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Clay Cross Dental

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 15 March 2017 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

Clay Cross Dental is located in premises close to the centre of the market town of Cal Cross in north Derbyshire. There are five treatment rooms, two of which are situated on the ground floor. The practice provides mostly NHS dental treatments (98%) There is a small car park for dental patients outside the practice, or a public car park a short distance away.

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 opening hours are – Monday to Friday: 9 am to 5:30 pm.

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 telephone number.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

The practice has ten dentists; one hygienist/ therapist; four qualified dental nurses; three trainee dental nurses; one practice manager; and two receptionists.

Summary of findings

Before the inspection we sent CQC comments cards to the practice for patients to complete to tell us about their experience of the practice and during the inspection we spoke with patients. We received responses from 51 patients through both comment cards and by speaking with them during the inspection. Those patients provided positive feedback about the services the practice provides. Among the themes we identified from patient feedback were that the practice was clean, patients found the staff welcoming and friendly, getting an appointment was relatively easy and there was a consistent approach.

Our key findings were:

- The patient areas of the premises were visibly clean and there were systems and processes in place to maintain the cleanliness.
- The systems to record accidents, significant events and complaints, learning points from these were recorded and used to make improvements.
- Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.
- There were effective systems at the practice related to the Control of Substances Hazardous to Health (COSHH) Regulations 2002.
- 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 were able to get an appointment that suited their needs.
- Dental care records demonstrated that the dentists involved patients in discussions about treatment options.
- Patients' confidentiality was protected within the practice.
- 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. However, there were some areas where refurbishment work was required.
- There was a whistleblowing policy accessible to all staff, who were aware of procedures to follow if they had any concerns about a colleague's practice.
- 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 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.
- Review the consent policy so that it makes specific reference to the Mental Capacity Act (MCA) 2005. Therefore, ensuring all staff are aware of their responsibilities under the Act as it relates to their role with particular emphasis on how it affects consent.
- 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 to assist patients and visitors who used a hearing aid.
- Review its audit protocols to document learning points that are shared with all relevant staff and ensure that the resulting improvements can be demonstrated as part of the audit process.

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.

There were systems for recording accidents, incidents and complaints.

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.

There were effective systems at the practice related to the Control of Substances Hazardous to Health (COSHH) Regulations 2002.

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 patient areas of the practice were visibly clean and there were 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).

Discussions about treatment options were recorded in dental care records.

All staff were supported to meet the requirements of the General Dental Council (GDC) in relation to their continuing professional development (CPD).

The practice was following National Institute for Health and Care Excellence (NICE) guidelines for the care and treatment of dental patients. This was with particular emphasis on 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 professionals when it was clinically necessary.

Summary of findings

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 both paper electronic dental care records were 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 and had no concerns with regard to confidentiality at the practice.

There were systems for patients to be able to express their views and opinions and the practice encouraged patients to do so.

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

The practice had two ground floor treatment rooms which allowed easy access for patients with restricted mobility. The practice did not have an induction hearing loop to assist patients who used a hearing aid.

Interpreters were readily available for patients whose first language was not English.

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. Staff said they felt well supported and there were systems for peer review and clinical discussion.

The practice had a system for carrying out audits of both clinical and non-clinical areas to assess the safety and effectiveness of the services provided. The practice was able to demonstrate that learning and improvements had resulted from the audit process.

Policies and procedures were reviewed annually.

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

Clay Cross Dental

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 15 March 2017. 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 no concerns.

We reviewed policies, procedures and other documents. We received feedback from 51 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. The practice had an accident book to record any accidents to patients or staff. The last recorded accident had been in March 2017 when a staff member accidentally injured their hand. The accident had been is had been reviewed and appropriate action taken.

The practice had not needed to make any RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) reports although staff said they were aware how to make these reports as a poster in the staff room gave information about completing RIDDOR reports.

There had been two significant events in the twelve months leading up to this inspection. The most recent significant event occurred in December 2016 and related to an equipment failure which produced a flood. This had been discussed in a staff meeting and action taken to prevent a further occurrence.

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. The practice received these direct by e mail with the most recent received in June 2016 and related to a medicine alert.

