

Ms. Naomi Fry

The Melbourne Dental Practice

Inspection Report

Castle Street
Melbourne
Derbyshire
DE73 8JA

Tel: 01332 862942

Website: www.melbournedentalpractice.co.uk

Date of inspection visit: 29 March 2016

Date of publication: 18/05/2016

Overall summary

We carried out an announced comprehensive inspection on 29 March 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

Melbourne Dental Practice is located in a single storey building close to the centre of Melbourne in south Derbyshire. The practice was first registered with the Care Quality Commission (CQC) in August 2011. The practice provides regulated dental services to both adults and children. The practice provides mostly NHS dental treatment (60%). Services provided include general dentistry, dental hygiene, crowns and bridges and root canal treatment.

The practice's opening hours are: Monday to Thursday: 8:30am to 5:20pm; Friday: 8:30am to 5pm. The practice closes for lunch between 1pm and 2pm. The practice does not open at weekends

Access for urgent treatment outside of opening hours is by telephoning the practice and following the instructions on the answerphone message. The practice provides emergency and out-of-hours cover as part of the local Derby emergency dental service.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. Like registered

Summary of findings

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 three dentists; five qualified dental nurses who also work on reception; one part-time decontamination nurse and one practice manager.

We received positive feedback from 39 patients about the services provided. This was through CQC comment cards left at the practice prior to the inspection and by speaking with patients in the practice.

Our key findings were:

- Patients expressed very positive views about the quality of care they received from all of the staff. Patients said they were treated with dignity and respect.
- Dentists assessed and identified the different treatment options, and discussed these with patients before treatment began.
- Patients' confidentiality was maintained.
- There were systems in place 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.
- Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.
- The practice had the necessary equipment for staff to deal with medical emergencies, and staff had been trained how to use that equipment. This included an automated external defibrillator, oxygen and emergency medicines.

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

- Review its responsibilities to the needs of people with a disability and the requirements of the Equality Act 2010 and consider purchasing a portable hearing induction loop to assist patients' who wear a hearing aid.

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.

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 (HTM 01-05).

X-ray equipment was regularly serviced to make sure it was safe for use. Staff had the skills and knowledge to operate X-ray machines safely.

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).

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 made referrals to other dental professionals when the required treatment was outside the scope of the practice. Patients with suspected oral cancer were referred to the hospital promptly for further treatment.

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 held securely.

Patients said staff were polite, caring and professional. Feedback identified that the practice treated patients with dignity and respect.

Patients said they received good dental treatment and the dentist's involved them in discussions about their dental care.

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

Are services responsive to people's needs?

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

Summary of findings

Patients said they were able to get an appointment at a time that suited their needs. Patients who were in pain or in need of urgent treatment could usually get an appointment the same day. If an appointment was not available there was a sit and wait service.

The practice had ground floor level access throughout for patients with restricted mobility, or with young children in pushchairs.

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

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?

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

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

The practice was carrying out regular audits of both clinical and non-clinical areas to assess the safety and effectiveness of the services provided.

Patients were able to express their views and comments, and the practice listened to those views and acted upon them. Regular feedback was given to patients following surveys to gather patients' views.

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

The Melbourne 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 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 29 March 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

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

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

We reviewed policies, procedures and other documents. We received feedback from 39 patients about the dental service.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had systems for recording and investigating accidents, significant events and complaints. This allowed them to be analysed and any learning points identified and shared with the staff. Documentation showed the last recorded accident had occurred in September 2015 this being an injury to a member of staff. Accident records went back over several years to demonstrate the practice had recorded and addressed issues relating to safety at the practice.

The practice had a policy for RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). RIDDOR is managed by the Health and Safety Executive, although since 2015 any RIDDORs related to healthcare have been passed to the Care Quality Commission (CQC). Staff said there had been no RIDDOR notifications made although they were aware how to make these on-line.

