Ishak Practices Ltd

Lincoln Dental Care

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 3 November 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 opened in 2009 having taken over a former NHS office building and converting it to a dental practice. Lincoln Dental Care is located on two floors of premises situated on the outskirts of Lincoln close to the ring road. All patient areas are located on the ground floor. The practice provides mostly NHS dental treatments (90%). There is a car park to the rear of the dental practice for patient parking. There are four treatment rooms all of which are located on the ground floor.

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's published opening hours are – Monday to Friday: 8 am to 8 pm; Saturday: 9 am to 4:30 pm and Sunday: 9 am to 12:30 pm. However, on the day of this inspection (a Thursday) there were no dental staff available until 2 pm to see patients. The principal dentist said this was due to a dentist being on maternity leave and a replacement dentist not yet having completed their pre-employment checks. The practice has an NHS contract to provide emergency dental services within their identified opening times of 8 am to 8 pm Monday to Friday; 9 am to 4:30 pm on a Saturday and Sunday mornings. However, those contracted hours were not being met. The principal dentist said they had informed NHS England about the difficulties they were facing.

Summary of findings

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

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

The practice has three dentists; one dental hygienist; two qualified dental nurses; two trainee nurses and two receptionists.

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

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 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 the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society.
- Review the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking the X-ray and quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.

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 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.

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

Summary of findings

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 within 24 hours.

Patient areas including treatment rooms were all 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. The practice had an induction hearing loop to assist patients who used a hearing aid.

There were arrangements for emergency dental treatment outside of normal working hours, including weekends and public holidays.

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 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.

Lincoln 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 3 November 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector 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 some concerns particularly with regard to staffing levels and the availability of dentists at the practice.

We reviewed policies, procedures and other documents. We received feedback from eight 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. The practice had an accident book. Documentation showed the last recorded accident had occurred in June 2016 this being an inoculation (needlestick) injury to a member of staff. The accident had been analysed and learning points recorded.

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. There was a RIDDOR poster giving information to staff in the decontamination room.

Records at the practice showed there had been two significant events in the twelve months leading up to this inspection. The last recorded event had occurred in April 2016 and related to a patient becoming unwell in the practice. The record showed all significant events had been analysed and discussed with staff as appropriate.

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 provider and analysed and circulated to staff as appropriate. The most recent alert had been received in June 2016 and related to a medicine safety alert. This was displayed on the staff room notice board.

A review of the information in the accident folder identified that patients were told when they had been affected by something that had gone wrong. The organisation had information and guidance relating to the Duty of Candour from the General Dental Council (GDC) which was accessible to all staff. Patients had received an apology and been informed of the actions taken as a result of things going wrong. The principal dentist was aware of when and how to notify CQC of incidents which cause harm. Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.

Reliable safety systems and processes (including safeguarding)

The practice had a policy for safeguarding vulnerable adults and children. 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 both within the policy and behind reception. 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 principal dentist said there had been no safeguarding referrals made by the practice.

The provider and the lead receptionist were the identified leads for safeguarding in the practice. They had received enhanced training in child protection to level two in July 2015 which was valid for three years to support them in fulfilling that role. We saw evidence that all staff had completed safeguarding training to level two on a number of dates during 2016. This was a result of safeguarding training being provided within the organisation and staff attending at times that suited them rather than training together in the practice.

The practice had guidance for staff on the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. 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 which were kept behind reception. 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 up to date Employers' liability insurance certificate which was due for renewal on 29 September 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

The practice had a recapping needles policy which informed staff how to handle sharps (particularly needles and sharp dental instruments) safely. The policy had been reviewed in January 2016. We saw the practice used a recognised system for handling sharps safely in accordance with the Health and Safety (Sharp Instruments in

Are services safe?

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 on the back of work surfaces in clinical areas which followed 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 that sharps boxes should be replaced every three months even if not full. Signing and dating allowed the three month expiry date to be identified.

During discussions with dentists we were told that dentists were using rubber dams when providing root canal treatment to patients. However, this was not always made clear in the dental care records for all dentists. Guidance from the British Endodontic Society is that rubber dams should be used whenever possible. 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.

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 systems in place to check expiry dates and monitor that equipment was safe and working correctly.

There was a first aid box, an eyewash station and a burns kit which were located centrally. 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 three 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 during 2016 having attended different sessions within the organisation.