Following the inspection the practice produced a Duty of Candour policy and sent a copy to the Care Quality Commission. 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. Discussions with the practice manager identified there had been no examples of the policy needing to be put into action. The practice manager also said they knew when and how to notify CQC of incidents which caused harm.

Reliable safety systems and processes (including safeguarding)

The practice had policies for both safeguarding vulnerable adults and children which had been reviewed in September 2016. The relevant contact telephone numbers and flow chart for protection agencies were available for staff both within the policy and in staff areas of the practice. 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. Documentation showed the policy had been followed when making the referral.

The practice manager was the identified lead for safeguarding in the practice. They had received training in child protection and safeguarding vulnerable adults to level two. The latest training update was in September 2016. We saw evidence that all staff had completed safeguarding training to level two during 2016.

The practice had guidance for staff on the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. There were risk assessments for all products and there were copies of manufacturers' product 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 up to date Employers' liability insurance certificate which was due for renewal on 17 June 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

The practice had a policy for dealing with sharps injuries which was on display in all clinical rooms. It was practice policy that needles were not re-sheathed. There were devices to allow this to be completed safely. This was in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. There were sharps bins for the disposal of needles, blades and matrix bands. We saw the sharps bins were wall mounted in clinical areas where they were accessible to dentists but not to patients.

We asked the dentist how they prevented patients from swallowing or inhaling root canal instruments during root canal treatment. They explained that they used a rubber dam to prevent this from happening.

Medical emergencies

The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The

Are services safe?

practice also had access to medical oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines and medical oxygen we saw were all in date and stored in a secure central location known to all staff.

The practice had an automated external defibrillator (AED) and all staff had completed basic life support and resuscitation training in July 2016. We saw certificates that had been issued to staff following this training.

Two members of staff had been trained in first aid. The practice had a first aid box and the contents were checked regularly.

Staff recruitment

We looked at the staff recruitment files for six staff members to check that the recruitment procedures had been followed.

We saw that staff recruitment records were in line with the regulations. Every member of staff had received a Disclosure and Barring Service (DBS) check. The DBS checks were renewed every three years.

Monitoring health & safety and responding to risks

The practice had a health and safety policy which had been reviewed in September 2016. We saw that risk assessments had been completed on different areas of the practice to identify potential hazards and identify the measures taken to reduce or remove them.

The practice had a fire risk assessment which had been reviewed in September 2016. Records showed that fire extinguishers had been serviced in February 2016. There was a manual fire alarm system installed with battery operated smoke alarms throughout the practice. Fire evacuation notices were displayed for staff and patients outlining the action to take if a fire occurred. The practice held a fire drill six monthly with the last one completed on 13 March 2017.

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.

A Business Continuity Plan was available in the practice and a copy was held off site. This had last been reviewed and updated in September 2016. The plan identified the steps for staff to take should there be an event which threatened the continuity of the service.

Infection control

The practice had an infection control policy which had been reviewed in August 2016. A copy was available to staff in the decontamination room. There was an identified lead person for infection control at the practice.

Records showed that regular six monthly infection control audits had been completed. This was as recommended in the guidance HTM 01-05.

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 practice had a spillage kit for mercury and a bodily fluids spillage kit both of which were in date.

There was a decontamination room 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 as identified in the guidance HTM 01-05. The practice was latex free to avoid any risk to staff or patients who might have a latex allergy.

We saw that there were gaps between the flooring and the wall in some clinical areas. In addition the hatches into the decontamination from the treatment room were damaged and required repair or replacement. We brought this to the attention of the practice manager who said arrangements would be made to repair the issue and that CQC would be informed when this was completed.

The practice used manual cleaning techniques and had the necessary equipment to complete manual cleaning including a digital thermometer, long handled brush and heavy duty gloves. 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). At the completion of the sterilising process, all instruments were dried, placed in pouches and dated with a use by date. However, the cleaning protocols were not clear, as they made reference to the washer

disinfector and an ultrasonic cleaner, both of which were available in the practice but not in use. The practice manager said the protocols would be rewritten to clarify the situation, and CQC notified when this had been completed.

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.

There were records to demonstrate that clinical staff had received inoculations against Hepatitis B and had received boosters when required. Records showed that blood tests to check the effectiveness of the inoculation had been taken.

