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Bingham Dental Practice

Inspection Report

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Date of inspection visit: 15 December 2015
Date of publication: 22/03/2016

Overall summary

We carried out an announced comprehensive inspection on 15 December 2015 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

Bingham Dental Practice is located within central Bingham, a market town. It is approximately nine miles east of the city of Nottingham and close to Newark-on-Trent. There are good public transport links within the area and a railway station within the town. The practice has car parking available to the front and rear of the building for its patients to use and there is a public car park within short walking distance.

The practice provides private dental services only and treats both adults and children. The practice serves a population of approximately 900. The practice shares the same building as Cromwell Dental Practice which provides mainly NHS dental services. Bingham Dental Practice utilises space within the ground floor of the building.

Both practices are owned by the same provider but run as separate services. Staff employed at the practice do however work within both dental practices depending on daily patient demand and some facilities are shared such as the dental decontamination unit.

There are 12 members of staff working within the practice team. This consisted of four dentists, five dental nurses, one hygienist, a receptionist and a cleaner. The practice manager role is undertaken by one of the principal dentists within the practice.

Summary of findings

The practice opening hours are Monday 8am to 6pm, Tuesday 8am to 5.30pm, Wednesday 2pm to 7pm, Thursday 9am to 1pm and Friday 8.30am to 1pm.

We received feedback from 43 patients which included CQC comment cards and patients we spoke with on the day. All feedback included extremely positive comments about the practice and the majority made particular reference to the staff. Comments supported that the practice was able to meet the needs of their patients. A number of comments stated that the dentists were reassuring towards their patients, giving them confidence and able to relax those who felt nervous. One person commented that it was the best practice they had ever belonged to. Remarks were also made regarding the cleanliness of the practice. We did not receive any adverse comments about care and treatment provided at the practice. One comment did however refer to the practice feeling cramped with limited accessibility.

Our key findings were:

- The practice had a system for recording and analysing significant events and complaints and sharing learning with staff.
- Staff had received safeguarding and whistle blowing training and knew the procedures to follow to raise any concerns.
- There were sufficient numbers of suitably qualified staff to meet patients' needs.
- Practice staff had been trained to handle emergencies and we found that appropriate equipment and medicines were readily available as defined by the UK Resuscitation Council.
- Robust infection control procedures were in place and the practice followed national guidance on decontamination of dental instruments.
- Patients' care and treatment was planned and delivered in line with evidence based guidelines, best practice and current legislation.
- Patients received clear and detailed explanations about their proposed treatment, costs, options and risks. Patients were therefore able to make informed decisions about their choice in treatments.
- We observed that patients were treated with dignity and respect and confidentiality was maintained.
- The appointment system met patients' needs for urgent or for more routine appointments.
- The practice was well-led and staff worked as a team. There was an open culture in place whereby staff felt able to raise any issues or concerns.
- Governance systems were effective and there was a range of clinical and non-clinical audits to quality assure the dental services provided.

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 had procedures in place to investigate and respond to significant events and complaints. There was a separate system to record details of accidents. The practice could demonstrate staff learning from all incidents recorded.

The practice had a safeguarding vulnerable adults and children policy and procedures. Staff were trained and demonstrated an awareness of the signs of abuse and knew their duty to report any concerns about abuse.

The practice had procedures and equipment for dealing with medical emergencies. There was an emergency medical kit available including oxygen and a AED (defibrillator) as recommended by the UK Resuscitation Council.

The practice followed national guidance from the Department of Health (DH) in respect of infection control. There were the necessary procedures and equipment available for effective infection control.

Are services effective?

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

Patients were assessed at the start of each consultation and updated their medical history.

Dentists and clinical staff had implemented current best practice guidance which included National Institute for Health and Care Excellence (NICE).

Advice was given to patients on how to maintain good oral hygiene and the impact of diet, tobacco and alcohol consumption on oral health.

There were enough suitably qualified and experienced staff to meet patients' needs.

Referrals were made to other services in a timely manner when further treatment or treatment outside the scope of the practice was required.

Staff were aware of the requirement to obtain consent from patients and evidence we were provided with supported this. However, some further training was required to ensure staff were specifically aware of the provisions of the Mental Capacity Act (MCA) 2005.

