Oradi Ltd

Wellingborough Dental Practice - 26

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 5 October 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

The practice is located in premises close to the centre of Wellingborough in Northamptonshire. There is road side parking close to the dental practice. There are four treatment rooms. Any patients with restricted mobility would be seen and treated at the provider's other practice on the opposite side of the road as this practice had level access and facilities to meet the needs of patients with restricted mobility

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

The practice's opening hours are – Monday to Thursday: 8am to 6:30 pm, Friday: 8 am to 5:30 pm. The practice is closed at weekends.

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

The practice had a number of registered managers: the practice manager and four dentists. A registered manager

Summary of findings

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.

The practice is registered with the Care Quality Commission (CQC) as an organisation.

The practice has five dentists; two therapists; ten qualified dental nurses; one trainee dental nurse and two receptionists.

We received feedback from 147 patients about the services provided. This was by speaking with patients, through comment cards left at the practice prior to the inspection and through patients who contacted CQC directly. The majority of feedback was positive with most patients happy with the care and treatment they received at the practice.

Our key findings were:

- The premises were visibly clean and there were systems and processes in place to maintain the cleanliness.
- Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Patients said they had no problem getting an appointment that suited their needs.
- Patients were able to access emergency treatment when they were in pain.
- Patients provided positive feedback about their experiences at the practice. Patients said they were treated with dignity and respect; and the dentist involved them in discussions about treatment options and answered questions.
- Patients' confidentiality was protected.
- There were systems to record accidents, significant events and complaints, and where learning points were identified these were shared with staff.
- The records showed that apologies had been given for any concerns or upset that patients had experienced at the practice.
- The practice followed the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control with regard to cleaning and sterilizing dental instruments.
- There were arrangements for patients with restricted mobility to be seen quickly and easily at a nearby practice (on the other side of the road) owned by the same provider.
- There was a whistleblowing policy accessible to all staff, who were aware of procedures to follow if they had any concerns.
- The practice had the necessary equipment for staff to deal with medical emergencies, and staff had been trained how to use that equipment. This included an automated external defibrillator, oxygen and emergency medicines.

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

Review its responsibilities to the needs of people with a disability and the requirements of the Equality Act 2010 and consider installing a hearing induction loop at the premises. This would assist patients who use a hearing aid whilst in the practice.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

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

The practice was visibly clean.

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

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

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

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

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

Are services effective?

No action

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

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

The practice was following National Institute for Health and Care Excellence (NICE) guidelines for the care and treatment of dental patients. Particularly in respect of patient recalls, lower wisdom tooth removal and the prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart).

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

Are services caring?

No action

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

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

Summary of findings

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

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

Are services responsive to people's needs?

No action 

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

Patients who were in pain or in need of urgent treatment could usually get an appointment the same day.

The practice was located on the ground floor which allowed easy access for patients with restricted mobility. A disabled access audit in line with the Equality Act (2010) had been completed to consider the needs of patients with restricted mobility.

However, the practice did not have an induction hearing loop to assist patients who wore a hearing aid.

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

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

Are services well-led?

No action 

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

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

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

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

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

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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 5 October 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector, a CQC manager and a dental specialist advisor.

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

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

We reviewed policies, procedures and other documents. We received feedback from XX patients about the dental service.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had systems for recording and investigating accidents, significant events and complaints. This allowed them to be analysed and any learning points identified and shared with the staff. Documentation showed the last recorded accident had occurred in July 2016 this being a minor injury to a patient who banged themself on the front door. We saw that any needlestick injuries to staff were analysed using an inoculation injury reporting form. This had on occasion led to the sharps policy to being reviewed. Accident records went back over several years to demonstrate the practice had recorded and addressed issues relating to safety at the practice.

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

Records at the practice showed there had been no significant events during 2016. The practice had systems and processes to record and analyse significant events. The practice had a managing untoward incidents policy which had been reviewed in May 2016.

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. These were received by the principal dentist and practice manager analysed and discussed in staff meetings as appropriate. The most recent alert had been received in June 2016 and related to a medicines interaction.