Records at the practice showed there had been four significant events in the 12 months up to the inspection visit. The last recorded significant event had occurred when a patient was given the wrong medical history form. This resulted in a review of how documents were managed at reception and we saw this was discussed in a team meeting.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts. These were sent out centrally by a government agency (MHRA) to inform health care establishments of any problems with medicines or healthcare equipment. Alerts were received by the practice manager and the principal dentist and forwarded to individual dentists and discussed in a staff meeting when relevant. The last MHRA the practice had received related to patients receiving cancer treatment and the potential interaction of different medicines. This was shared in paper copy with all members of staff.

Reliable safety systems and processes (including safeguarding)

The practice had a joint policy for safeguarding vulnerable adults and children. The policy had been reviewed in March 2016. The policy identified how to respond to and escalate any safeguarding concerns. Discussions with staff showed

that they were aware of the safeguarding policy, knew who to contact and how to refer concerns to agencies outside of the practice when necessary. The relevant contact telephone numbers were on display in the staff room.

The principal dentist was the identified lead for safeguarding in the practice. They had received enhanced training in child protection which had been updated in March 2015 to support them in fulfilling that role. We saw the practice had a safeguarding file which contained all of the relevant information should there be any concerns relating to safeguarding.

Staff training records showed that all staff at the practice had undertaken level two training in safeguarding adults and children. We saw the dates for update and refresher training for all staff were booked through 2016.

There was a policy and risk assessment to assess the risks associated with the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. The policy had been reviewed and updated in January 2016. This policy directed staff to identify and risk assess each chemical substance at the practice. Steps to reduce the risks included the use of personal protective equipment (gloves, aprons and masks) for staff, and the safe and secure storage of hazardous materials. There were data sheets from the manufacturer to inform staff what action to take if an accident occurred for example in the event of any spillage.

The practice had a sharps policy which informed staff how to handle sharps (particularly needles and sharp dental instruments) safely. We saw the practice used a recognised system for handling sharps safely in accordance with the regulations and practice policy. The practice policy was that only dentists handled 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.) The guidance indicated sharps bins should not be located on the floor, and should be out of reach of small children. The location of the sharps bins followed the guidance. However, ideally these should be fixed to the wall. The principal dentist sent evidence after the inspection that wall mounts for the sharps boxes had been ordered.

Copies of the how to deal with sharps injuries were displayed in the practice.

Are services safe?

Discussions with dentists and a review of patients' dental care records identified the dentists were using rubber dams when carrying out root canal treatments. Guidelines from the British Endodontic Society say that dentists should be using rubber dams. A rubber dam is a thin rubber sheet that isolates selected teeth and protects the rest of the patient's mouth and airway during treatment. We saw the practice had a plentiful supply of rubber dam kits.

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. We saw there was a system in place for checking and recording expiry dates of medicines, and replacing when necessary.

There was a first aid box in the practice and we saw evidence the contents were being checked regularly. Two staff members had completed an emergency first aid at work course in November 2015 and were the designated first aiders for the dental practice.

There was an automated external defibrillator (AED) held in 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.

Staff at the practice had completed basic life support and resuscitation training on 16 March 2016 with the ambulance service. Further training was booked for 12 October 2016 for all staff.

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

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

Monitoring health & safety and responding to risks

The practice had both a health and safety policy and environmental risk assessments; both had been updated in October 2015. Risks to staff and patients had been identified and assessed. For example there were risk assessments for: Legionella, working with mercury, radiation and Control Of Substances Hazardous to Health (COSHH).

Records showed that fire detection and fire fighting equipment such as fire alarms and emergency lighting were regularly tested. The fire risk assessment had been updated in March 2016. The fire extinguishers had been serviced in July 2015. The last recorded fire drill had been in October 2015.

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.

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

Are services safe?

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 September 2015. A copy of the policy was available to staff in a folder in the decontamination room. 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 as identified in the guidance HTM 01-05. The last audit had been completed in March 2016 and the previous one in August 2015. We saw the practice completed internal audits of infection control as well as the required six monthly audits.

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 both mercury and bodily fluids, both kits were in date.

There was a dedicated decontamination room that had been organised in line with HTM 01-05. The decontamination room had been divided into two separate areas with a clean side and a dirty side. There was a clear flow between them to reduce the risk of cross contamination and infection. 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.

