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Dentoral Dental Practice - Leicester

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 25 January 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

Dentoral Dental Practice is located close to the centre of Leicester. There are good public transport links to Leicester and to the outskirts of the City. Car parking is limited to on street only as the practice does not have parking facilities.

The practice provides mainly NHS dental services and a small amount of private dental services. It treats both adults and children. The practice serves a population of approximately 4,000. There are a greater number of local residents with an Asian ethnic background and higher levels of deprivation within the area.

There are four dentists working in the practice including the principal dentist. Two of the dentists were on long term leave when we inspected the practice. There are also four dental nurses employed. The practice does not currently have a hygienist but we were told by the practice that that they were seeking to recruit one.

In addition, the practice has a practice manager (who is also qualified as a dental nurse) and a receptionist to provide support to the dental team.

The practice opening hours are: Mondays, Tuesdays, Thursdays and Fridays 9:30am to 5:30pm and Wednesdays 9:30am to 12:30pm.

Summary of findings

We received feedback from 13 patients. All feedback included positive comments about the practice. Some comments supported that the practice was responsive because patients would be seen quickly if required. We did not receive negative comments about the practice from patients we spoke with.

Our key findings were:

- The practice had a system for recording and analysing significant events and complaints and sharing learning with staff. However, we found limited examples to demonstrate the robustness of those systems in place.
- Staff had received safeguarding and whistleblowing training and knew the procedures to follow to raise any concerns.
- There were sufficient numbers of suitably qualified staff to meet patients' needs.
- Staff had been trained to handle emergencies and appropriate equipment and medicines were readily available. However, we found that the practice did not have an AED (automated external defibrillator) in place. The practice manager informed us that they had made a decision to place an order for an AED prior to our inspection and we were provided with evidence of the order details.
- Infection control procedures were in place and the practice followed national guidance.
- There was limited assurance that patients' care and treatment was planned and delivered in line with evidence based guidelines, and current best practice.This was because the one dentist present on the day of the inspection was unaware of current best practice guidelines.
- We examined documents maintained by the primary dentists who operated at this practice. We found these documents examined were limited in respect of information held regarding patient care and treatment. We were not assured that patients received clear explanations about their proposed treatment, costs, options and risks or that they were involved in making decisions about it.
- Patients were treated with dignity and respect and confidentiality was maintained.
- The appointment system met patients' needs whether they wanted to be seen urgently or for more routine appointments.
- There was evidence that staff worked as a team and this approach had a positive outcome in some areas. There were a number of areas where robust leadership was required. This included compliance with best practice guidance and statutory standards.
- Whilst some governance systems were in place, there was limited assurance regarding clinical and non-clinical audits to monitor the quality of services.

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 the practice's protocols for completion of dental care records giving due regard to guidance provided by the Faculty of General Dental Practice (FGDP) regarding clinical examinations and record keeping.
- Introduce protocols regarding the prescribing and recording of antibiotic medicines in consideration of guidance provided by the Faculty of General Dental Practice in respect of antimicrobial prescribing.
- Review its audit protocols to ensure audits of various aspects of the service, such as radiography and dental care records are undertaken at regular intervals to help improve the quality of service. Practice should also ensure, that where appropriate audits have documented learning points and the resulting improvements can be demonstrated.
- Review and incorporate guidance issued by the Department of Health regarding the delivery of better oral health.
- Review the practices recruitment policy giving due regard to Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks are in place for all new staff.
- To respond to the local needs of their population group by raising awareness in practice literature of the impact of lifestyle choices on patients' health, eg smoking cessation and dietary factors.

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. There was a limited number of incidents recorded which meant the practice could not demonstrate staff learning from events.

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

We were advised that the dentists did not use rubber dam when carrying out root treatment on patients. A rubber dam is a thin rubber sheet, used in dentistry to isolate the operative site from the rest of the mouth and protect the patient's airway. This was contrary to best practice and guidance from the British Endodontic Society.

The practice had a whistle blowing policy for staff to raise concerns in confidence. Staff knew the procedure for whistleblowing and who they could speak with about any concerns.

The practice had procedures and equipment for dealing with most medical emergencies. At the time of the inspection the practice did not have an AED (defibrillator) as recommended by the UK resuscitation council. However, we were told that the practice had placed an order for an AED prior to the inspection.

Staff recruitment procedures were in place. Policy and procedure required strengthening however, to ensure people using the service were protected against risks of inappropriate or unsafe care.

The practice followed national guidance from the Department of Health in respect of infection control.

X-rays were carried out in line with the Ionising Radiation Regulations 1999 (IRR 99) but were not in accordance with the Faculty of General Dental Practitioners (FGDP) guidelines.

Are services effective?

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

There was limited evidence in the dental records we looked at to support that patients were assessed at the start of each consultation to update their medical history. This was because the records we examined did not reflect that results of assessments, treatment options and costs were explained.