Additional emergency equipment available at the practice included: airways to support breathing, a bag valve mask for manual resuscitation, oxygen masks for adults and children 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 five staff members to check that the recruitment procedures had been followed. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all staff 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 found that not all staff had received a DBS check. However, a review of practice policy had seen applications submitted for all staff who had not received one within the month before this inspection. Completed certificates had not been received for all staff but were expected imminently. We discussed the records that should be held in the recruitment files with the principal dentist.

Are services safe?

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: fire, sharps and manual handling.

Records showed that fire extinguishers had been serviced in June 2016. The practice had a fire risk assessment which identified the steps to take to reduce the risk of fire. We saw there was an automatic fire detection system and emergency lighting installed within the premises. Records showed the practice held a fire drill annually with the last one completed on 20 March 2016.

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

Also displayed in the decontamination room were posters relating to fire safety and the manual handling regulations 1992. Which gave staff information about specific aspects of health and safety.

A business continuity plan was available in the practice and a copy was held off site. This identified the steps for staff to take should there be an event which threatened the continuity of the service.

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 available to staff in the decontamination room and behind reception in the policy file. 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 in September 2016. The audits had not highlighted any issues.

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 was one decontamination room where dental instruments were cleaned and sterilised and then bagged, date stamped and stored. 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 had latex free gloves available to avoid any risk to staff or patients who might have a latex allergy.

A trainee dental nurse demonstrated the decontamination process. We saw the procedures were as outlined in the published guidance (HTM 01-05).

The practice had both a washer disinfector, a machine for cleaning dental instruments similar to a domestic dish washer and an ultrasonic bath. An ultrasonic bath is a piece of equipment specifically designed to clean dental instruments through the use of ultrasound and a liquid. As a backup the practice had the necessary equipment for manual cleaning including a long handled brush, heavy duty gloves and a digital thermometer as identified in the guidance (HTM 01-05). However, staff said it was very rare that manual cleaning was used at the practice. 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 two autoclaves. 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 policy 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 assessed. This process had been completed by an external contractor in September 2015. The practice had been rated as a moderate risk for Legionella. Recommendations to reduce the risk at the premises had been made. We saw that the practice had implemented the recommendations and were taking steps to reduce the risks. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The practice had taken steps to reduce the risks associated with Legionella with regular flushing of dental water lines as identified in the relevant guidance.

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 June 2016. There was a Landlords gas safety certificate dated 17 March 2016. The pressure vessel checks on the compressor which produced the compressed air for the dental drills had been completed in September 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 identified in the Guidance on Emergency Medicines set out in the 'British National Formulary' (BNF). However, we saw that one of the emergency medicines Glucagon (a hormone which helps to raise blood glucose levels when necessary in patients who have diabetes) was being stored in the refrigerator. There were no records to demonstrate the refrigerator temperatures were being monitored. However, the principal dentist said this would commence with immediate effect.

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 the three dentists at the practice. 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 the X-ray machines which was sent to the Care Quality Commission (CQC) the day after the inspection. 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 14 September 2011 confirmed this had been completed. However, the HSE did not respond and therefore there was no further evidence.

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 mostly 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. However, there were some examples where this had not been recorded, and this information had not always been identified within the X-ray audits.

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.

New patients at the practice completed a medical history form which was scanned into their electronic dental records. Returning patients updated their information on an electronic tablet which was reviewed with the dentist in the treatment room. 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. A poster in the waiting room explained the NICE guidelines and recall intervals for patients.

The practice had an NHS contract to see patients who are not registered with a dentist who require emergency treatment.

Health promotion & prevention

The practice had one waiting room for patients. There were posters and leaflets relating to good oral health and hygiene on display. There was a 'Kids Zone' in the waiting room with toys and books available. Posters explained the dangers of sugar on the teeth, and explained how children could protect their teeth.

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. Leaflets in the waiting room explained the importance of fluoride and the benefits for patients' teeth.

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. Where appropriate within dental care records we saw the risk assessments for caries (tooth decay) and periodontal disease (gum disease) were also recorded

Staffing

The practice had three dentists; one dental hygienist; two qualified dental nurses; two trainee nurses 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.

The principal dentist explained that staff recruitment had been difficult due to a shortage of dentists in the Lincoln area and reluctance for dentists to relocate to Lincoln from elsewhere in the country. Records within the practice showed there were sufficient numbers of staff to meet the needs of patients attending the practice for treatment, although not to deliver the service over the number of hours identified in the published opening hours.

