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Ferndale House Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 8 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

Ferndale House Dental Practice is located in premises situated on the northern side of Chesterfield town centre. There are four treatment rooms two of which is situated on the ground floor. The practice provides only private dental treatments. The practice has its own car park at the rear of the premises or there is pay and display car parking available for dental patients close to the dental practice.

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

The practice's opening hours are – Monday: 9 am to 7:30 pm and Tuesday to Friday: 9 am to 5:30pm.

The practice has three dentists; one orthodontist; One oral surgeon; one hygienist; seven qualified dental nurses including one receptionist; and one office manager.

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

Summary of findings

The principal dentist is registered with the Care Quality Commission (CQC) as an individual registered person. 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 three dentists; four qualified dental nurses including the practice manager; and one receptionist.

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 38 patients through both comment cards and by speaking with patients during the inspection. Those patients provided positive feedback about the services the practice provides. Among the themes we identified from patient feedback were: staff were respectful, the practice was clean, treatment was explained, and it was easy to get an appointment that suited.

Our key findings were:

- 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.
- The system for receiving Medicines and Healthcare products Regulatory Agency (MHRA) alerts needed to be reviewed.
- The practice had a consent policy including reference to the Mental Capacity Act 2005.
- 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.
- The practice offered a sedation service for patients. Sedation at the service was carried out safely and was in line with the national guidance.
- 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, the frequency of infection control audits needed to be reviewed and soil tests for the ultrasonic cleaner introduced.
- 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, medical oxygen and emergency medicines.

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

- Review the practice's infection control procedures and protocols giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance. This with particular regard to carrying out six monthly infection control audits and completing soil tests on the ultrasonic cleaners.
- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as, Public Health England (PHE).

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

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

When patients received sedation this was done safely with a consultant anaesthetist overseeing the procedure. Sedation was carried out in line with national guidance.

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 was visibly clean and had infection control procedures to ensure that patients were protected from potential risks. Audits of the decontamination process at the time of the inspection were not as recommended by the current guidance.

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

No action



Are services effective?

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

All patients were clinically assessed by a 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. 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).

There was a consent policy which made reference to the Mental Capacity Act 2005.

No action



Summary of findings

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

Are services caring?

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

Patient confidentiality was maintained and dental care records were stored securely.

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.

No action



Are services responsive to people's needs?

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 toilets were not fully accessible but alternative arrangements had been highlighted.

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.

No action



Are services well-led?

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

There was a clear management structure at the practice. Staff were aware of their roles and responsibilities within the dental team, and knew who to speak with if they had any concerns. Staff said they felt well supported and there were systems for peer review and clinical discussion.

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. The practice was able to demonstrate that learning and improvements had resulted from the audit process.

Policies and procedures were reviewed regularly.

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

No action



Ferndale House Dental Practice

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 registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an announced, comprehensive inspection on 8 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 38 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?

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 June 2016 when a staff member suffered a minor injury in the decontamination room. The records and discussions with the principal dentist identified appropriate action had been taken following this accident.

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.

To analyse and learn from significant events the practice kept records when a significant event had occurred. Learning points were identified and shared with staff. The records in the practice showed there had been two significant events in the twelve months leading up to this inspection. The most recent significant event occurred in January 2017 and related to equipment failure during treatment. Significant events were discussed in staff meetings with the dates of the relevant staff meeting recorded on the form.

The practice had signed up to receive 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. However, the practice had not received any alerts for some time and the office manager said they would check to find out why. The practice received MHRA alerts directly to a nominated e mail address and these had been discussed in staff meetings as appropriate.

The practice had a Duty of Candour policy which had been reviewed in April 2016. 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 principal dentist identified there had been one example of the policy needing to be put into action. This had been in October 2015 and was down to human error.

The event had been recorded as a significant event, was discussed in a staff meeting at the patient affected was given a full and open apology. Discussions with the principal dentist identified 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 safeguarding vulnerable adults and children which had been reviewed in September 2016. The policies identified how to respond to and escalate any safeguarding concerns. The relevant contact telephone numbers for protection agencies were available for staff both within the policy and in the reception area. 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 principal dentist was the identified lead for safeguarding in the practice. They had received training in child protection and safeguarding vulnerable adults to level two during 2016. We saw evidence that all staff had completed safeguarding training to level two in October 2016.

The practice had guidance for staff on the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. A designated member of staff was responsible for reviewing the COSHH file and ensuring data sheets were up to date. There were risk assessments for all products and there were copies of manufacturers' product data sheets. Data sheets provided information on how to deal with 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 18 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 treatment rooms. It was practice policy that only dentists' handle needles and needles were not re-sheathed. The practice used a system for the safe

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handling of sharps. This was in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. A sharps risk assessment had been reviewed in June 2016.