There was a Legionella risk assessment which had been completed by an external contractor and was due for renewal in July 2017. 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. Quarterly dip slides had been completed at the practice. Dip slides are a means of testing the microbial content (bacteria) in a liquid through dipping a sterile carrier into that liquid and monitoring any bacterial growth.

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 had been completed on electrical equipment at the practice in September 2014 and was identified for renewal in September 2017. The pressure vessel checks on the compressor which produced the compressed air for the dental drills had been completed in October 2016. This was in accordance with the Pressure Systems Safety Regulations (2000). Records showed the autoclaves had been serviced and validated in December 2016.

We saw that some dental instruments were damaged. We brought this to the attention of the practice manager who made arrangements to have the dental instruments replaced.

Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities. Prescription pads were not pre-stamped which added to their security and the stamp was held securely.

Radiography (X-rays)

We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER).

The practice had five intraoral X-ray machines (intraoral X-rays concentrate on one tooth or area of the mouth). In addition there was an extra-oral X-ray machine for taking X-rays of the entire jaw and lower skull. However, this was not being used and had been decommissioned.

This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for each X-ray set along with the three yearly maintenance logs, Health and Safety Executive notification and a copy of the local rules. The maintenance logs were within the current recommended interval of three years.

We saw examples of dental care records where X-rays had been taken. These showed that dental X-rays were not always justified, reported on and quality assured. This was not in line with guidance from the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000 which identified X-rays should be graded and justified on every occasion.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice held both electronic and paper dental care records for each patient. The decision on which system was down to each individual dentist's choice. We noted that the electronic records were more detailed than the paper dental records. Dental care records contained information about the assessment, diagnosis, and treatment. The care records showed a thorough examination had been completed, and identified any risk factors such as smoking and diet for each patient.

Patients completed a medical history form which became part of their dental care records. Returning patients updated their information which was reviewed with the dentist in the treatment room.

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.

We saw the dentists used national guidelines on which to base treatments and develop treatment plans for managing patients' oral health. Discussions with the dentists 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 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 informed patients about NICE guidelines on recalls.

Health promotion & prevention

The practice had one waiting room for patients. There were leaflets and posters to demonstrate good oral hygiene techniques, and provide information to patients regarding treatments available and the warning signs for oral cancer.

Children seen at the practice were offered fluoride varnish application and fluoride toothpaste if they were identified as being at risk. The use of fluoride varnish was in accordance with the government document: 'Delivering better oral health: an evidence based toolkit for prevention.' Discussions with staff showed they had a good knowledge and understanding of 'delivering better oral health' toolkit.

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. In some dental care records we saw the risk assessments for tooth decay and gum disease were also recorded.

Staffing

The practice had ten dentists; one hygienist/ therapist; four qualified dental nurses; three trainee dental nurses; one practice manager; 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 practice manager checked that staff who were registered with the GDC were up to date with their registration. In addition clinical staff who were required to have indemnity insurance had provided evidence their insurance cover was up to date.

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 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 what training staff had undertaken together with certificates for courses attended. This was to ensure staff remained up-to-date and continued to develop their dental skills and knowledge. We saw the CPD details for relevant staff during the inspection.

Records at the practice showed that all staff had received an annual appraisal. This was completed with the practice manager. We saw evidence of new members of staff having an in-depth induction programme.

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 and for minor oral surgery.

Are services effective?

(for example, treatment is effective)

The practice did not provide a sedation service. Therefore if a patient required sedation they were referred elsewhere either to a dental practice who provided sedation or to the local hospitals who provided this service.

The practice also made referrals for NHS orthodontic treatment and to the Maxillofacial department at the local hospital; or a local practice with a contract for minor oral surgery for wisdom tooth removal. For patients with suspicious lesions (suspected cancer) referrals were sent through to the hospital within the two week time frame for urgent referrals.

Consent to care and treatment

The practice had a patient consent policy which was due to be reviewed in September 2017. The policy did not make direct reference to the Mental Capacity Act 2005 (MCA). However, some of the issues were explored within the policy. 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.

The practice used the standard NHS FP17DC form to record patients' consent. This form recorded both consent and provided a treatment plan. The dentists discussed the treatment plan with the patients and explained the treatment process. This allowed the patient to give their informed consent. A hard copy of the consent form was retained by both the practice and the patient.

