

Mr. Ravi Kumar Sivasubramanian

High Street Dental Practice

Inspection Report

11 High Street
Bedford
Bedfordshire
MK40 1RN

Tel: 01234 263000

Website: www.highstreetdentalbedford.com

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Overall summary

We carried out an announced comprehensive inspection on 13 September 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

The practice is located on two floors of premises in Bedford town centre, although only the ground floor was used for patient services. The practice provides mostly NHS dental treatments, with approximately 95% of the treatment provided to NHS patients. There is pay and display car parking within the town centre and roadside car parking a little further out from the town centre. There are six treatment rooms, although only three were in use. These treatment rooms were all located on the ground floor.

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

The practice's opening hours are – Monday to Friday: 8:30 am to 5 pm, with the practice closed for lunch 1:30 pm to 2:30 pm. On Tuesdays and Thursdays the practice stays open until 7:15 pm. The practice is closed at weekends.

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

The principal dentist is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'.

Summary of findings

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

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

The practice has two dentists; four qualified dental nurses; one trainee dental nurse; and one receptionist.

We received positive feedback from 34 patients about the services provided. This was by speaking with patients and through comment cards left at the practice prior to the inspection.

Our key findings were:

- The premises were visibly clean and there were systems and processes in place to maintain the cleanliness.
- Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Patients said they had no problem getting an appointment that suited their needs.
- Patients were able to access emergency treatment when they were in pain.
- Patients provided positive feedback about their experiences at the practice. Patients said they were treated with dignity and respect; and the dentist involved them in discussions about treatment options and answered questions.
- Patients' confidentiality was protected.
- There were systems to record accidents, significant events and complaints, and where learning points were identified these were shared with staff.
- The records showed that apologies had been given for any concerns or upset that patients had experienced at the practice.
- The practice followed the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control with regard to cleaning and sterilizing dental instruments.
- There was a whistleblowing policy accessible to all staff, who were aware of procedures to follow if they had any concerns.
- The practice had the necessary equipment for staff to deal with medical emergencies, and staff had been trained how to use that equipment. This included an automated external defibrillator, oxygen and emergency medicines.

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

- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society
- Review its responsibilities to the needs of people with a disability and the requirements of the Equality Act 2010 and consider installing a hearing induction loop to assist patients and visitors who used a hearing aid.

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.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts and took appropriate action including sharing information with staff.

The practice was visibly clean.

All staff had received up-to-date training in safeguarding vulnerable adults and children. There were clear guidelines for reporting concerns and the practice had a lead member of staff to offer support and guidance over safeguarding matters. Staff knew how to recognise the signs of abuse, and how to raise concerns when necessary.

The practice had emergency medicines and oxygen available. However there was no automated external defibrillator (AED) although one was ordered during the inspection. Regular checks were being completed to ensure the emergency equipment was in good working order.

Recruitment checks were completed on all new members of staff. This was to ensure staff were suitable and appropriately qualified and experienced to carry out their role.

The practice had infection control procedures to ensure that patients were protected from potential risks. Regular audits of the decontamination process were as recommended by the current guidance.

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

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).

The practice was following National Institute for Health and Care Excellence (NICE) guidelines for the care and treatment of dental patients. Particularly in respect of patient recalls, lower wisdom tooth removal and the prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart).

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

No action



Are services caring?

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

Patient confidentiality was maintained and electronic dental care records were password protected.

No action



Summary of findings

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

There were systems for patients to be 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 who were in pain or in need of urgent treatment could usually get an appointment the same day.

The practice was located on the ground floor which allowed easy access for patients with restricted mobility. A disabled access audit in line with the Equality Act (2010) had been completed to consider the needs of patients with restricted mobility. The practice did not have a hearing induction loop to assist patients who used a hearing aid.

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

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.

The practice had a system for carrying out regular audits of both clinical and non-clinical areas to assess the safety and effectiveness of the services provided. Policies and procedures had been kept under review.