There were sharps bins (secure bins for the disposal of needles, blades or any other instrument that posed a risk of injury through cutting or pricking.) We saw the sharps bins were located in the decontamination rooms where they were accessible to dentists but not to patients. The 2013 regulations indicated sharps bins should not be located on the floor and should be out of reach of small children.

Discussions with dentists identified they were using rubber dams when providing root canal treatment to patients. 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 dams, 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 latex free rubber dam kits available.

Medical emergencies

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

There was an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.

All staff at the practice had completed basic life support and resuscitation training in June 2016. We saw certificates that had been issued to staff following this training.

There was a first aid box which was located in surgery two. Some of the contents were out of date and arrangements were made to replace the whole first aid box during the inspection. We saw a first aid certificate for one member of staff who had completed a first aid at work course. The certificate identified the training was in date at the time of the inspection.

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.

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. 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. The DBS checks were renewed every three years. We discussed the records that should be held in the recruitment files with the office manager.

Monitoring health & safety and responding to risks

The practice had a health and safety policy which had been reviewed in February 2017 and identified the principal dentist as the lead person who had responsibility within the practice for different areas of health and safety. As part of this policy each area of the practice had been risk assessed to identify potential hazards and identify the measures taken to reduce or remove them. Risk assessments had been reviewed in February 2017.

Records showed that fire extinguishers had been serviced in July 2016. The practice had a fire risk assessment which identified the steps to take to reduce the risk of fire. The risk assessment had been reviewed in February 2016. We saw there was an automatic fire alarm system installed with emergency lighting and smoke alarms throughout the practice. Fire evacuation notices were displayed for staff and patients outlining the action to take if a fire occurred. Records showed the practice held a fire drill annually with the last one completed in March 2016.

Are services safe?

The practice had a health and safety law poster on display in the staff room on the top floor. 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 October 2016. The plan identified the steps for staff to take should there be an event which threatened the continuity of the service. A list of emergency contacts formed part of the plan.

The practice offered a sedation service with both intravenous and inhalation sedation available. Intravenous sedation used a medicine introduced via a vein to help the patient relax, while inhalation sedation relied on the use of a gas to induce the relaxed state.

In April 2015, the Royal College of Surgeons and the Royal College of Anaesthetists published guidance on 'Standards for Conscious Sedation in the Provision of Dental care.' We saw the practice was working towards meeting the newer standards. The practice was meeting the standards set out in the previous guidance: Conscious Sedation in the Provision of Dental Care (Department of Health 2003). Patients were assessed at an initial appointment which allowed time for them to consider the risks and benefits of the sedation procedure as explained by the principal dentist. This also gave the opportunity for patients to withdraw if they so wished. Patients were provided with written guidance for before and after the sedation. The practice required that an escort come with the patient on the day that sedation was scheduled. This was to safeguard the patient afterwards and on their way home. The escort was formally briefed by the practice staff on their duties. The sedationist was supported by trained staff and resuscitation equipment was available. Four dental nurses assisting with sedation had completed immediate life support training in November 2016 and January 2017. The principal dentist was an experienced sedationist who had lectured in sedation at the local dental hospital. Two nurses had additional training in sedation.

Intravenous sedation was achieved with a single medicine called Midazolam. A reversal agent called Flumazanol was available if required. Inhalation sedation was achieved by the use of nitrous oxide.

Infection control

Dental practices should be working towards compliance with the Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05):

Decontamination in primary care dental practices' in respect of infection control and decontamination of equipment. This document sets out clear guidance on the procedures that should be followed, records that should be kept, staff training, and equipment that should be available.

The practice had an infection control policy which had been reviewed in February 2017. A copy was available to staff in both decontamination rooms. 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. The principal dentist was the lead for infection control at the practice. Certificates in the practice showed that staff had received regular update training in infection control procedures.

The practice had been advised that infection control audits were only required on an annual basis and records showed that infection control audits had been completed. Annually. The guidance HTM 01-05 states that infection control audits should be completed on a six monthly basis. The last audit had been completed in March 2016 and was due to be repeated during the week of this inspection. The latest audit had scored 98%.

The practice had a clinical waste contract, and waste matter was collected regularly. Clinical waste was stored securely away from patient areas while awaiting collection. The clinical waste contract also covered the collection of amalgam, a type of dental filling which contains mercury and is therefore considered a hazardous material. The practice had a spillage kit for mercury but did not have one for bodily fluids.

There were two decontamination rooms one on each floor. This was 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.