Are services caring?

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

All comments from patients at the practice were extremely positive about the care and treatment they received. Patient's confidentiality was maintained at all times. Staff treated patients with privacy, dignity and respect.

Patient electronic dental records were password protected on the computer. We observed the paper dental records were stored on open shelves behind the reception desk. Dental records were therefore not held securely. When we discussed this with practice management, we were advised that they had made a decision to order a security gate system. We were subsequently shown the order details.

We observed the building was suitably alarmed to protect the contents of the building.

Summary of findings

Are services responsive to people's needs?

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

The practice provided patients with detailed information about the services they offered on their website and within the practice. The appointment system responded promptly to patients' routine needs and when they required urgent treatment.

Longer appointment times were available for patients who required extra time or support.

There was a complaints policy and procedure in place. There was assurance regarding the process to be followed in the event of complaints received and how staff learning would be disseminated.

Are services well-led?

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

The provider took an active lead in the day to day running of the practice. There were governance arrangements in place which were evidenced during our review of documentation held.

The practice had an open and honest culture. We were told that there was a focus at the practice of delivering high quality care and this was evidenced during our inspection.

The practice's philosophy put the patient first, and they were at the heart of everything the practice did. We saw that the dentists reviewed their clinical practice and introduced changes to continously improve.

Patients were invited to give feedback at any time they visited the practice and we observed a patient suggestion box in the reception area.

Bingham Dental Practice

Detailed findings

Background to this inspection

We carried out an announced comprehensive inspection on 15 December 2015. The inspection took place over one day. The inspection team consisted of one CQC inspector and a dentist specialist advisor.

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 examined during the inspection.

Prior to the inspection we asked the practice to send us some information which we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, the details of their staff members, their qualifications and proof of registration with their professional bodies.

We also reviewed the information we held about the practice as well as information available to the public. We found there were no areas of concern.

During the inspection we spoke with the provider, the practice manager, (one of the principal dentists acted as the practice manager), receptionist, hygienist and two dental nurses. We reviewed a sample of dental records, policies, procedures and other documents held which included some staff files. We reviewed feedback from 43 patients. This included CQC comment cards completed and patients we spoke with on the day.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had procedures in place to investigate, respond to and learn from significant events and complaints. We saw evidence of significant events which had been documented and noted a reactive approach adopted by the practice. For example, following a staff injury involving hot water, the practice ordered equipment to reduce the risk of re-occurrence. Discussions took place in practice meetings which were documented and lessons learnt where appropriate.

The system for managing incidents provided a framework for reporting and learning from incidents. There was a separate system to record details of accidents. In addition there was a system for reporting Injuries under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013. Staff we spoke with were aware of these reporting systems. No incidents had been reported in the last 12 months.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts via one of the senior dental nurses. These alerts identify any problems or concerns relating to a medicine or piece of medical equipment, including those used in dentistry. Alerts were shared with staff at the weekly staff meetings when considered relevant. We saw evidence of MHRA alerts which had been checked by the dental nurse.

Reliable safety systems and processes (including safeguarding)

The practice had a safeguarding vulnerable adults and children policy and procedures which contained key information and contact details for the local authority to raise any concerns.

There was an identified lead for safeguarding in the practice who had undertaken level 2 safeguarding training. Level 2 training has been designed to ensure that dental professionals understand the important role they play when recognising and responding to safeguarding issues.

The staff members we spoke with demonstrated an awareness of the signs of abuse and their duty to report any concerns about abuse. Staff discussion over policies took place on a regular basis during practice meetings.

From records we reviewed, we noted a presentation on safeguarding had been delivered by the safeguarding lead in February 2015 and e-learning was also provided to staff. This was monitored for completion.

We asked how the practice managed the use of instruments which were used during root canal treatment. The dentist explained that these instruments were single use only. They also explained that root canal treatment was carried out using a latex free rubber dam. (A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth). Patients could be assured that the practice followed appropriate guidance by the British Endodontic Society in relation to the use of the rubber dam.

The practice had a whistle blowing policy for staff to raise concerns in confidence. Staff told us that they felt confident that they could raise concerns and knew the procedure for whistleblowing and who they could speak with about those concerns.