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

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

No action



High Street 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 13 September 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

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

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

We reviewed policies, procedures and other documents. We received feedback from 34 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

There were systems to record and investigate 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 July 2012 this being a minor injury to a member of staff. The accident had been analysed and learning points recorded. 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 not made any RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) reports although staff said they were aware how to make these reports.

Records at the practice showed there had been no significant events during 2016. The last recorded event had occurred in April 2013 and related to a needlesick injury to a member of staff. The record showed this significant event had been analysed and discussed with staff.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts. These were sent out centrally by a government agency (MHRA) to inform health care establishments of any problems with medicines or healthcare equipment. These were received by the principal dentist analysed and discussed in staff meetings as appropriate. The most recent alert had been received in January 2015 and related to child looped cords and chains on window blinds.

People who use services are told when they are affected by something that goes wrong, given an apology and informed of any actions taken as a result. The provider knows when and how to notify CQC of incidents which cause harm.

Reliable safety systems and processes (including safeguarding)

The practice had policies for safeguarding vulnerable adults and children. The policies had been reviewed and updated in August 2016. The policies identified how to respond to and escalate any safeguarding concerns. The relevant contact telephone numbers and a flow chart for action were available for staff. 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 enhanced training in child protection in April 2014 to support them in fulfilling that role. We saw evidence that all staff had completed safeguarding training during 2015 and 2016.

The practice had information to guide staff in the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. This identified the risks associated with the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. There were hard copies of manufacturers' product data sheets and risk assessments. 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 17 February 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. 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. We saw there were devices in each clinical area for the safe removal and disposal of needles and sharps.

There were sharps bins (secure bins for the disposal of needles, blades or any other instrument that posed a risk of injury through cutting or pricking.) We saw the sharps bins were located in clinical areas which followed the guidance which indicated sharps bins should not be located on the floor, and should be out of reach of small children.

Discussions with dentists and a review of patients' dental care records identified not all dentists were not using rubber dams when providing root canal treatment to patients. This did not follow guidance from the British Endodontic Society. A rubber dam is a thin, square sheet, usually latex rubber, used in dentistry to isolate the

Are services safe?

operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment (treatment involving the root canal of the tooth) is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured.

Medical emergencies

The dental practice had equipment in preparation for any medical emergencies that might occur. This included emergency medicines and oxygen which were located in a secure central location. We checked the medicines and found they were all in date. There were systems in place to check expiry dates and monitor that equipment was safe and working correctly.

There was a first aid box in the practice which was located behind reception.

At the start of the inspection we saw the practice did not have an automated external defibrillator (AED) at the practice. However, the principal dentist ordered an AED during the inspection and we saw evidence this had been done. 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. Having an AED at the practice would comply with the Resuscitation Council UK guidelines.

All staff at the practice had completed basic life support and resuscitation training which was valid until 20 July 2017.

Additional emergency equipment available at the practice included: airways to support breathing, oxygen masks for adults and children, 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 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.

Monitoring health & safety and responding to risks

The practice had a health and safety policy which had been reviewed in January 2016. The policy 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 environmental risk assessments had been completed. For example there were risk assessments for: fire, infection control and hazardous substances.

Records showed that fire extinguishers had been serviced in January 2016. The practice had a fire risk assessment however, this needed to be updated and expanded. We saw there was an automatic fire detection system installed within the premises. The fire evacuation procedure was on display within the practice. Records showed the last fire drill had been completed on 29 June 2016 when a faulty detector was set off in error.

The practice had a health and safety law poster on display in the back of reception. 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.

Are services safe?

The practice had an infection control policy which had a number of general British Dental Association guidelines. An updated service specific infection control policy was sent to the Care Quality Commission following this inspection. Dental nurses had set responsibilities for cleaning and infection control in each individual treatment room. The practice had systems for testing and auditing the infection control procedures.

Records showed that regular six monthly infection control audits had been completed. This was as recommended in the guidance HTM 01-05. The last audit was completed in September 2016 and scored 95%. An action plan dated 7 September 2016 had been produced to address the infection control issues highlighted during the audit.