We saw that instruments were being cleaned and sterilised at the practice. A dental nurse demonstrated the decontamination process. We saw the procedures were as outlined in the published guidance (HTM 01-05).

The practice was using manual cleaning to clean dental instruments. We saw the water temperature was being monitored as this is a crucial part of the manual cleaning process. Afterwards 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 steam autoclaves, which were designed to sterilise unwrapped 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. 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.

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

There were records to demonstrate that 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 practice manager and the principal dentist were the identified lead persons for Legionella at the practice. There was a Legionella risk assessment which had been updated in April 2015 by an external contractor. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The practice was aware of the risks associated with Legionella and had taken steps to reduce them with regular water tests, which were recorded. The Legionella risk assessment rated the practice as a low to medium risk for Legionella.

We discussed the practice policy for flushing the dental unit water lines with a dental nurse. This was done for two minutes at the start of the day, and for 30 seconds between patients, and again at the end of the day. A concentrated chemical was used for the continuous decontamination of dental unit water lines to reduce the risk of Legionella bacterium developing. This followed the published guidance for reducing risks of Legionella.

Equipment and medicines

There were records to demonstrate that equipment was maintained and serviced in line with manufacturer's

Are services safe?

guidelines and instructions. Portable appliance testing (PAT) had been completed on electrical equipment at the practice and was booked to be renewed in June 2016. Fire extinguishers were checked and serviced by an external company and staff had been trained in the use of equipment and evacuation procedures. The fire alarm had last been serviced in July 2015. We saw the annual landlord's gas safety certificate which was dated 29 January 2016. The practice also had a five year electrical safety certificate dated 6 September 2013. The vessel pressure checks on the compressor which produced the compressed air for the dental drills had been completed in March 2016.

Records showed that equipment used in the cleaning and sterilising process for infection control had been maintained and serviced within the time frame identified by the manufacturer.

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

Radiography (X-rays)

The practice had a radiation protection file which contained all of the information related to the different X-ray machines and their safe operation. The practice had three 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 radiation protection supervisors (RPS) this being the principal dentist. 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.

Records showed the X-ray equipment had last been inspected in March 2014. The Ionising Radiation Regulations 1999 (IRR 99) require that X-ray equipment is inspected at least once every three years.

The practice used non-digital X-ray images for the intraoral X-ray machines. We saw there were safety protocols in place for the use of chemicals and equipment used in the process.

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

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

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice held dental care records for each patient. We saw the dental care records for ten patients to evidence that dentists had recorded important information. For example grading and justification of X-rays, advice given to patients and valid consent. We saw the 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 risk factors such as smoking and diet for each patient.

We saw that patients at the practice always completed a medical history form, or updated their details. The dentist checked the medical history with the patient before treatment began. 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 dentists used national guidelines on which to base treatments and develop treatment plans for managing patients' oral health. Discussions with 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 (a condition that affects the heart) and lower wisdom tooth removal. A review of the records identified that the dentists were following NICE guidelines in their treatment of patients.

Health promotion & prevention

There was a wide variety of information for patients on display in the waiting room. There was assorted literature about the services offered at the practice, local community information and oral health information.

The practice offered fluoride application to children who were found to be at risk. This was in accordance with the government document: 'Delivering better oral health: an

evidence based toolkit for prevention.' This document had been produced to support dental teams in improving patients' oral and general health. We saw that the practice had a copy of the guidance and was using it when making judgements within the practice.

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

Staffing

The practice had three dentists; five qualified dental nurses who also worked on reception; one part-time decontamination nurse and one practice 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.

We looked at staff training records and these identified that staff 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. Examples of training completed included: radiography (X-rays), infection control, and safeguarding.

We discussed staff appraisals with the practice manager. Every member of staff had received an appraisal of their performance during July and August 2015. This had been with the practice manager of the principal dentist. Records at the practice evidenced that appraisals had been completed for all staff. We saw that staff had a development plan and their training needs and wishes had been reviewed.