The practice showed an awareness of the duty of candour and this was encouraged through the significant event reporting and complaint handling process. Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Reliable safety systems and processes (including safeguarding)

The practice had a policy for safeguarding vulnerable adults and children. The policy was due for review in November 2016. The policy identified how to respond to and escalate any safeguarding concerns. The relevant contact telephone numbers and a flow chart were available for staff Discussions with staff showed that they were aware of the safeguarding policies, knew who to contact and how to refer concerns to agencies outside of the practice when necessary. The practice manager said there had been one safeguarding referral made by the practice. Concerns had been raised about a child patient, and those concerns were discussed in the practice and a safeguarding referral had been made to the local authority safeguarding team.

The practice manager was the identified lead for safeguarding in the practice. They had received enhanced training in child protection and vulnerable adults to level three. This had been completed in May 2016 to support them in fulfilling that role. We saw evidence that all staff had completed safeguarding training to level two also in May 2016.

The practice had a specific policy to give staff guidance on Control Of Substances Hazardous to Health (COSHH) Regulations 2002. The policy was rewritten and updated in August 2016. This identified the risks associated with the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. There were hard copies of manufacturers' product data sheets and every computer in the practice had a link to COSHH data sheets. Data sheets provided information on how to deal will spillages or accidental contact with chemicals and advised what protective clothing to wear. The practice had an identified lead member of staff for COSHH and any new products were identified and shared with every member of staff.

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 31 July 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

The practice had a sharps policy which informed staff how to handle sharps (particularly needles and sharp dental instruments) safely. The policy had been reviewed in March 2016. 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. Practice policy was that only dentists handled sharp instruments. We saw there were devices in each clinical area for the safe removal and disposal of needles and sharps.

There were sharps bins (secure bins for the disposal of needles, blades or any other instrument that posed a risk of injury through cutting or pricking.) We saw the sharps bins were located in clinical areas in line with the guidance which indicated sharps bins should not be located on the floor, and should be out of reach of small children. Sharps bins were signed and dated. The National Institute for Healthcare Excellence (NICE) guidelines: 'Healthcare-associated infections: prevention and control in primary and community care' advise – sharps boxes should be replaced every three months even if not full. Signing and dating allowed the three month expiry date to be identified.

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

Medical emergencies

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

There was a first aid box in the practice; arrangements were made to replace the first aid box in the practice to ensure all contents were up to date. We saw evidence the contents were being checked regularly. We saw certificates demonstrating two members of staff had completed a first aid at work course and that the training was still in date.

There was an automated external defibrillator (AED) at the practice. An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. The AED was being checked regularly to ensure it was working correctly. This complied with the Resuscitation Council UK guidelines.

All staff at the practice had completed basic life support and resuscitation training on 8 February 2016.

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

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

Staff recruitment

We looked at the staff recruitment files for 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 recruitment files. This includes: proof of identity; checking the person's skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed). DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

We saw that staff recruitment files for staff recruited in the six months up to this inspection contained more detail. This was because the practice had been developing and improving the recruitment files and recording more information during the recruitment process.

We found that all members of staff had received a DBS check. The practice was routinely taking references for new members of staff and were keeping a record of interview

notes. 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 a health and safety policy which had been reviewed in November 2015. The policy identified the practice manager as the lead person who had responsibility within the practice for different areas of health and safety. As part of this policy environmental risk assessments had been completed. For example there were risk assessments for: security, fire, infection control and sharps.

Records showed that fire extinguishers had been serviced in January 2016. The practice had a fire risk assessment which had been reviewed in September 2016. We saw there was an automatic fire detection system and emergency lighting installed within the premises. Records showed the practice held a fire drill twice a year, with the last one completed on 15 March 2016. The building was over three floors and staff had set fire marshal responsibilities within the building.

The practice had a health and safety law poster on display in the staff room. 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.

The practice had a business continuity plan which had been updated on the day of the inspection to accommodate a new member of staff who had started that day. The plan gave detailed information on how threats to the service would be dealt with and managed to ensure continuity of the service. For example: if there was loss of electricity, heating, computers, or telephones. The plan guided staff in the steps to take to minimise the disruption to patients.