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.

There was one decontamination room. This was where dental instruments were cleaned and sterilised. Staff wore personal protective equipment during the process to protect themselves from injury. This included the use of heavy duty gloves, aprons and protective eye wear. The practice was latex free to avoid any potential latex allergy. As a result latex free gloves were available

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 ultrasonic bath. An ultrasonic bath is a piece of equipment specifically designed to clean dental instruments through the use of ultrasound and a liquid. 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 vacuum autoclaves which were designed to sterilise wrapped 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. There were records to demonstrate this and that equipment was functioning correctly. Records showed that the equipment was in good working order and being effectively maintained.

The practice had a policy for dealing with blood borne viruses. There were records to demonstrate that clinical staff had received inoculations against Hepatitis B and had received blood tests to check the effectiveness of that inoculation. Health professionals who are likely to come into contact with blood products, or who are at increased risk of sharps injuries should receive these vaccinations to minimise the risk of contracting blood borne infections.

The practice had a risk assessment for dealing with the risks posed by Legionella. This had been completed by an external contractor in March 2011. We saw that the risk assessment had been reviewed and updated in October 2015. The risk assessment had identified the overall risk for the practice as medium. 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. Portable appliance testing (PAT) had been completed on electrical equipment at the practice in April 2016. The pressure vessel checks on the compressor which produced the compressed air for the dental drills had been completed in July 2016. Records showed the autoclaves had been serviced in February and May 2016.

The practice had all of the medicines needed for an emergency situation, as recommended in the British National Formulary (BNF).

Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities.

Radiography (X-rays)

There was a Radiation Protection file which contained the relevant information and records relating to the X-ray machines and their safe use on the premises.

Are services safe?

The practice had three intraoral X-ray machines (intraoral X-rays concentrate on one tooth or area of the mouth). A fourth which was not in use had been decommissioned as had the extra-oral X-ray machine (an orthopantomogram known as an OPG) for taking X-rays of the entire jaw. Both machines were still in situ, but neither was in a working condition.

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

The practice had critical examination documentation for the X-ray machines. 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 September 2016. The Ionising Radiation Regulations 1999 (IRR 99) require that X-ray equipment is inspected at least once every three years. The regulations also required providers to inform the Health and Safety Executive (HSE) that X-rays were being carried out on the premises. Documentary evidence dated 2 September 2005 confirmed this had been completed.

The practice used digital X-rays, which allowed the image to be viewed almost immediately, and relied on lower doses of radiation. This therefore reduced the risks to both the patients and staff.

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

Patients' dental care records showed that information related to X-rays was 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. Dental care records contained information about the assessment, diagnosis, and treatment and also recorded the discussion and advice given to patients by dental healthcare professionals. The care records showed a thorough examination had been completed, and identified with risk factors such as smoking and diet for each patient.

Patients at the practice completed a medical history form. If there were any changes patients these were updated on the computer in the treatment room with the dentist. The patients' medical histories included any health conditions, medicines being taken, whether the patient had any allergies and whether they might be pregnant.

The dental care records showed that dentists assessed the patients' periodontal tissues (the gums) and soft tissues of the mouth. The dentists used the basic periodontal examination (BPE) screening tool. BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to a patient's gums.

We saw the dentist used national guidelines on which to base treatments and develop treatment plans for managing patients' oral health. Discussions with the dentist showed they were aware of National Institute for Health and Care Excellence (NICE) guidelines, particularly in respect of recalls of patients, prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart) and lower wisdom tooth removal. A review of the records identified that the dentists were following NICE guidelines in their treatment of patients.

We saw separate notes for patients who had received implants. These detailed the risks, costs and probable outcome for each patient.

Health promotion & prevention

The practice had one waiting room and posters and leaflets relating to good oral health and hygiene were on display. This included information about support to stop smoking, good oral hygiene and the practice leaflet.