We looked at staff training records for clinical staff to identify that they were maintaining their continuing professional development (CPD). CPD is a compulsory requirement of registration with the 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, infection control, and safeguarding. However, the CPD records for two members of staff were not available on the day of the inspection and could not be reviewed.

Records at the practice showed that all staff had an annual appraisal. This was completed with the organisation's area manager. The provider also reviewed and audited dentists' dental records as part of the appraisal process. We also saw evidence of new members of staff having an in-depth induction programme with an identified staff support within the practice.

Working with other services

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 other local dental services, orthodontic practices and for minor oral surgery. The standard NHS referral documentation was being used.

The practice did not provide a sedation service. Therefore if a patient required sedation they were referred elsewhere. This was usually through a local community dental practice for NHS patients or to a private practice within Lincoln where the referral waiting time was less. If the practice was unable to perform minor oral surgery they referred to the Intermediate minor oral surgery (IMOS) service. Children or patients with special needs who required more specialist dental care would be referred to the community dental service.

The practice referral system was monitored through a hand written tracking system. The head receptionist was the lead person for tracking referrals. Telephone calls were made to ensure referral letters had been received and check progress.

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 with referrals faxed through to the hospital. A dentist gave an example of how a referral had been made and the patient had had begun treatment for oral cancer at the hospital. The practice also made referrals for NHS orthodontic treatment (where badly positioned teeth are repositioned to give a better appearance and improved function)

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 within the policy 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 how consent was recorded in the patients' dental care records. The records showed the dentist had discussed the treatment plan with the patients, which allowed patients to give their informed consent. As most patients received NHS treatment the practice recorded consent on a computerised copy of the FP17 DC form, the standard NHS consent form.

The consent policy made reference to identifying who had parental responsibility where a child was unable to consent for themselves. The policy also directed dentists to ensure they were aware of the up-to-date advice on the law relating 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 observed staff speaking with patients. We saw that staff were polite, and had a professional approach. We saw that 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 the X-ray processing room or an unused treatment room.

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 held securely and password protected.

Involvement in decisions about care and treatment

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

The practice offered mostly NHS treatments (90%) and the costs of NHS and private treatment were clearly displayed in the waiting room.

We spoke with the dentists to find out how the diagnosis and dental treatment was discussed with patients. The dentists demonstrated in the patient care records how the treatment options and costs were explained and recorded. Patients were given a written copy of the treatment plan which included the costs. We noted that patients' dental care records identified the diagnosis and treatment options discussed with patients.

Where necessary the dentist gave patients information about preventing dental decay and gum disease. In 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.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The patient areas of the practice were located on ground floor premises on the outskirts of Lincoln. There was a car parking to the rear of the 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 within 24 hours. To facilitate this, the practice made a specific appointment slots available for patients who were in pain or alternatively patients could sit and wait to be seen. We spoke with three patients during the inspection who said getting an appointment was not difficult. Two patients said they had been seen in an emergency and this had been within 24 hours of contacting the practice.

We reviewed the appointment book, and saw that patients were allocated sufficient time to receive their treatment and have discussions with the dentist. The appointment book also identified where patients were being seen in an emergency.

Tackling inequity and promoting equality

The practice had an equal opportunities policy which made reference to the Equality Act (2010) and gave staff guidance on treating patients without prejudice or discrimination.

There were four treatment rooms all situated on the ground floor. This allowed patients with restricted mobility easy access treatment at the practice. The treatment rooms were large enough for patients to manoeuvre a wheelchair or push chair. The design of the dental chairs would also make transferring from a wheelchair easy if this was required. Access for patients using a wheelchair or with a pushchair was through automatic doors at the front of the practice.

The practice had one ground floor toilet for patients to use. This was compliant with the Equality Act (2010) in that it was a large room with support bars and an emergency pull cord to summon assistance. There were lever operated taps on the hand wash basin and an automatic hot air hand dryer. The door to the toilet was wider than usual to allow easier access for wheelchair users.

The practice had completed an access audit in line with the Equality Act (2010) this had been reviewed and updated in September 2016. The practice could accommodate patients with restricted mobility; with level access to the ground floor treatment rooms and automatic doors for patient access. The practice had 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. A poster in the waiting room identified the different languages available for either telephone or face to face interpreting. Another poster gave details of a sign language interpreting service with contact details and informing patients they could either arrange this themselves or ask the practice to make the arrangements.

A poster in the waiting room informed patients the practice leaflet was available in languages other than English and made patients aware that a large print version was also available. The practice leaflet made patients aware of the interpreting service and access arrangements.