The practice had procedures in place to assess the risks in relation to the control of substances hazardous to health (COSHH). This included any chemical which could cause harm if accidentally spilt, swallowed, or came into contact with the skin. For example, cleaning materials and all dental materials used in the practice. Each of these had been risk assessed and recorded in the COSHH file which all staff were aware of.Hazardous materials were stored safely and securely. The practice kept data sheets from the manufacturers in the COSHH file to inform staff what action to take in the event of a spillage, accidental swallowing or contact with the skin. Staff and patients were provided with personal protective equipment (PPE) (gloves, aprons, masks and visors to protect the eyes). We found sufficient PPE available for practice staff and patients.

Medical emergencies

The practice had robust procedures and equipment in place for dealing with medical emergencies. Training records we reviewed showed all staff had received basic life support training including the use of the automated external defibrillator. (AED). An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. Staff received annual training in dealing with medical emergencies from an accredited training provider. In addition, we noted a practice meeting

had taken place in June 2015, whereby staff were asked to discuss their response to various scenarios involving emergency situations. The practice had also developed a patient transfer form document for handover to a medical emergencies response team should a patient become unexpectedly ill. We noted that the practice team had implemented the use of a code word if an emergency medical situation arose in respect of a patient. This was introduced so staff did not alert other patients attending the practice.

Emergency medicines, a defibrillator (AED) and oxygen were available if required. This was in line with the Resuscitation Council UK guidelines. We checked the emergency medicines and all medicines were in date. We saw records which demonstrated that staff had checked medicines and equipment to monitor stock levels, expiry dates and to make sure that equipment was in working order.

The practice had a first aid kit available within the practice, and we were informed that two members of staff were nominted to administer First Aid – having completed appropriate first aid training. Training records showed that the staff were next due to renew their training in June 2016.

Staff recruitment

We reviewed staff recruitment files for four members of staff. The practice had a recruitment policy for the employment of new staff. The policy included some of the checks required for new staff such as the requirement for two references and ensuring indemnity insurance was in place. The policy did not include the requirement for Disclosure Barring Service checks (DBS), personal identity and evidence of qualifications. DBS checks identify whether a person has a criminal record or on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

On our review of the staff files held however, we found that a process for DBS checks was in place. One member of staff who had been more recently appointed had a risk assessment placed on their file whilst a DBS check was in process. We also found evidence of identity, qualifications, and General Dental Council (GDC) registration information on the files we reviewed. We also saw satisfactory evidence of references which had been obtained prior to staff employment. When we discussed the recruitment policy with the provider, we were advised that they had made a decision to update their policy to reflect the processes which were actually in place. We did not see a process in place for renewal of DBS checks for existing staff but were also advised that a procedure would be implemented.

The practice had an induction system for new staff. We reviewed the induction documentation for the newest member of staff and saw that the documentation was complete and detailed.

There were sufficient numbers of suitably qualified and skilled staff working within the practice. A system was in place to ensure that where absences occurred staff would cover for their colleagues.

Monitoring health & safety and responding to risks

There were arrangements in place to deal with potential emergencies. There was a health and safety policy to guide staff. Staff were aware of the policy and discussions of policies took place regularly in staff meetings.

The practice had a fire risk assessment that identified fire risks. Fire extinguishers were also serviced annually and fire alarms were checked regularly. Fire drills were undertaken on a six monthly basis. The last fire drill in May 2015 had been documented for lessons to be learned as some of the process had not been followed correctly by all staff. For example, high visibility jackets had not been located for their use. The documentation we reviewed supported that the practice adopted a robust and stringent approach to ensuring the health and safety of staff and patients.

The practice also undertook environmental risk assessments and checks of equipment and the premises. Policies included infection control and a legionella risk assessment. Processes were in place to monitor and reduce these risks so that staff and patients were safe.