Children seen at the practice were offered fluoride varnish application and fluoride toothpaste if they were identified as being at risk. This was in accordance with the

government document: 'Delivering better oral health: an evidence based toolkit for prevention.' This has been produced to support dental teams in improving patients' oral and general health. Discussions with the dentist showed they had a good knowledge and understanding of 'delivering better oral health' toolkit. There was a copy of this document in the practice. We saw that the NHS Dental Services had audited the FP17 consent forms and written to the practice in January 2013. This was in relation to the provision of fluoride varnish application for children.

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.

We saw evidence the practice had visited local schools to offer oral hygiene advice. This included talking to school children about ways to avoid dental decay, and improvements to the way the children cleaned their teeth.

Staffing

The practice had two dentists; four qualified dental nurses; one trainee dental nurse; and one receptionist. 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.

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 three staff members and these showed 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), medical emergencies, infection control, and safeguarding.

Are services effective?

(for example, treatment is effective)

Records at the practice showed that all staff had an annual appraisal. As part of the appraisal process staff completed a review of their own learning objectives and these were discussed during the process. We also saw evidence of new members of staff having an 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 to the local hospital particularly for suspected oral cancer which was within the two week referral protocol.

The practice did not provide a sedation service. Therefore if a patient required sedation they were referred elsewhere. This was usually to the community dental service or to hospital.

The practice did not have a clear system for monitoring or tracking referrals.

Consent to care and treatment

The practice had a consent policy, however, this was not dated and it was not possible to see if it had been kept under view. The practice also had information about the Mental Capacity Act 2005 (MCA). The issue of capacity was

explored within the information and this included making best interest decisions as identified in the MCA. The MCA provides a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make particular decisions for themselves.

We saw how consent was recorded in the patients' dental care records. The records showed the dentist had discussed the treatment plan with the patients, which allowed patients to give their informed consent. As most patients received NHS treatment the practice recorded consent on the FP17 DC form, the standard NHS consent form. The practice kept a supply of specific consent forms for different treatments, and a specific consent form for private treatment. Treatment plans and consent forms for complex treatment or implants were produced when required on the computer.

The consent policy made reference to obtaining consent from children under the age of 18. We talked with dental staff about this and identified they were aware of Gillick competency. This refers to the legal precedent set that a child may have adequate knowledge and understanding of a course of action that they are able to consent for themselves without the need for parental permission or knowledge.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

During the inspection we observed reception staff speaking with patients. We saw that staff were polite, welcoming and had a professional approach. We saw that when staff spoke with patients this was in a dignified and respectful manner.

The reception desk was located within the waiting room. We asked reception staff how patient confidentiality was maintained at reception. Staff said that details of patients' individual treatment were never discussed at the reception desk. In addition if it were necessary to discuss a confidential matter, there were areas of the practice where this could happen.

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 password protected and held securely.

Involvement in decisions about care and treatment

We received positive feedback from 34 patients about the services provided. This was through CQC comment cards left at the practice prior to the inspection and by speaking to patients in the practice.

The practice offered mostly NHS treatments and the costs were clearly displayed in the reception area. The fees for private treatment were attached to the practice leaflet.

We spoke with the dentist about how patients had their diagnosis and dental treatment discussed with them. The dentist demonstrated in the patient care records how the treatment options and costs were explained and recorded. Patients were given a written copy of the treatment plan which included the costs.

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 practice was located on two floors of premises in Bedford town centre, although only the ground floor was used for patient services. There was pay and display car parking within the town centre and roadside car parking a little further out from the town centre. There were six treatment rooms, although only three were in use. These treatment rooms were all located on the ground 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 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. To facilitate this the practice had a sit and wait system or patients were given treatment slots for patients who had cancelled or not turned up.

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 had an equal opportunities policy.

All patient areas were situated on the ground floor. This allowed patients with restricted mobility easy access to treatment at the practice. The treatment rooms were large enough for patients to manoeuvre a wheelchair or push chair.

