

Mr David James Allen

Gordon Road Dental Care

Inspection Report

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Overall summary

We carried out an unannounced comprehensive inspection on 26 July 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

Gordon Road Dental Care is a dental practice providing mostly private dental treatment. The practice is located in premises in the West Bridgeford area of Nottingham. The practice is situated on the first floor of premises close to the centre of West Bridgeford. There is a public pay and display car park available close to the practice. The practice has two treatment rooms, both of which are located on the first floor.

The current provider at the practice was first registered with the Care Quality Commission (CQC) in November 2015. The practice provides regulated dental services to both adults and children. This is mostly private treatment (90%). Services provided include general dentistry, dental hygiene, crowns and bridges, and root canal treatment.

The practice's opening hours are – Monday to Friday: 8:30 am to 6 pm.

Access for urgent treatment outside of opening hours is by telephoning the practice and following the instructions on the answerphone message or for patients under the age of 18 years by telephoning the 111 NHS 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 one dentist; three qualified dental nurses and a practice manager. Dental nurses also work on the reception desk.

We received positive feedback from 33 patients about the services provided. This was through CQC comment cards given out during the inspection and by speaking with patients in the practice.

Our key findings were:

- Patients at the practice and through CQC comment cards provided positive feedback about their experiences at the practice. Patients said they were treated with dignity and respect.
- The practice was well equipped.
- Dentists identified the different treatment options, and discussed these with patients.
- Patients' confidentiality was maintained.
- The practice was visibly clean and tidy.
- 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.

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 was visibly clean and tidy and there were infection control procedures to ensure that patients were protected from potential risks. The infection control procedures followed the Department of Health guidance HTM 01-05.

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 the 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 the relevant 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 non-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 it was appropriate to do so. There were clear procedures for making referrals in a timely manner.

No action



Are services caring?

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

Patient confidentiality was maintained within the practice.

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

Patients said they received good dental treatment and they were involved in discussions about their dental care.

No action



Summary of findings

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.

Patients said they were easily able to get an appointment. Patients who were in pain or in need of urgent treatment would be seen the same day.

The practice had limited access for patients with restricted mobility. The patient areas were located on the first floor and there was no lift available. The practice had completed a disabled access audit to consider the needs of patients with restricted mobility.

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

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 full set of policies and procedures which had been kept under review and updated when required.

Staff were aware of their roles and responsibilities within the dental team, and knew who to speak with if they had any clinical 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.

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

No action



Gordon Road Dental Care

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an announced, comprehensive inspection on 26 July 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 three members of staff during the inspection.

We reviewed policies, procedures and other documents. We received feedback from 33 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 recorded and investigated accidents, significant events and complaints. This allowed them to be analysed and any learning points identified and shared with the staff. Documentation showed there had been no accidents recorded in the previous two years.

The practice was aware of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). RIDDOR is managed by the Health and Safety Executive. Staff said there had been no RIDDOR notifications made although the practice was aware of how to make these on-line.

Records at the practice showed there had been two significant events in the 12 months up to the inspection visit. The last recorded significant event, which occurred in January 2016, was a safeguarding incident. Record showed that significant events had been well managed and appropriate action taken. Learning points were shared with staff following significant events.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts. These were sent out centrally by a government agency (MHRA) to inform health care establishments of any problems with medicines or healthcare equipment. These were received electronically by the practice manager on a regular basis. The practice manager shared them with staff when appropriate.

Reliable safety systems and processes (including safeguarding)

The practice had a child protection policy which had been reviewed in January 2016 and a vulnerable adult's policy which had been reviewed in October 2015. The policies identified how to respond to and escalate any safeguarding concerns. 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 relevant contact telephone numbers were on display in the waiting room and in staff areas of the practice.

The principal dentist was the identified lead for safeguarding in the practice. All staff had received three hours of safeguarding training to level two in January 2016 with on-line refresher training for all staff in June 2016.