Infection control

The practice had an infection control policy, which was scheduled for regular review. The policy identified cleaning schedules at the practice including the treatment rooms and the general areas of the practice. The practice manager told us that the practice employed an environmental cleaner but dental nurses had set cleaning responsibilities in each treatment room. The practice had systems for testing and auditing the infection control procedures. We saw records of an Infection Prevention Society (IPS) infection control audit that had been completed in line with recommendations in the Department of Health

Are services safe?

document HTM01-05. We also saw evidence of a hand washing audit undertaken, where all staff were found to be compliant. Infection control and handwashing were also subject to discussion in practice meetings held.

We found that there was an adequate supply of liquid soaps and hand towels throughout the practice. Sharps bins were signed and dated and were not filled past their identified capacity. A clinical waste contract was in place and waste matter was appropriately sorted, and stored until collection.

We looked at the procedures the practice used for the decontamination of used or dirty dental instruments. The practice had a dedicated local decontamination unit (LDU) that had been constructed according to the Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' Within the decontamination room there were clearly defined dirty and clean areas to reduce the risk of cross contamination and infection. Staff wore appropriate personal protective equipment during the process and these included heavy duty gloves, aprons and protective eye wear. We observed this practice was conforming to best practice as defined by HTM01-05.

We found that instruments were being cleaned and sterilised in line with the published guidance (HTM01-05). During our inspection, a dental nurse demonstrated the decontamination process to us, and we saw the procedures used were in line with the guidance. The practice cleaned their instruments using a washer disinfector. This was a machine similar to a domestic dishwasher specifically designed to clean dental instruments. As a backup the practice also had an ultrasonic bath. An ultrasonic bath is a piece of equipment specifically designed to clean dental instruments through the use of ultrasound and water. Instruments were then rinsed and examined visually with an illuminated magnifying glass and sterilised in an autoclave. An autoclave is a pressure chamber used to sterilize dental instruments by subjecting them to high pressure saturated steam at 121 °C (249°F) for around 15–20 minutes depending on the size of the load and the contents. At the end of the sterilising procedure the instruments were dried on racks, packaged, sealed, stored and dated with an expiry date. We looked at the sealed instruments in the surgeries and found that they were stored correctly and all had an expiry date that met the recommendations from the Department of Health.

The equipment used for cleaning and sterilising was maintained and serviced in line with the manufacturer's instructions. Daily records were kept of decontamination cycles (validation) to ensure that equipment was functioning properly. This allowed the clinical staff (the dentists and dental nurses) to have confidence that equipment was sterilising the dental instruments effectively and patients were not exposed to cross infection. Records showed that the equipment was in good working order and being effectively maintained.

Records examined showed that staff had received inoculations against Hepatitis B. People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of contracting Hepatitus B. A needle stick injury is the type of injury received from a sharp instrument or needle. We saw evidence that the provider had a needle stick injury policy which the staff were aware of. A member of staff was able to describe what action they would take if they had a needle stick injury and this reflected the practice policy.

There was a legionella risk assessment in place. This ensured the risks of Legionella bacteria developing in water systems within the premises had been identified and steps taken to reduce the risk of patients and staff developing Legionnaires' disease. (Legionella is a bacterium which can contaminate water systems in buildings.) Records showed that the Legionella risk assessment was in date.

Equipment and medicines

Medical equipment was monitored to ensure it was in working order and in sufficient quantities. Records of checks carried out were available for audit purposes.

Medicines in use at the practice were stored and disposed of in line with published guidance. There were sufficient stocks available for use. Emergency medicines were checked and were in date. Emergency medicines were located centrally but securely for ease of use in an emergency.

Radiography (X-rays)

Are services safe?

X-ray equipment was situated in individual treatment rooms and X-rays were carried out in line with local rules that were relevant to the practice and equipment. The local rules were displayed in each area where X-rays were carried out.

A radiation protection advisor and a radiation protection supervisor had been appointed to ensure that the equipment was operated safely and by qualified staff only. This was as identified in the Ionising Radiation Regulations 1999 (IRR 99). Those authorised to carry out X-ray procedures were clearly identified. This protected people who required X-rays to be taken as part of their treatment. The practice's radiation protection file contained documentation to demonstrate the X-ray equipment had been maintained at the recommended intervals. Records we viewed demonstrated that the X-ray equipment was regularly tested and serviced with repairs undertaken when necessary.