The practice had one ground floor toilet which had been adapted to meet the needs of patients with restricted mobility. The toilet was fitted with support bars and grab handles and there was level access from the street throughout the patient areas of the practice.

The practice had completed an access audit in line with the Equality Act (2010) this had been reviewed and updated in September 2016. The practice could accommodate patients with restricted mobility; with level access from the street to the treatment rooms. The practice did not have a hearing induction loop to assist patients who used a hearing aid. The Equality Act requires where 'reasonably possible' hearing loops are to be installed in public spaces, such as dental practices.

The practice had access through the local authority to a recognised company to provide interpreters. Additionally NHS England provided information on accessing interpreters and this included the use of sign language.

Access to the service

The practice's opening hours were - Monday to Friday: 8:30 am to 5 pm, with the practice closed for lunch 1:30 pm to 2:30 pm. On Tuesdays and Thursdays the practice stayed open until 7:15 pm. The practice was closed at weekends.

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

Concerns & complaints

The practice had a complaints procedure for patients. We saw this procedure was in need of updating. The procedure explained how to complain and identified time scales for complaints to be responded to. The procedure included other agencies to contact if the complaint was not resolved to the patient's satisfaction.

Information about how to complain was displayed in reception.

From information received before the inspection we saw that there had been two formal complaints received in the 12 months prior to our inspection. The documentation showed the complaints had been handled appropriately and an apology and an explanation had been given to the patient.

Are services well-led?

Our findings

Governance arrangements

We saw a number of policies and procedures at the practice and saw that in many examples they were not dated and it was not possible to tell if they had been reviewed and where relevant updated.

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. We spoke with two members of staff who said they liked working at the practice and there was a close working team. Staff said there was a supportive approach from management 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 we saw contained sufficient detail and identified patients' needs, care and treatment.

Leadership, openness and transparency

We saw that staff meetings were scheduled for once a month throughout the year. The agenda for the full staff meeting covered areas such as: significant events, infection control, and health and safety. Staff meetings were minuted and minutes were available to all staff. When there were learning points to be shared with staff we saw evidence these had been discussed and shared as appropriate.

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

The practice had a whistleblowing policy however, this was not dated. The whistleblowing policy identified how staff could raise any concerns they had about colleagues' under-performance, conduct or clinical practice. The policy did not identify any external agencies who could be contacted. Therefore the policy was in need of reviewing and updating.

Documentation relating to accidents, significant events and complaints identified the culture of the practice encourages candour, openness and honesty.

Learning and improvement

We saw the practice completed a range of audits throughout the year. This was for clinical and non-clinical areas of the practice. The audits identified both areas for improvement, and where quality had been achieved. Examples of completed audits included: Regular six monthly infection control audits which had an action plan when action was required to address issues. X-ray (radiographs) had been completed during 2016. Dental care records had been audited during the period January to March 2016. This included audit of medical histories, BPE (basic periodontal examination), and the recording of options discussed with the patient. A copy of this audit was sent to the Care Quality Commission following the inspection.

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) and safeguarding had been completed by all relevant staff.

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

The practice had a NHS Friends and Family Test (FFT) comment box which was located in the waiting room. The FFT is a national programme to allow patients to provide feedback on the services provided. The FFT comment box was being used specifically to gather regular feedback from NHS patients, and to satisfy the requirements of NHS England. The latest information on the NHS Choices website showed five patients had responded and 80% said they would recommend the practice to their family and friends. The principal dentist said that in response to requests raised in the FFT comments, the practice had introduced later opening hours.

There had been two patient reviews recorded on the NHS Choices website in the year up to this inspection. There were eight reviews in total dating back to 2012. Reviews had been mixed with some positive and some negative comments. We noted the practice had not responded to any of the patient comments on the NHS Choices website.

Are services well-led?

The practice operated its own satisfaction survey on an on-going basis. We saw the most recent information which had been provided by 11 patients. Feedback from all 11 patients was positive.

The principal dentist had carried out a short snap survey of his own patients in April 2016. This had also provided positive comments and feedback.