Working with other services

The practice made referrals to other dentists and dental services in the area. Referrals would be made when the practice was not able to offer a particular service or if the patient required more specialised treatment. For example: the practice did not offer conscious sedation (the use of medicines to help the patient relax and to block pain during a dental procedure). Therefore if a patient required

Are services effective?

(for example, treatment is effective)

conscious sedation they would be referred to a dentist who offered that service. In addition some patients required oral surgery which was best carried out in a hospital environment. In those circumstances the patient would be referred to the maxillofacial department at one of the NHS hospitals.

Patients with suspected oral cancer would also be referred to the Derby Royal hospital. Referrals would be sent by FAX and followed up with a telephone call to ensure the referral had been received. We saw copies of referral forms used for this purpose in the practice.

The practice also made referrals for patients who required orthodontic treatment which is a specialised form of dentistry involved with moving and straightening teeth.

Consent to care and treatment

The practice had a consent policy. In addition there were several documents relating to consent in the practice. This included information about the Mental Capacity Act 2005 (MCA) and best interest decisions. The MCA provided a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make particular decisions for themselves.

Staff training records showed all staff were expected to complete on-line training in the MCA during 2016.

Consent for NHS patients was recorded in the patients' dental care records using the standard NHS consent form (FP17 DC). This form also contained the treatment plan and dental care records showed dentists discussed the treatment plan, and explained the dental process. This allowed the patient to give their informed consent. For private patients there was a signed copy of the treatment plan in patient's notes which indicated their consent with the proposed treatment.

The consent policy made reference to 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. Discussions with dentists showed the dentists understood the principle and were able to give an example of when Gillick had been used in the practice.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We observed staff speaking with patients during the inspection. We saw that staff were friendly, polite and welcoming. Our observations showed that patients were treated with dignity and respect.

The reception desk was located within the waiting room. We asked how patient confidentiality was maintained with reception staff. Staff said if it were necessary to discuss a confidential matter, the manager's office was behind the reception area and was ideal for the purpose. Staff said that all details of patients' individual treatment were discussed in the privacy of the treatment room.

We observed staff speaking with several patients throughout the day. This was at the reception desk and when dental nurses brought patients to the treatment room. We saw that patient confidentiality was maintained at the practice. We asked two patients about confidentiality. They said they had no concerns about their confidentiality at the practice.

Involvement in decisions about care and treatment

We received feedback from 39 patients on the day of the inspection. This was through Care Quality Commission (CQC) comment cards, and through talking to patients in

the practice. Feedback was wholly positive with many patients taking the time to give examples to illustrate the care they had received. Patients praised the reception staff for being friendly, and approachable. Patients also commented positively about the dental care and treatment they had received. Many patients said they were treated with respect. Some patients commented that the dentists involved patients in discussions and decisions about their dental care and treatment.

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

We spoke with two dentists about how each patient had their diagnosis and dental treatment discussed with them. We saw evidence on the patient care records of how the treatment options and costs were explained and recorded before treatment started. Patients were given a written copy of the treatment plan which included the costs.

Where necessary dentists gave patients information about preventing dental decay and gum disease. We saw several examples of this in patients' dental care records. Dentists had highlighted the particular risks associated with smoking and diet, and this was 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 practice was located in a building on a main road close to the centre of Melbourne. There was car parking available to the front of the practice and this included disabled parking. There were three ground floor treatment rooms.

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.

We spoke with two patients during the inspection. Patients said they had not experienced a problem getting an appointment. Reception staff had been welcoming and friendly. Staff said that when patients were in pain or where treatment was urgent the practice made efforts to see the patient within 24 hours, and usually the same day. The practice offered same day appointments to patients who were in pain. There was also a sit and wait system for patients who were unable to get an appointment and who were in pain or had a dental emergency.

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

Tackling inequity and promoting equality

The practice was situated in a single storey building with level access, and a ramp to the front door. This enabled patients who used a wheelchair or with restricted mobility to access treatment at the practice. The level access also assisted patients with young children in pushchairs.

The practice had access to all forms of public transport with a bus stop located close by.