The practice monitored the quality of its X-ray images on a regular basis and maintained appropriate records. This reduced the risk of patients being subjected to further unnecessary X-rays. Patients were required to complete medical history forms and the dentist considered each patient's individual circumstances to ensure it was safe for them to receive X-rays. Patient's notes showed that information related to X-rays was recorded and followed guidance from the Faculty of General Dental Practice (UK) (FGDP-UK). This included justification for taking the X-ray, quality assurance and reporting on X-ray results.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Discussions with the dentist identified that at the start of each patient consultation, patients received a full dental assessment. The assessment included taking a medical history from new patients and updating information for returning patients. This included health conditions, current medicines being taken and whether the patient had any allergies.

The dentist we spoke with told us that the results of each patient's assessment was discussed with them and treatment options and costs were explained. The patient notes were updated with the proposed treatment after discussing the options. Patients we spoke with said they were involved in those discussions, and were able to ask questions. This was supported by our observations.

Patients were monitored through follow-up appointments in line with National Institute for Health and Care Excellence (NICE) guidelines. The dentist was aware of NICE guidelines which included recalls of patients, prophylactic anti-biotic prescribing and removal of wisdom teeth.

We reviewed feedback left by patients in CQC comment cards. All feedback was extremely positive with patients expressing their high levels of satisfaction with their treatment received. The majority of patients referred to the word excellent in describing their treatment. Patients also spoke highly about the staff, and particularly the dentists.

Health promotion & prevention

The waiting room and reception area at the practice contained a range of literature that explained the services offered at the practice in addition to information about effective dental hygiene and how to reduce the risk of poor dental health. Patients were advised of the importance of having regular dental check-ups as part of maintaining good oral health. Patients were provided with information on how to maintain good oral hygiene and the impact of diet, tobacco and alcohol consumption on oral health. Our review of information recorded in dental records supported that the dentists were providing preventive care and advice as detailed within the Public Health England document 'Delivering better oral Health: an evidence-based toolkit for prevention'.

Staffing

The practice had four dentists working at the practice including two who were principal dentists. There were five dental nurses, one hygienist, a receptionist and a cleaner. The practice manager role was undertaken by one of the principal dentists. We spoke with members of staff and noted how motivated they all were to support excellence of care for patients.

Dental staff had appropriate professional qualifications and were registered with their professional body. Prior to our inspection we checked the status of all dental professionals with the General Dental Council (GDC) website. We saw that all registrations with were up to date. Staff were encouraged to maintain their continuing professional development (CPD) to maintain their skill levels. CPD is a compulsory requirement of registration with the GDC. CPD contributes to the staff members' professional development. Staff files showed details of the number of hour's staff members had undertaken and training certificates were also in place in the files.

Staff training was monitored and training updates and refresher courses were provided. Records we viewed showed that staff were up to date with training, for example, basic life support and infection control. Staff we spoke with said they were supported in their learning and development and to maintain their professional registration.

The practice had a system for appraising staff performance annually. Staff said they felt supported and involved in discussions about their personal development. Our review of appraisal documentation supported that staff were able to speak openly about their roles, their personal development and were able to give their opinions on practice related matters. The staff we spoke with told us that the provider was supportive and always available for advice and guidance.

Working with other services

The practice had systems in place to refer patients to other practices or specialists if the treatment required was not provided by the practice. This included referral for specialist treatments such as conscious sedation or referral to the dental hospital if the problem required more specialist attention.

Consent to care and treatment

Are services effective?

(for example, treatment is effective)

The practice had a policy for consent to care and treatment with staff. We saw detailed evidence that patients were presented with treatment options and consent forms which were signed by the patient. The provider was aware of and understood the use of Gillick competency in young persons. The Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Discussions with patients also supported that consent was discussed at their consultations and treatment.

Documentation we reviewed within the practice demonstrated staff were aware of the need to obtain consent from patients and this included information regarding those who lacked capacity to make decisions. Staff had been provided with training in relation to vulnerable adults but this had not specifically incorporated awareness of the provisions contained within the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. When we discussed this with the provider, we were informed that they had made a decision to incorporate specific MCA training in to the staff practice meeting agenda.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We saw that staff at the practice were treating patients with dignity and respect. Discussions between staff and patients were polite, respectful and professional. We also saw that staff maintained patient's privacy, and discussions took place either in a treatment room or a separate area if this was required.