We saw the practice had made one safeguarding referral in January 2016 when safeguarding concerns were passed to the local authority.

The practice had information to guide staff in the use and handling of chemicals in the practice. The information identified the risks associated with the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. The practice COSHH folder contained risk assessments which identified the steps to take 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. Manufacturers' product data sheets were also available for each product in the COSHH file.

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 28 May 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

The practice had a sharps policy which informed staff how to handle sharps (particularly needles and sharp dental instruments) safely. The policy had been reviewed in April 2016. We saw the practice used a recognised system for handling sharps safely in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, and practice policy. The policy identified that only dentists handled sharp instruments such as needles.

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.) Sharps bins were located in the treatment rooms in accordance with the guidance which states sharps bins should not be located on the floor, and should be out of reach of small children.

Discussions with the dentist 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 recommend 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 supply of rubber dam kits in the practice.

Medical emergencies

The dental practice had equipment to deal with any medical emergencies that might occur. This included

Are services safe?

emergency medicines and oxygen which were located in a secure central location. We checked the medicines and equipment and saw they were all in date. We saw there was a system in place for staff to check and record expiry dates of medicines and equipment, and to replace when necessary.

There was a first aid box in the practice and we saw evidence the contents were being checked regularly. The practice manager had completed a first aid at work course on 23 February 2015.

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. Pads for both adults and children were available for the AED and both sets of pads were within their use by date.

Staff at the practice had completed basic life support and resuscitation training on 27 January 2016.

Additional emergency equipment available at the practice included: airways to support breathing 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

The practice had a recruitment and selection policy which had been reviewed in February 2016. We looked at the staff recruitment files for five staff members to check that the recruitment procedures had been followed. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all staff recruitment files. This includes: proof of identity; checking the person's skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed). DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

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

Monitoring health & safety and responding to risks

The practice had a health and safety policy which had been reviewed in September 2015. As part of this policy environmental risk assessments had been completed. For example there were risk assessments for: manual handling, radiation (X-rays) and the practice was latex free (to avoid the risk of allergic reactions caused by latex).

The practice had a fire risk assessment which had been reviewed and updated in July 2016. Records showed that the fire extinguishers had been serviced in March 2016. The practice had completed a fire evacuation drill on 14 July 2016. Certificates identified staff had completed a three hour fire safety training course in March 2015.

There was 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 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 2016. The policy was available to staff in hard copy within the practice and in the decontamination room. A designated dental nurse was the lead person for infection control within the practice. Each dental nurse 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 and documentation to evidence this.

Are services safe?

Records showed that regular six monthly infection control audits had been completed. The most recent audit was dated February 2016. This audit scored 99%. The audit cycle was as recommended by HTM 01-05.

The practice had a clinical waste contract with a recognised company. We saw that clinical waste was collected on a regular basis. The waste was stored 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. However, mercury was no longer used at the practice so this made the spillage kit surplus to requirements. There was a spillage kit for bodily fluids which was within its use by date.

There was a decontamination room where dental instruments were cleaned and sterilised. There was a clear flow from dirty to clean areas to reduce the risk of cross contamination and infection. Staff wore personal protective equipment (PPE) during the process to protect themselves from injury. This included the use of heavy duty gloves, aprons and protective eye wear. Information was displayed within the decontamination room to offer staff guidance in the use of PPE.

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 had one washer disinfectant (a machine for cleaning dental instruments similar to a domestic dish washer). After cleaning the dental instruments were rinsed and examined using an illuminated magnifying glass. Finally the instruments were sterilised in an autoclave (a device for sterilising dental and medical instruments). The practice had two autoclaves, one I day to day use, and a second as a back-up in the event of failure of the first. Both were steam autoclaves which were designed to sterilise unwrapped instruments. At the completion of the sterilising process, all instruments were dried, and placed in pouches and dated with a use by date.