Are services safe?

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

The practice had one washer disinfectant, this being a machine for cleaning dental instruments similar to a domestic dish washer. There were also three ultrasonic cleaners which were used alongside the washer disinfectant. An ultrasonic cleaner is a piece of equipment specifically designed to clean dental instruments through the use of ultrasound and a solvent solution. 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 which were designed to sterilise dental instruments. 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. However the practice was not completing soil tests on the ultrasonic cleaners. A soil test would identify the ultrasonic cleaner was working correctly and cleaning was effective. Records showed that the equipment was 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 boosters when required. Records showed that blood tests to check the effectiveness of the inoculation had been taken. 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 assessment had been in association with an external contractor in August 2015. The assessment was due for renewal in August 2017. 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. We saw documentary evidence to identify that monthly dip slides had been completed. 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. In addition six monthly water samples were sent to a laboratory for testing.

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 October 2016 and was identified for renewal in October 2017. The gas supply at the practice had been checked and the practice had a landlord's gas safety certificate dated 27 May 2016. The pressure vessel checks on the compressor which produced the compressed air for the dental drills had been completed in February 2017. This was in accordance with the Pressure Systems Safety Regulations (2000). Records showed the autoclaves had been serviced on a six monthly basis with the last dated September 2016. The washer disinfectant had also been serviced and validated in September 2016.

Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities. The practice had robust security measures in place for prescription pads. This included keeping a log of prescription numbers to monitor the security of the prescription pads and maintain an audit trail. Prescription pads were not pre-stamped which added to their security and the stamp was held securely.

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) and one extra-oral X-ray machine (an orthopantomogram known as an OPG) for taking X-rays of the entire jaw and lower skull.

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 principal dentist. The provider had appointed an external

Are services safe?

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 dated 1997. 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 October 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 confirmed the HSE had been informed in February 1991.

All four X-ray machines were fitted with rectangular collimation therefore the Ionising Radiation Regulations

(Medical Exposure) Regulations 2000 (Regulation 7) were being followed. Rectangular collimation is a specialised metal barrier attached to the head of the X-ray machine. The barrier has a hole in the middle used to reduce the size and shape of the X-ray beam, thereby reducing the amount of radiation the patient receives and the size of the area affected.

The practice used non-digital X-rays and regular checks were carried out on the equipment to ensure it was working correctly.

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.

Patients' dental care records showed that information related to X-rays was recorded in line with guidance from the Ionising Radiation (Medical Exposure) Regulations 2000. This included grading of the X-ray, views taken, justification for taking the X-ray and the clinical findings.

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. 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 at the practice completed a medical history form which was checked in the treatment room. Returning patients updated their information which was also reviewed with the dentist in the treatment room. The patients' medical histories included any health conditions, medicines being taken, whether the patient might be pregnant or had any allergies.

During patient examinations 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. The dentists were using BPE for all patients other than young children which was in line with published guidance.

We saw dentists used national guidelines on which to base treatments and develop treatment plans for managing patients' oral health. Discussions 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.

Health promotion & prevention

The practice had two waiting rooms for patients, one on each floor. There was a presentation for patients in the waiting room which identified the amount of sugar in different food stuffs. This was to help patients make informed choices about healthy options and to recognise the risks to oral health. Leaflets and posters in the waiting rooms offered advice on good oral hygiene including tooth brushing techniques. There were free samples of toothpaste for patients available in the practice.

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.' This has been produced to support dental teams in improving patients' oral and general health. There was a copy of this document available in the practice.

We saw 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.

Staffing

The practice had three dentists; one orthodontist; One oral surgeon; one hygienist; seven qualified dental nurses including one receptionist; and one office manager. 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 office manager had a system for checking that staff 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 how many hours training staff had undertaken together with training certificates for courses attended. This was to ensure staff remained up-to-date and continued to develop their dental skills and knowledge. Training records for clinical staff were clear and we saw copies of training certificates and CPD details for relevant staff during the inspection. Examples of training completed included: radiography (X-rays), medical emergencies, infection control, safeguarding and the Mental Capacity Act 2005.

Are services effective?

(for example, treatment is effective)

Records at the practice showed that all staff had received an appraisal and training review. This was completed on a six monthly basis and was tied to the business plan. 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.

The practice provided a sedation service and therefore received referrals from other dental practices if a patient required sedation or for minor oral surgery.

The practice also made referrals for NHS orthodontic treatment (where badly positioned teeth are repositioned to give a better appearance and improved function).

Referrals were made to the Maxillofacial department at the local hospital or a local practice with a contract for minor oral surgery for NHS treatment such as 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.