Patient electronic dental records were password protected on the computer. We observed the paper dental records were stored on open shelves behind the reception desk. Dental records were therefore not held securely. When we discussed this with practice management, we were advised that they had made a decision to order suitable equipment to secure the records. We were subsequently shown the order details for the purchase of a lockable roller shutter for the cabinets.

We reviewed Care Quality Commission comment cards that had been completed by patients, about the services provided. All comment cards contained extremely positive comments about the services provided. Patients said that practice staff were friendly, professional and the dentistry was of a high standard. Many of the patients who provided feedback had been registered with the practice for a number of years.

Involvement in decisions about care and treatment

Patients we spoke with were all very positive about their experience of the practice. Patients remarked upon the high quality of the dentistry at the practice and how caring and friendly the staff were. We were told that the dentists ensured patients felt relaxed throughout their treatment. All patients spoken with said that treatment was explained clearly including the cost and they had been involved in care decisions, discussions or had been able to ask questions or offer an opinion. We also found that treatments and costs were explained clearly in literature at the practice as well as on the practice's website.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided patients with information about the services they offered on their website. In addition, we saw a range of patient information was available in the waiting room. We found the practice had an appointment system to respond to patients' routine needs and when they required urgent treatment. Those who were in pain were offered an emergency appointment during normal working hours. Our discussions with patients and review of a sample of dental records supported that a responsive system was in place.

The length of appointments and the frequency of visits for each patient was based on their individual needs and treatment plans. Staff members told us that longer appointment times were available for patients who required extra time or support, such as patients who were particularly nervous or anxious. The practice's website advertised that it catered for nervous patients. The practice offered acupuncture to those patients who suffered with anxiety or those who had a dental phobia. Comments in CQC comment cards referred to the efforts made by the practice dentists to help assure patients who felt apprehensive.

If patients required services that were not provided at the practice, there were established referral pathways to ensure patients' care and treatment needs were met.

Tackling inequity and promoting equality

The practice provided private dental treatment mainly to adults and was situated in the centre of Bingham.

The practice building included level access, treatment rooms on the ground floor and a downstairs toilet which was accessible to people with restricted mobility. Doorways and corridors were wide enough to accommodate those who used wheelchairs. When we inspected the practice, we were advised that an Equality Act 2010 audit had not yet been conducted to ensure access for all patients who had impairments. During our discussions with practice management, we were informed that they had made a decision to arrange for an independent audit of the practice to take place immediately. We were subsequently provided with details of the audit which had been arranged.

Access to the service

The arrangements for emergency dental treatment outside of normal working hours were through a local group of private practitioners on a rota. This included one of the principal dentists at the practice. This meant patients could always seek urgent dental treatment out of normal surgery hours. A telephone number was made available for patients in need of emergency treatment outside of normal working hours. Patients were advised to telephone the practice to obtain the contact details and information was left on the practice answerphone. The practice opening hours were Monday 8am to 6pm, Tuesday 8am to 5.30pm, Wednesday 2pm to 7pm, Thursday 9am to 1pm and Friday 8.30am to 1pm.The practice opening hours gave patients in full time employment or education the opportunity to attend for a convenient appointment.

Feedback from patients about the appointments system was positive. Patients said that appointments were easy to arrange, and emergency treatment was usually on the same day.

Concerns & complaints

The practice had a complaints procedure that explained to patients the process to follow, the timescales involved for investigation and the person responsible for handling the issue. The policy also included the details of other external organisations that a complainant could contact should they remain dissatisfied with the outcome of their complaint or felt that their concerns were not treated fairly. Staff we spoke with were aware of the procedure to follow if they received a complaint.

We saw evidence relating to six complaints received over the past year. We reviewed the complaints documentation and found that the practice had followed due process and procedure in their responses to complainants. For example, in respect of written complaints, the complainant received an initial acknowledgement within timescales set by the practice for its response, as outlined in its complaint handling policy. Discussions took place in practice meetings and lessons were learnt where appropriate. In one complaint we reviewed, the principal dentist had discussed the matter with the clinician involved and they explored if it could have been addressed any differently. We

Are services responsive to people's needs?