Occasionally instruments were manually cleaned. This was particularly if they were heavily soiled. The guidance HTM 01-05 identifies that the water temperature for manual cleaning should not exceed 45 degrees centigrade. The

taps within the decontamination room were automatic and had been pre-set at 43 degrees centigrade. A thermometer was available for random checking of the water temperature.

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 the equipment was functioning correctly. Records showed that the equipment was in good working order and being effectively maintained.

We saw 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 had a risk assessment for dealing with the risks posed by Legionella. This had been completed by an external contractor in January 2015. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The practice was aware of the risks associated with Legionella and had taken steps to reduce them with regular flushing of dental water lines as identified in the relevant guidance.

Equipment and medicines

The practice kept records to demonstrate that equipment was maintained and serviced in line with manufacturer's guidelines and instructions. Arrangements had been made to carry out portable appliance testing (PAT) on electrical equipment at the practice on 5 April 2016.

The practice had all of the medicines needed for an emergency situation, as recommended in the British National Formulary (BNF). Medicines were stored securely and appropriately and there were sufficient stocks available for use.

Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities. The annual pressure vessel checks on the compressor which produced the compressed air for the dental instruments had been completed on 4 June 2015. We saw that this was booked to be repeated on 11 August 2016.

Radiography (X-rays)

Are services safe?

The practice had an electronic Radiation Protection file which contained all of the relevant information and records relating to the X-ray machines and their safe use on the premises.

The practice had two intraoral X-ray machines (intraoral X-rays concentrate on one tooth or area of the mouth). These were located in each of the individual treatment rooms, although only one machine was being used.

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 radiation protection advisor (RPA). This was a company specialising in servicing and maintaining X-ray equipment, which were available for technical advice regarding the machinery. The Ionising Radiation Regulations 1999 (IRR 99) requires that an RPA and an RPS to be appointed and identified in the local rules. Their role is to ensure the equipment is operated safely and only by qualified staff.

Records showed the X-ray equipment had last been inspected on 8 June 2016. The X-ray machines had a critical

examination report produced on 1 October 2015. The Ionising Radiation Regulations 1999 (IRR 99) require that X-ray equipment is inspected at least once every three years to ensure it is safe and working correctly.

The practice used digital X-rays for the X-ray machine in regular use and had obtained a quotation to convert the second machine to digital X-rays as well. Digital X-rays allowed the image to be viewed almost immediately, and relied on lower doses of radiation. This therefore reduced the risks to both the patients and staff.

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

Patients' dental care records showed that information related to X-rays was recorded in line with guidance from the Ionising Radiation (Medical Exposure) Regulations 2000. This included grading of the X-ray, views taken, justification for taking the X-ray and the clinical findings. We saw that the Faculty of General Dental Practice (FGDP UK) guidelines: 'selection criteria for dental radiography' (2013) were being followed.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice held electronic dental care records for each patient. They contained information about the patients' clinical assessment, diagnosis, and treatment and also recorded the discussion and advice given to patients by dental professionals. The dental care records showed a thorough examination had been completed, and identified risk factors such as smoking and diet for each patient.

All patients at the practice completed a medical history form at each visit. The form was completed and the information was uploaded into the patient's dental care records. 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 widely 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 the timescales for recalling patients; prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart); and lower wisdom tooth removal. A review of the records identified that the dentists were following NICE guidelines in their treatment of patients.

Health promotion & prevention

The practice had a variety of information for patients in the waiting room. There were leaflets about services and treatments provided.

Discussions with dentists identified that children were offered fluoride application varnish and fluoride toothpaste if they were identified as being at risk. This was in accordance with the government document: 'Delivering better oral health: an evidence based toolkit for prevention.' This had been produced to support dental teams in improving patients' oral and general health.

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 one dentist; three qualified dental nurses and a practice manager. Dental nurses also worked on the reception desk. 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.