We saw how consent was recorded in the patients' dental care records. Dentists had identified the different treatment options and recorded these had been discussed with the patients. This led the patients concerned to make informed choices about their treatment and give valid consent.

We talked with dental staff about their awareness 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. We saw that staff had an understanding of Gillick competency.

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 friendly and welcoming manner. 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 was necessary to discuss a confidential matter, there were areas of the practice where this could happen such as an unused treatment room. There was a poster in the waiting room informing patients that arrangements were in place to hold confidential discussions if required.

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. Patients said they had no concerns regarding confidentiality in the practice.

Involvement in decisions about care and treatment

We received positive feedback from 51 patients about the services provided. This was through CQC comment cards left at the practice prior to the inspection, and by speaking with patients in the practice during the inspection.

The practice offered mostly NHS treatments (98%) and the costs of NHS and private treatments were clearly displayed in the waiting room. If patients were receiving treatment they were given a treatment plan which included the costs.

We spoke with dentists about how patients had their diagnosis and dental treatment discussed with them. Dentists demonstrated in the patient care records how the treatment options and costs were explained and recorded.

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 two floors including the ground floor. There was parking including disabled parking close to the dental practice.

The practice had separate staff and patient areas, to assist with confidentiality and security. Clinical and non-clinical areas were separated by a door with a keypad.

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. The practice made specific appointment slots available for patients who were in pain or required emergency treatment.

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

There were five treatment rooms two of which were situated on the ground floor. This allowed patients with restricted mobility easy access to treatment at the practice.

There was a lower section of the reception desk which meant patients who were using a wheelchair could speak with the receptionist and were able to make eye contact.

The practice had one first floor toilet for patients to use. Patients with restricted mobility who could not access the stairs would not be able to access the toilet in the practice. The practice manager said there were plans to improve the access including making a ground floor toilet that would be fully accessible and compliant with the Equality Act 2010.

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 used a recognised company to provide interpreter services for patients who could not speak English. A poster in the waiting room informed patients this was available.

Access to the service

The practice's opening hours were – Monday to Friday: 9 am to 5:30 pm.

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 telephone number.

The practice operated a text message reminder service for patients who had appointments with the dentist 48 hours before their appointment was due.

Concerns & complaints

The practice had a complaints policy which 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 complaints policy.

Information about how to complain was displayed in the waiting room.

From information reviewed in the practice we saw that there had been eight 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 when required.

Are services well-led?

Our findings

Governance arrangements

We saw a number of policies and procedures at the practice these had been reviewed in the twelve months up to this inspection.

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 manager or one of the dentists. We spoke with two members of staff who said they liked working at the practice, understood the management structure and felt they were able to raise issues with managers.

Dental care records were complete, legible, accurate, and secure. The dental care records contained sufficient detail and identified patients' needs, care and treatment.

Leadership, openness and transparency

We saw that full staff meetings at this practice were scheduled for once a month throughout the year. Staff meetings were minuted and minutes were available to all staff. Meetings for dentists were also held once a month, these meetings were also minuted.

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

The practice produced a policy relating to the Duty of Candour following the inspection. This policy directed staff to be open and to offer apologies when things had gone wrong. Discussions with staff showed they understood the principles behind the duty of candour. The practice manager said there had been no examples where the Duty of Candour policy had been used.

The practice had a whistleblowing policy which had been reviewed in September 2017 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.

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, radiography (X-rays) which checked the quality of the X-rays including the justification (reason) for taking the X-ray and the clinical findings which had been recorded in the dental care records. We did not see any evidence the practice had audited their dental care records.

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. We saw that 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 gathered information for the NHS Friends and Family Test (FFT). 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. Information was sent directly to NHS England on a monthly basis.

There were five patient reviews recorded on the NHS Choices website in the 12 months before this inspection. Four reviews provided positive feedback. Reviews dating back over a number of years before this were available on the NHS Choices website and provided mixed feedback. We noted the practice had not responded to the patient comments on the NHS Choices website.

The practice had a suggestion box in the waiting room which gave patients the opportunity to provide feedback. A poster beside the suggestion box identified comments received during 2016 and the action taken in response.