(for example, to feedback?)

noted that apologies were given to patients where it was considered appropriate and the practice had sought to recompense some of its complainants even when this had not been requested.

There were several testimonials on the practice website in which patients had shared positive experiences of the practice.

Care Quality Commission (CQC) comment cards also reflected that patients were extremely satisfied with the services provided.

Are services well-led?

Our findings

Governance arrangements

The provider took an active lead in the day to day running of the practice. One of the principal dentists also undertook the role of practice manager and had a thorough understanding of the day to day operation of the practice.

The practice had arrangements in place for monitoring and improving the services provided for patients. For example, patients were invited to complete satisfaction surveys. We reviewed a practice survey analysis in November 2015 which showed that patients rated the services provided highly. Information displayed within the practice waiting area invited patients to feedback their opinions anonymously.

Minutes of staff meetings identified that issues of safety and quality were regularly discussed. The practice manager planned practice meeting agendas a year in advance to ensure that key areas such as audits, infection control, medical emergencies and safeguarding were always included for review. Standing items on agendas included staff discussion on any near misses and anything that could be improved. This provided an open forum for staff and management to engage, provide opinion and share any lessons learned. Staff said they found monthly meetings beneficial.

We found that there were robust governance arrangements in place. This was demonstrated by audits of patients' notes and various other audits undertaken including an X –ray audit, oral cancer audit and patient waiting time audit. We found that there was regular review and update of policies and procedures. These included health and safety, infection prevention and control and patient confidentiality. Staff were able to demonstrate many of the policies through their actions, and this indicated they had read and understood them. The practice also used a dental patient computerised record system and all staff had been trained to use the system. We reviewed a random sample of policies and procedures and found them to be in date and having review dates identified. We saw that staff were aware of their roles and responsibilities within the practice.

Leadership, openness and transparency

The practice had an open and honest culture which included focus on safety. We found clear lines of responsibility and accountability within the practice. Staff told us that they could speak with the provider and practice manager if they had any concerns. Our observations together with comments from patients and staff supported that clinical staff were able to discuss any professional issues openly.

Staff said they felt well cared for, respected and involved in the practice, with monthly staff meetings in which they were encouraged to participate.

We were told that there was a focus at the practice of delivering high quality care. Response to patients' complaints had been recorded, and showed an open and transparent approach. Documentation showed a willingness to engage with complainants and resolve matters wherever possible.

Management lead through learning and improvement

The practice strove to deliver high quality, consistent dental care and this was a key element of their statement of purpose. The practice highlighted patient safety as a priority and encouraged all feedback from patients. We found staff were aware of the practice values and ethos and demonstrated that they worked towards these.

Staff members we spoke with said that the practice put the patient first, and this was at the heart of everything the practice did. We saw that clinical staff reviewed their clinical practice and introduced changes to make improvements. This was demonstrated in its complaints procedures, continuous audit cycle and reference to best practice such as NICE and FGDP guidelines.

We saw innovative new technology used within the practice. This included investment in a piece of machinery which allowed dentists to construct, produce and insert individual ceramic restorations in a single patient appointment rather than over a course of multiple appointments. The practice also advertised their use of a laser which was used to treat gum disease.

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

The practice ensured that patients were involved in making decisions about their care and treatment and this information was recorded in their records. Comments on the practice website were positive and included comments that they received a professional service and good quality care and treatment.

Are services well-led?

Feedback from patients to CQC in the comment cards received and the patients we spoke with said that they were extremely happy with the care and treatment they received.

Staff said that patients could give feedback at any time they visited and this was supported by information displayed in the practice waiting area inviting patients to give their views.

The practice had systems in place to review the feedback from patients who had complained. A system was in place to assess and analyse complaints and then learn from them if relevant, acting on feedback when appropriate.

The practice held regular staff meetings and appraisals had been undertaken. Staff told us that information was shared and that their views and comments were sought informally and generally listened to. We were also informed that they felt part of a team and well supported. The practice also held off site social team events twice yearly which demonstrated effective engagement with all those working within the practice.