Individual staff members maintained their own records of continuing professional development (CPD). Core subjects were usually completed as a team, for example basic life support training and safeguarding. CPD is a compulsory requirement of registration with the GDC. The practice manager said they monitored staff CPD and records would be brought into the practice when required.

Records at the practice showed that appraisals had been completed for all staff. As part of the appraisal system staff identified their learning needs for the coming year. We saw that the newest member of staff had an induction programme and was being mentored by the head nurse.

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. Examples of referrals made would be when the patient required: sedation; implants; oral surgery or complicated or complex treatment; or orthodontic treatment.

The practice used a referral portal which was being trialled in the area. All referrals were sent through to the Queens Medical Centre (QMC) from where it was possible to track the progress of any referrals

Consent to care and treatment

The practice had a consent policy which had been reviewed in August 2016 made reference to the Mental Capacity Act 2005 (MCA) and informed consent and the ability to consent. The policy identified adults who lacked

Are services effective?

(for example, treatment is effective)

capacity and made reference to best interest decisions. 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.

Consent was recorded in the practice using a specific form. This form recorded both consent and provided a treatment plan. This form was signed manually and a copy was kept

in the dental care record. The dentist discussed the treatment plan with the patients and explained the treatment process. This allowed the patient to give their informed consent.

Discussions with dental staff identified they were aware of Gillick competency. This refers to the legal precedent set that a child may have adequate knowledge and understanding of a course of action that they are able to consent for themselves without the need for parental permission or knowledge.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The reception desk was located in the waiting room. We asked how patient confidentiality was maintained at reception. Staff said if it were necessary to discuss a confidential matter, there were areas of the practice where this could happen. The practice manager's office was close to reception and this would be the most convenient. Staff said that patients' individual treatment was not discussed at the reception desk.

During the inspection we observed how staff interacted with patients. We saw that staff spoke politely and professionally with patients. We spoke with three patients in the practice who said that staff had dealt with them with dignity and respect.

We saw that patient confidentiality was maintained at the practice. We asked three patients about confidentiality. They said they had no concerns and had not had any experience of their confidentiality being breached. Computer screens could not be overlooked by patients standing at the reception desk. We saw that patients' dental care records were password protected and held securely.

Involvement in decisions about care and treatment

We received feedback from 33 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 from patients was positive on the day of the inspection with patients saying they had a positive experience. Patients said they were involved in their treatment and were able to ask questions and talk with staff about their treatment plan.

The practice offered mostly private treatments and the costs were clearly displayed in leaflets and posters in the practice and on the practice website.

We spoke with a dentist about how each patient had their diagnosis and dental treatment discussed with them. We saw evidence in 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 the dentist gave patients information about preventing dental decay and gum disease, and we saw examples in patients' dental care records. The dentist had highlighted the risks associated with smoking and diet, and this was recorded in patients' 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 premises in the West Bridgeford area of Nottingham. The practice was situated on the first floor of premises close to the centre of West Bridgeford. A public pay and display car park was available close to the practice. The practice had two treatment rooms, both of which were located on the first floor.

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 was a sufficient supply of instruments to meet the needs of the practice.

We spoke with one patient during the inspection. They said the practice was very busy and sometimes this meant there was a waiting time for routine appointments. Patients in person and through comment cards said reception staff were welcoming. Staff said that when patients were in pain or where treatment was urgent the practice made efforts to see the patient the same day.

We reviewed the appointment book, and saw that patients were allocated sufficient time to receive their treatment and have discussions with the dentist. The practice offered specific emergency appointments available at the end of the morning and afternoon sessions for patients who were in pain or who required emergency treatment.

Tackling inequity and promoting equality

The practice had a disability and human rights policy which had been reviewed in February 2016. The practice was located on the first floor with access via a flight of stairs. Fire regulations had prevented the practice from installing a stair lift. The difficulty with accessing the practice for patients with restricted mobility was explained when the patients first contacted the practice. As a result patients who used a wheelchair or with severely restricted mobility were not able to access treatment at the practice.