We saw that an Equality Act (2010) access audit had been completed in November 2013. The toilet facilities included grab rails and an emergency pull cord.

The practice did not have a portable hearing induction loop to assist patients who used a hearing aid. The Equality Act requires that 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, and this included the use of sign language.

Access to the service

The practice's opening hours were: Monday to Thursday: 8:30am to 5:20pm; Friday: 8:30am to 5pm. The practice closed for lunch between 1pm and 2pm. The practice does not open at weekends

Access for urgent treatment outside of opening hours was by telephoning the practice and following the instructions on the answerphone message. The practice provided emergency and out-of-hours cover as part of the local Derby emergency dental service.

The practice sent text message reminders to patients the day before their appointment.

Concerns & complaints

The practice had a complaints policy which was on display in the waiting room. The policy explained to patients how they might complain, and whom to make their complaint to. The policy also identified other agencies to contact if the complaint was not resolved to the patients satisfaction.

From information received before the inspection we saw that there had been one formal complaint received in the 12 months prior to our inspection. We discussed this with the principal dentist and saw the complaint record. This showed the complaint had been dealt with in a timely manner and in line with the practice complaints policy.

Are services well-led?

Our findings

Governance arrangements

We saw a range of policies and procedures at the practice and saw they had been reviewed and where relevant updated on an annual basis. Most policies and procedures had been reviewed since the beginning of 2016.

Staff said they understood their role and could speak with the principal dentist or the practice manager if they had any concerns. Staff said they understood the management structure at the practice. We spoke with three members of staff who said they were happy working at the practice, and there was good communication within the staff team.

We saw ten 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. We were assured that patients' dental care records met the required standards and followed published guidance by the Faculty of General Dental Practice (FGDP UK).

Leadership, openness and transparency

We saw that staff meetings were scheduled for once a month throughout the year. The agenda covered areas such as: significant events, complaints and health and safety. Staff meetings were minuted and the minutes were available to all staff.

We spoke with several staff at the practice who told us they were happy working at the practice. Staff said there was a good team and everyone worked well together. Staff said they could voice their views, and raise concerns, and were encouraged to do so at team meetings. The principal dentist was available to discuss any clinical concerns and offered clinical support to the nurses. Observations showed there was a friendly and welcoming attitude towards patients from staff throughout the practice. Discussions with different members of the team showed there was a good understanding of how the practice worked, and knowledge of policies and procedures.

The practice had a whistleblowing policy which had been reviewed in March 2016. This policy identified how staff could raise any concerns they had about colleagues' conduct or clinical practice. This was both internally and with identified external agencies. A copy of the policy was

on display in the staff room. We discussed the whistleblowing policy with a dental nurse who was able to give a clear account of what the procedures were for, and when and how to use them.

Learning and improvement

We saw that audits were completed throughout the year. This was for both clinical and non-clinical areas of the practice. The audits identified both areas for improvement, and where quality had been achieved, particularly in respect of the clinical areas. Examples of completed audits included: Radiography (X-rays) in March 2016, infection control completed every six months in line with the current guidance (HTM 01-05), and record keeping audits completed in October 2015 and March 2016.

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 need to complete 150 hours over the same period.

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 being used specifically to gather regular feedback from the NHS patients, and to satisfy the requirements of NHS England. The responses within the boxes were analysed on a monthly basis. The most recent data on the NHS Choices website showed that 62 patients responded and 100% would recommend the dentist. Patients had commented through the FFT box that the text reminder service was not working properly. This had prompted staff to check the system on a daily basis to ensure that text message reminders had been sent.

Comments left on the NHS Choices website about the practice were mixed. We noted the practice had not always responded to any comments on the NHS Choices website.

The practice carried out its own survey on a six monthly basis. This was through comment cards available to patients in the waiting room. The results were analysed

Are services well-led?

and discussed in staff meetings and feedback was given to patients on the results. An example of comments from patients leading to action by the practice was: Patients

requested higher chairs in the waiting room, as many patients were elderly and had difficulty rising. In response the practice had purchased two higher chairs for the waiting room.