The practice also made internal referrals for patients who were seeing the sedationist, the oral surgeon or the hygienist.

Consent to care and treatment

The practice had a patient consent policy which had been reviewed in February 2017. The policy referenced the Mental Capacity Act 2005 (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. Discussions with the office manager showed an understanding on the MCA and how it might apply to dentistry. Training records showed that all staff had completed training in the MCA within the 12 months up to this inspection.

The consent policy identified what information would be recorded in the dental care record to demonstrate that valid consent had been obtained. Dentists provided patients with a treatment plan which had been discussed with the dentist. The treatment plan 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.

The consent policy identified 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. This was both at the reception desk and on the telephone. We saw that staff were polite, and spoke with patients giving due regard to dignity and respect.

The reception desk was located within the ground floor 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 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. Feedback received from patients during the inspection and on CQC comment cards identified patients had no concerns regarding confidentiality in the practice.

Involvement in decisions about care and treatment

We received positive feedback from 38 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 only offered private dental treatments and the costs of private treatments were available from reception. New patients were sent a welcome pack which included a price list. Returning patients were sent a price list for their six monthly appointments. Fees were reviewed in January of each year.

During the inspection we asked dentists how they discussed the diagnosis and dental treatment with patients. Dentists showed us a number of examples in dental care records where treatment options and costs had been 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 the ground and first floor. There was pay and display parking including disabled parking close to the dental practice.

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

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

Staff said that when patients were in pain or where treatment was urgent the practice made efforts to see the patient the same day. 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 identified 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 gave staff guidance on treating patients without discrimination.

There were four treatment rooms two of which was situated on the ground floor. Both ground floor treatment rooms were accessible for wheelchair users. This allowed patients with restricted mobility easy access to treatment at the practice. A removable ramp was available to help patients who used a wheelchair to negotiate the front step into 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 ground floor toilet and one first floor for patients to use. The toilets were not accessible for patients who used a wheelchair and therefore were not compliant with the Equality Act (2010). This was due to the constraints of the building. Patients were made aware that the practice did not have fully accessible toilet facilities.

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 interpreter services for patients who could not speak English. British sign language interpreters were also available. However, staff said interpreters were rarely used.

Access to the service

The practice's opening hours were – Monday: 9 am to 7:30 pm and Tuesday to Friday: 9 am to 5:30pm.

The practice had a website: www.ferndaledental.co.uk. This allowed patients to access the latest information or check opening times or treatment options on-line.

Access for urgent treatment outside of opening hours was by telephoning the practice and following the instructions on the answerphone message. Dentists at the practice took part in a rota system to provide out-of-hours emergency dental treatment.

The practice operated a text message reminder service for patients who had appointments with the dentist 24 hours before their appointment was due. Some patients preferred telephone calls rather than texts, and these telephone calls were made the afternoon before the 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.

From information reviewed in the practice we saw that there had been no formal complaint received in the 12 months prior to our inspection. The documentation showed the last complaint had been received in October 2015. We saw that 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

We saw a number of policies and procedures at the practice these had been reviewed at various times 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 principal dentist. Staff said they liked working at the practice.

We saw a selection of dental care records to assess if they 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. Clinical meetings were held once every three months. Clinical meetings were also minuted.

Discussions with staff showed there was a good understanding of how the practice worked, and knowledge of policies and procedures. Staff said they were happy working at the practice and felt part of the team.

The practice had a policy relating to the Duty of Candour which 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. There had been one examples where the Duty of Candour policy had been used. Human error had led to a patient receiving an explanation and an apology.

The practice had a whistleblowing policy which had been reviewed in March 2017. This 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: Annual infection control audits. The practice had been advised that these were only required annually rather than six monthly as identified in the published guidance. Following the inspection the audit schedule was changed to six monthly. We saw that audits of radiography (X-rays) were completed at the practice by the dentists. The radiography audits 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. The practice had audited their dental care records for each clinician.

Clinical staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council. Training records at the practice showed that clinical staff were completing their CPD and the hours completed had been recorded. Dentists are required to complete 250 hours of CPD over a five year period, while other dental professionals are required to complete 150 hours over the same period. We saw that key CPD topics such as IRMER (related to X-rays), 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 invited feedback from patients. We discussed how the practice gathered formal feedback and saw that patients were able to leave written feedback on an on-going basis. This was through a comment box in reception. In addition the practice took part in a formal patient satisfaction survey. The last such survey was completed in September 2016. Responses from this survey were generally positive.

Patients could also leave feedback through the practice website at: www.ferndaledental.co.uk. However, the office manager said that so far very patients had chosen to leave feedback in this way.