The restrictions with access for wheelchair users imposed by the layout of the building were highlighted in the practice leaflet however; this was not clear on the practice website. The principal dentist said this would be addressed.

The practice had good access to all forms of public transport being situated on a main road with a bus stop located close by.

The practice had toilet facilities for the use of patients and staff. These were situated on the first floor within the practice.

The practice was in the process of completing an access audit in line with the Equality Act (2010).

The practice had a hearing induction loop available to assist patients who used a hearing aid. The Equality Act required where 'reasonably possible' hearing loops to be installed in public spaces, such as dental practices.

The practice had access to an external company who would provide interpreters if needed. Staff said they had never needed to use this service, but it was available if needed. .

Access to the service

The practice's opening hours were – Monday to Friday: 8:30 am to 6 pm.

Access for urgent treatment outside of opening hours was by telephoning the practice and following the instructions on the answerphone message or for patients under the age of 18 years by telephoning the 111 NHS service.

The practice operated a text message service, e mail reminders and on occasion telephone reminder for patients when their appointment was due.

Concerns & complaints

The practice had separate complaints procedures for both NHS and private patients. These had been reviewed in January 2015. The procedures explained how to complain and included other agencies to contact if the complaint was not resolved to the patients satisfaction.

We noted information about how to complain was not on display or available on the practice website.

The practice had received one complaint in the year up to this inspection. This was in July 2016. We saw this complaint was still on-going despite apologies and an explanation had been given to the patient.

Are services well-led?

Our findings

Governance arrangements

We saw a number of policies and procedures at the practice and saw that all policies, procedures and risk assessments were kept under review. We saw they had been reviewed and where relevant updated during the 12 months before the inspection.

Discussions with staff at the practice demonstrated they understood their roles and could speak with either the dentist or the practice manager if they had any concerns. We spoke with two members of staff who said they liked working at the practice, and there was a good team.

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

Leadership, openness and transparency

There was a practice manager in post. The practice manager was a qualified dental nurse by background. They had identified a management training course as a goal for their personal development.

We saw that staff meetings were scheduled for once a month throughout the year. The agenda covered areas such as: medical emergencies. Minutes of staff meetings were available to all staff.

Staff said they could voice their views, and raise any concerns, and were encouraged to do so at team meetings. Staff said the dentist was approachable and was available to discuss any clinical concerns. Discussions with different members of the team showed there was a good understanding and knowledge of policies and procedures.

The practice had a whistleblowing policy which had been reviewed in February 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 whistleblowing policy was on display on the staff room noticeboard.

Learning and improvement

We saw that the practice was carrying out a schedule of audits throughout the year. This was for both clinical and

non-clinical areas of the practice. The system of audits allowed the practice to identify both areas for improvement, and where quality had been achieved. This was particularly in respect of the clinical areas. Examples of completed audits included: a monthly cleaning audit, a medication audit in January 2016; a patient failure to attend audit in July 2016; a handwashing audit in July 2016; and clinical records had been audited monthly and radiography (X-rays) February 2016.

Clinical staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council. 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. We saw the records for three members of staff and saw that the practice manager maintained an over view of the CPD records and certification.

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

The practice had a patient satisfaction survey which was completed on an annual basis. A small sample of patients were randomly selected. We saw the results were analysed and points raised by patients were discussed with the staff team. The records showed the last survey had been completed in August 2015 and was therefore due to be repeated. Responses from the August 2015 survey had been positive. We saw that arrangements had been made to repeat the patient satisfaction survey.

There was a comment book in the waiting room for patients to record their thoughts and comments and thereby give instant feedback to the practice. We saw this had many positive comments from patients.

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. Analysis of the results identified the majority of patients would recommend the practice to their family and friends. The latest data published on the NHS

Are services well-led?

Choice website (www.nhs.uk) showed 73 patients had responded and 99% would recommend the practice to their friends and family. There were no patient reviews of the practice on the NHS Choices website.