Infection control

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

The practice had an infection control policy which was due for review in November 2016. A copy of the policy was available to staff in all clinical areas. Dental nurses had set responsibilities for cleaning and infection control in each individual treatment room. The practice had systems for testing and auditing the infection control procedures.

Records showed that regular six monthly infection control audits had been completed. This was as recommended in the guidance HTM 01-05. The last audit was completed on 28 June 2016 and scored 98%.

The practice had a clinical waste contract, and waste matter was collected regularly. Clinical waste was stored securely away from patient areas while awaiting collection. The clinical waste contract also covered the collection of amalgam, a type of dental filling which contains mercury and is therefore considered a hazardous material. The practice had spillage kits for mercury and bodily fluids. Both spillage kits were within their use by date.

There were two decontamination rooms. This was where dental instruments were cleaned and sterilised. Staff wore personal protective equipment during the process to protect themselves from injury. This included the use of heavy duty gloves, aprons and protective eye wear. The practice was latex free to avoid any potential latex allergy. As a result alternative latex free gloves were available

A dental nurse demonstrated the decontamination process. We saw the procedures were as outlined in the published guidance (HTM 01-05). The practice had introduced a head rest cover which informed staff that a treatment room had been cleaned and prepared ready to use. To assist dental nurses in cleaning and preparing treatment rooms the practice had a treatment room assessment form. This form also operated as an audit tool to ensure treatment rooms were prepared to the required standard.

The practice used manual cleaning to clean dental instruments. We saw a long handled brush as identified in the guidance (HTM 01-05) was used for manual cleaning. We saw the water temperature was being routinely

measured. HTM01-05 identifies that water temperature should not exceed 45 degrees centigrade during manual cleaning as higher temperatures bind protein to the instruments.

After cleaning instruments were rinsed and examined using an illuminated magnifying glass. Finally the instruments were sterilised in one of the practice's autoclaves (a device for sterilising dental and medical instruments). The practice had four autoclaves within the building. At the completion of the sterilising process, all instruments were dried, placed in pouches and dated with a use by date.

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

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

The risks associated with Legionella had been risk assessed. This process had been completed by an external contractor in May 2015 and was due to be reviewed in February 2017. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The practice was aware of the risks associated with Legionella and had taken steps to reduce them with regular flushing of dental water lines as identified in the relevant guidance. We saw staff flushing water lines during the inspection.

Equipment and medicines

The practice kept records to demonstrate that equipment was maintained and serviced in line with manufacturer's guidelines and instructions. Portable appliance testing (PAT) had been completed on electrical equipment at the practice in December 2016. The pressure vessel checks on the compressor which produced the compressed air for the dental drills had been completed in June 2016. This was in accordance with the Pressure Systems Safety Regulations (2000). Records showed the autoclaves had been serviced in July 2016.

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

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

Radiography (X-rays)

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

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

X-rays were carried out in line with local rules that were relevant to the practice and specific equipment. The local rules for the use of each X-ray machine were available in each area where X-rays were carried out.

The Radiation Protection file identified the practice had a radiation protection supervisor (RPS) this being one of the principal dentists. The provider had appointed an external radiation protection advisor (RPA). This was a company specialising in servicing and maintaining X-ray equipment, who were available for technical advice regarding the machinery. The Ionising Radiation Regulations 1999 (IRR 99) requires that an RPA and an RPS be appointed and identified in the local rules. Their role is to ensure the equipment is operated safely and by qualified staff only.

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

Records showed the X-ray equipment had been inspected in July 2016. The Ionising Radiation Regulations 1999 (IRR 99) require that X-ray equipment is inspected at least once every three years. The regulations also required providers to inform the Health and Safety Executive (HSE) that X-rays were being carried out on the premises. Documentary evidence dated 1 August 2001 confirmed this had been completed.

Are services safe?

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

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

Patients' dental care records showed that information related to X-rays was recorded in line with guidance from 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. We saw that the Faculty of General Dental Practice (FGDP UK) guidelines: 'selection criteria for dental radiography' (2013) were being followed.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice held electronic dental care records for each patient. Dental care records contained information about the assessment, diagnosis, and treatment and also recorded the discussion and advice given to patients by dental healthcare professionals. The care records showed a thorough examination had been completed, and identified with risk factors such as smoking and diet for each patient. There were electronic tablets available in reception which allowed patients to update their medical history forms. The practice also had the facility for patients to provide electronic signatures into their dental care records to record consent.

