Staff talked about the emphasis on preventative dentistry at the practice, and 'prevention being better than cure'. Staff said that the patients were at the heart of everything that was done at the practice and talked about meeting patients' needs.

The principal dentist demonstrated that there was a schedule of audits completed throughout the year. This was for both clinical and non-clinical areas of the practice. The audits identified both areas for improvement, and confirmed that quality was being achieved particularly in respect of clinical areas such as the taking of radiographs (X-rays). Examples of audits we saw during the inspection included: Infection control, patients record cards, consent and radiographs (X-rays).

Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. Training records at the practice showed that training opportunities were available to all staff. This was a mixture of in-house and external training.

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

The practice used the NHS Friends & Family comment box which was located in the waiting room. This was to gather regular feedback from the NHS patients, and to satisfy the requirements of NHS England. The responses within the boxes were analysed on a monthly basis. Since the Family & Friends test was introduced in April 2015 the practice has received steady stream of responses each month. Analysis of the Friends & Family information showed all of the responses were positive. All respondents were either likely or highly likely to recommend the practice to their family and friends.

However, the practice had not given any feedback to the patients regarding the comments that had been made. This was discussed with the principal dentist. The practice would be looking to provide feedback to patients each month in the future.

Are services well-led?

We visited the NHS Choices website and reviewed the comments that patients had left about the practice. In the 12 months leading up to the inspection there had been two comments posted on the website. Both comments were positive. The practice had not provided a response to either of the comments. We discussed this with the principal dentist, who agreed that it would be in the practice's interests to provide a written response. The principal dentist said they would look into doing this.