Access to the service

The practice's published opening hours were – Monday to Friday: 8 am to 8 pm; Saturday: 9 am to 4:30 pm and Sunday: 9 am to 12:30 pm. However, on the day of this inspection (a Thursday) there were no dental staff available until 2 pm to see patients. The principal dentist said this was due to a dentist being on maternity leave and a replacement dentist not yet having completed their pre-employment checks. The practice had an NHS contract to provide emergency dental services within their identified opening times of 8 am to 8 pm Monday to Friday; 9 am to 4:30 pm on a Saturday and Sunday mornings. However, those contracted hours were not being met. The principal dentist said they had informed NHS England about the difficulties they were facing.

The practice did not have a website. Patients were therefore not able to access the latest information or check opening times or treatment options on-line. Information was available on the NHS Choices website: www.nhs.uk. We saw the information relating to opening times had not

Are services responsive to people's needs?

(for example, to feedback?)

been updated since 28 May 2012 and did not reflect the actual opening times we saw during the inspection. There were no signs on display to identify the reduced opening hours for treatment.

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

The practice operated an e mail and telephone reminder service with patients who had appointments with the dentist. Patients received an e mail a week before their appointment was due and a telephone call the day before their appointment was due.

Concerns & complaints

The practice had a complaints policy which had been reviewed in September 2015. The policy explained how to complain and identified time scales for complaints to be responded to. Other agencies to contact if the complaint was not resolved to the patients satisfaction were identified within the complaint resolution policy.

Information about how to complain was displayed in the waiting room for both private and NHS patients.

From information received before the inspection we saw that there had been four 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. The policies were not individually dated, although a document at the front of each policy file indicated all policies would be reviewed in April each year. Within the policy files we saw there were copies of any relevant General Dental Council (GDC) guidance or related guidance from other professional bodies.

We spoke with staff who said they understood the structure of the practice. Staff said if they had any concerns they would raise these with either the practice owner or one of the dentists. We spoke with two members of staff who said they liked working at the practice.

We were shown 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

We saw that full staff meetings were scheduled for once a month throughout the year. The agenda for the full staff meeting covered areas such as: significant events, infection control, and health and safety. The practice was reviewing progress and overall performance at each staff meeting. 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.

Discussions with staff showed there was a good understanding of how the practice worked, and knowledge of policies and procedures.

The practice had guidance relating to the duty of candour which directed staff to be open and to offer apologies when things had gone wrong. This guidance had been produced by the General Dental Council (GDC) Documentation showed an example of this had been when a patient had expressed dissatisfaction with the outcome of their treatment. The documentation showed that a written apology and explanation had been sent to the patient. Discussions with dentists at the practice showed they had a good understanding of duty of candour.

The practice had a whistleblowing policy which 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 behind reception.

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. The practice schedule identified that planned audits occurred in April and September each year. Examples of completed audits included: Regular six monthly infection control audits with the last one completed in September 2016; referrals, hand washing and medical histories had been audited in both April 2016 and September 2016. Fluoride varnish for children, waiting tomes and patient satisfaction had been audited in April 2016. Consent had been audited in September 2016. The audits identified trends and learning with action points going forward. We saw that audits of radiography (X-rays) checked the quality of the X-rays but did not include checking the justification for taking the X-ray or the clinical findings had been recorded in the dental care records. We discussed this with the principal dentist who said the audit tool would be amended to include this information in future audits.

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. Not all CPD records were available; however, the ones we saw had key CPD topics such as IRMER (related to X-rays), medical emergencies and safeguarding training had been completed by all relevant staff.

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

Are services well-led?

was being used specifically to gather regular feedback from NHS patients, and to satisfy the requirements of NHS England. The latest information in the practice showed positive feedback with 100% of patients who responded saying they would recommend the practice to family and friends.

There had been 20 patient reviews recorded on the NHS Choices website in the year up to this inspection. Reviews were mixed with 15 positive and five negative reviews. The negative reviews mostly focussed on where patients had received emergency treatment. There had been 35 reviews posted prior to this. Following the inspection we noted the practice had responded to the patient comments on the NHS Choices website.

The practice operated its own satisfaction survey on an on-going basis. There was a suggestion box in the waiting room and patients were invited to provide feedback directly to the practice through this means. The latest results which had been analysed in September 2016 showed 30 patients had responded and results were positive in relation to waiting times, cleanliness of the practice and staff attitude.