Patients at the practice completed a medical history form which was repeated on an annual basis. The form was scanned into the patient's notes. This was checked by the dentist if there were any significant changes patients were asked to complete a new medical history form. The patients' medical histories included any health conditions, medicines being taken and whether the patient had any allergies.

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

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

Health promotion & prevention

The practice had one waiting room where information for patients relating to good oral hygiene and health was on display.

Children seen at the practice were offered fluoride varnish application and fluoride toothpaste if they were identified as being at risk. This was in accordance with the government document: 'Delivering better oral health: an evidence based toolkit for prevention.' This has been produced to support dental teams in improving patients' oral and general health. Discussions with the dentist showed they had a good knowledge and understanding of 'delivering better oral health' toolkit. We saw a copy of this document in the practice. Dentists also gave out reminder slips to patients with advice from the delivering better oral health toolkit. This included: brushing twice a day, using interdental brushes or floss and avoiding alcohol and tobacco.

We saw several examples in patients' dental care records that the dentist had provided advice on the harmful effects of smoking, alcohol and diet and their effect on oral health. With regard to smoking, the dentist had particularly highlighted the risk of dental disease and oral cancer. The dental care records contained an oral cancer risk assessment.

Staff from the practice had visited five local nursery schools to give positive messages with regard to dental health, tooth brushing, and sugar. Every child received a pack with a toothbrush, toothpaste, a timer, a balloon and tooth brushing chart. This had been funded by the practice.

We saw photographic evidence of a visit to a nursery, and the practice's participation in National Smile month and Stoptober the national initiative to stop smoking

Staffing

The practice had five dentists; two therapists; ten qualified dental nurses; one trainee dental nurse and two receptionists. 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.

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

We looked at staff training records for six staff members and these showed that staff were maintaining their continuing professional development (CPD). CPD is a compulsory requirement of registration with the GDC. The

Are services effective?

(for example, treatment is effective)

training records showed how many hours training staff had undertaken together with training certificates for courses attended. This was to ensure staff remained up-to-date and continued to develop their dental skills and knowledge. Examples of training completed included: radiography (X-rays), medical emergencies, infection control, and safeguarding. The practice manager monitored staff members CPD during their annual appraisal and maintained an overview of progress towards achieving CPD.

Records at the practice showed that all staff had an annual appraisal. As part of the appraisal process staff completed a review of their own learning objectives and these were discussed during the process. We also saw evidence the practice had an in-depth induction programme for new staff.

Working with other services

The practice had a referral policy which provided guidelines for staff on making referrals to other services. The policy had been reviewed in August 2016.

The practice made referrals to other dental professionals based on risks or if a service was required that was not offered at the practice. We saw the practice referred to the children's clinic at the local hospital if the practice was unable meet the child's needs. The practice offered a range of different dental services including oral surgery so referrals were relatively rare.

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

The practice referral system was monitored through a tracking system at reception. All referrals were recorded and telephone calls were made to ensure referral letters had been received and check progress.

Consent to care and treatment

The practice had a consent policy which made reference to the Mental Capacity Act 2005 (MCA). The issue of capacity was explored and this included making best interest decisions as identified in the MCA. The MCA provides a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make particular decisions for themselves. We saw that every member of staff had received a copy of the 'Mental Capacity Act guidance for Dental practitioners'.

Every treatment room had a digital camera which allowed dentists the opportunity to show patients the inside of their mouth on a screen. This helped the dentist to explain the treatment options and helped patients to understand what they were consenting to. Copies of photographs were available for patients to take away with them. Dentists discussed options and backed these up with leaflets, models of the mouth and teeth and photographs. This led dentists to the conclusion that patients were making informed decisions and choices with regard to their treatment. A digital signature pad in the treatment room gave patients the opportunity to provide written consent directly into their own dental care records.

The consent policy made reference to obtaining consent from children under the age of 18. We talked with dental staff about this and identified they were aware of Gillick competency. This refers to the legal precedent set that a child may have adequate knowledge and understanding of a course of action that they are able to consent for themselves without the need for parental permission or knowledge.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

During the inspection we spoke with staff and saw them speaking with patients. We saw that staff were welcoming, friendly and helpful. We saw that all staff spoke with patients with due regard to dignity and respect.

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

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

Involvement in decisions about care and treatment

We received positive feedback from 147 patients about the services provided. This was by speaking with patients, through comment cards left at the practice prior to the inspection and through patients who contacted CQC directly.

The practice offered a mixture of NHS and private dental treatment and the costs for both NHS and private treatment were clearly displayed in the practice.

We spoke with dentists about how patients had their diagnosis and dental treatment discussed with them. The dentists demonstrated in the patient care records how the treatment options and costs were explained and recorded. Digital cameras allowed dentists the opportunity to show patients the inside of their mouth on a screen. This helped the dentist to explain the treatment options and helped patients to understand what their treatment entailed. Copies of photographs were available for patients to take away with them with a written explanation of the treatment plan and costs.

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice was located in premises close to Wellingborough town centre in Northamptonshire. There was road side parking close to the dental practice.

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

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

Staff said that when patients were in pain or where treatment was urgent the practice made efforts to see the patient the same day. To facilitate this, the practice made a specific appointment slots available for patients who were in pain during both the morning and afternoon session.

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 had an equality and diversity policy which had been reviewed in September 2016 and an equal opportunities policy which had been reviewed in November 2015.

One treatment room was located on the ground floor. This allowed patients with restricted mobility easy access treatment at the practice.

The practice had two ground floor toilets one of which had been adapted to meet the needs of patients with restricted mobility. The toilet was fitted with support bars and grab handles and there was an alarm to summon assistance if required. However, the practice was not fully accessible to patients in a wheelchair. Therefore patients who had higher needs with regard to access were seen at the practice over the road which was owned by the same provider. This practice was accessible to patients in a wheelchair.

The practice had completed an access audit in line with the Equality Act (2010) this had been reviewed and updated in July 2016. The practice could accommodate patients with restricted mobility; with level access from the street to the treatment rooms. The practice did not have a hearing induction loop to assist patients who used a hearing aid. The Equality Act requires where 'reasonably possible' hearing loops are to be installed in public spaces, such as dental practices.

The practice had access to a recognised company to provide interpreters this included the use of sign language. Staff at the practice spoke a number of Asian languages so it was often possible to overcome language difficulties in-house. The principal dentist said that sometimes patients brought a family member with them to interpret. However, this was under review due to the issues of confidentiality involved in interpreting within a family.

Staff job application forms had an equal opportunity monitoring form to help practice staff ensure that job interviews were fair and equal.

Access to the service

The practice's opening hours were – Monday to Thursday: 8am to 6:30 pm, Friday: 8 am to 5:30 pm. The practice was closed at the weekend.

Access for urgent treatment outside of opening hours was by telephoning the practice and following the instructions on the answerphone message.

The practice had a website: www.oradi.co.uk. Information about treatments and services were available to patients through the website. However, opening times were not on display. The practice also had a Facebook page with contact details for the practice.

The practice operated a text message reminder service with patients receiving a text reminder. This was sent when the appointment was booked, and again 48 and 24 hours before the appointment was due.

Concerns & complaints

The practice had two complaints procedures, one for NHS patients and for private patients which had been reviewed in August 2016. The procedure explained how to complain and identified time scales for complaints to be responded to and included other agencies to contact if the complaint was not resolved to the patients satisfaction.

Information about how to complain was displayed behind reception and was available in the practice leaflet. Information regarding how to complain was available on the practice website, this included an electronic form for patients to raise concerns or complain.

Are services responsive to people's needs?

(for example, to feedback?)

From information received before the inspection we saw that there had been a number of formal complaints received in the 12 months prior to our inspection. The documentation showed the complaints had been handled appropriately and an apology and an explanation had been given to the patient.

Are services well-led?

Our findings

Governance arrangements

We saw a number of policies and procedures at the practice and saw they had been reviewed and where relevant updated during 2016. The practice manager identified that all policies were updated on a minimum of an annual basis.

We spoke with staff who said they understood the structure of the practice. Staff said they were able to raise any concerns with either the practice manager of the principal dentists. We spoke with two members of staff who said they were happy working at the practice. Staff said the practice was a good place to work and there was a good team.

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

Leadership, openness and transparency

There was a practice manager who had been working in that role since August 2015. The practice had supported this member of staff to develop their role during their time at the practice. The practice manager was due to complete a Level five diploma in leadership and management in March 2017.

We saw that full staff meetings were scheduled for three monthly, although the practice manager said this was under review with monthly meetings being considered. We saw that clinical discussions were held during team meetings and focus groups looked at particular issues such as the CQC key lines of enquiry. Staff meetings were minuted and minutes were available to all staff. When there were learning points to be shared with staff we saw evidence these had been discussed and shared as appropriate. To illustrate learning points the practice manager inserted photographs into the agenda so staff could understand particular issues being discussed. For example in relation to infection control and cleanliness or storage of instruments and equipment.

Discussions with staff showed there was a good understanding of how the practice worked, and knowledge of policies and procedures. Every member of staff had a memory stick which contained the key policies and procedures.

The practice had a duty of candour policy which directed staff to be open and to offer apologies when things had gone wrong. Staff said one example of this had been when an equipment failure had meant patients appointments had been cancelled at short notice. The practice had offered an apology and explanation to the patients who were affected. Discussions with dentists at the practice showed they had a good understanding of duty of candour.

The practice had a whistleblowing policy which had been reviewed in November 2015. The whistleblowing policy identified how staff could raise any concerns they had about colleagues' under-performance, conduct or clinical practice. This was both internally and with identified external agencies. A copy of the policy was available on any computer within the practice and also in the staff handbook which had been given to every member of staff.

Learning and improvement

We saw the practice completed a range of audits throughout the year. This was for clinical and non-clinical areas of the practice. The audits identified both areas for improvement, and where quality had been achieved. Examples of completed audits included: Regular six monthly infection control audits with the last one completed in June 2016. X-ray (radiographs) had been completed in December 2015 and June 2016 and the results had been analysed with action points. Pie charts had been produced to show the results and these were posted on the staff room notice board. Dental care records had been audited twice per year with the last one in February 2016. The results had been shared with staff and also had pie charts on the notice board to show the results. We saw several examples of clinical audits of treatments such as endodontics (concerned with the study and treatment of the dental pulp – the inside of the tooth or teeth), sedation and in-house infection control.

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

Are services well-led?

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

The practice had a NHS Friends and Family Test (FFT) comment box which was located in the waiting room. The FFT is a national programme to allow patients to provide feedback on the services provided. The FFT comment box was being used specifically to gather regular feedback from NHS patients, and to satisfy the requirements of NHS England. The practice had produced a child friendly version of the FFT form which was given to children to complete. This was a simplified version with room for the child to draw a picture. The latest information from August 2016 relating to FFT showed six patients had responded and 100% said they would recommend the practice to their family and friends.

There had been 55 patient reviews recorded on the NHS Choices website in the year up to this inspection. A further 25 dated back to 2014. Of the reviews posted in the year up to this inspection visit 51 had been positive. We noted the practice had not responded to any of the patient comments on the NHS Choices website.

The practice operated its own satisfaction survey on an on-going basis. We saw the most recent survey had been completed in 2016 and 560 patients had responded. The data had been analysed and showed that patient feedback was overwhelmingly positive. Staff maintained a positive comments and compliments book at reception.

Prior to this inspection the practice had encouraged patients to contact the Care quality Commission (CQC) directly and provide feedback about the practice. Over 100 patients took the opportunity to do so.

The principal dentist had employed a 'mystery shopper' (someone who came to the practice for an appointment posing as a new patient and fed back to the dentist afterwards how well they had been treated and the timeliness of being seen.) The mystery shopper fed back that they had never had such an in-depth examination or discussion about their mouth and teeth.