The dentist we spoke with had not incorporated national guidance from the Department of Health and National Institute for Health and Care Excellence (NICE) into practice. This included patient recall, antibiotic prescribing and improving oral health.

There was limited assurance that advice was provided to patients on how to maintain good oral hygiene and the impact of diet, tobacco and alcohol consumption on oral health. This was because documentation we looked at did not include records of any advice given.

There were enough suitably qualified and experienced staff to meet patients' needs. Staff were encouraged to update their training, and maintain their continuing professional development (CPD).

Summary of findings

We were advised that referrals were made to other services in a timely manner when further treatment or treatment outside the scope of the practice was required. Documentation we looked at did not include information as to whether such referrals had been made.

Staff were aware of the Mental Capacity Act (MCA) 2005 and consent. Documentation we looked at did not include any information related to consent being recorded.

Are services caring?

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

Comments from patients at the practice were 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 records, which were paper only, were held securely under lock and key.

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 information about the services they offered on their website and some information was on display in the practice. The appointment system responded to patients' routine needs and when they required urgent treatment.

The practice building was suitable for those who had impaired mobility although we noted it could be improved. There were no downstairs toilet facilities available. The practice made a decision on the day of the inspection to book an external contractor to conduct an Equality Act 2010 audit.

Two reviews left by members of the public on NHS Choices were negative regarding the professionalism of the practice. These had not been responded to by the practice.

There was a complaints policy and procedure. The practice told us they had only received one complaint which was ongoing. Records supported that the complaint was being responded to in a timely manner.

Are services well-led?

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

Information we obtained supported that the practice manager took a lead in the day to day running of the practice. We saw that the practice manager, dental nurses and receptionist worked well with each other as a team.

We identified however, that there were a number of areas where robust leadership was required. This included compliance with best practice guidance and statutory standards.

The comments in the Care Quality Commission (CQC) comment cards we received and the patients we spoke with said that they were happy with the care and treatment they received.

The practice had sought feedback from its patients in a recent questionnaire issued. We did not see information displayed in the practice or contained on the website however, which invited patients to feedback their opinions.

Dentoral Dental Practice - Leicester

Detailed findings

Background to this inspection

We carried out an announced comprehensive inspection on 25 January 2016. 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 looked at during the inspection.

Prior to the inspection we asked the practice to send us some information which we looked at. 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 looked at the information we held about the practice as well as information available to the public.

During the inspection we spoke with one dentist, the practice manager, four dental nurses and one receptionist. We looked at policies, procedures, 40 dental record cards and other documents held which included some staff files. We reviewed feedback from 13 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 and respond to significant events and complaints if they arose. We were informed that they would become subject to discussion in practice management staff meetings. We were told that no significant events had been recorded although one complaint had been received. This was ongoing at the time of our inspection. Our review of the complaint showed the practice had complied with its own policy in respect of complaints management. The practice were unable to demonstrate shared learning from events and complaints due to the limited records held.

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 twelve months.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts. These alerts identify any problems or concerns relating to a medicine or piece of medical equipment, including those used in dentistry. Alerts came to a named individual at the practice who told us they reviewed them and would share with the staff team if appropriate. The staff we spoke with could not recall any alerts where the practice had been affected.

Reliable safety systems and processes (including safeguarding)

The practice had a safeguarding vulnerable adults and children policy and procedures. Staff members demonstrated an awareness of the signs of abuse and their duty to report any concerns about abuse. Safeguarding training had been undertaken by all staff in a practice meeting held within the last twelve months. There was an identified lead for safeguarding in the practice who had undertaken Level 2 safeguarding training. The training has been designed to ensure that dental professionals understand the important role they play when recognising and responding to safeguarding issues. The safeguarding contact details for the local authority were available.

Practice staff advised us that the dentists did not use rubber dam when carrying out root canal treatment. (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). This meant that patients could not be assured that the practice followed appropriate guidance by the British Endontic Society in relation to the use of the rubber dam.

We saw evidence that medical alerts were flagged to clinicians when treatments took place. This included alerts regarding patients who had a latex or antibiotic allergy. We saw that patients had been given a medical history form to complete and this was inserted into the patients' paper dental records.

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 within the dentistry practice. Each type of substance that had a potential risk was recorded and rated as to the risk to staff and patients. Measures were clearly identified to reduce such risks. These included the use of personal protective equipment for staff (gloves, aprons, masks and visors to protect the eyes) and patients. Hazardous materials were stored safely and securely. The practice kept data sheets from the manufacturers to inform staff what action to take in the event of a spillage, accidental swallowing or contact with the skin. All staff we spoke with were aware of COSHH.

Medical emergencies

The practice had procedures in place for dealing with most medical emergencies. We found however, that the practice did not have an AED (defibrillator) at the time of our inspection. 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. We were informed that a decision had been made prior to our inspection to purchase an AED and we

were provided with evidence of the order details. Training records we looked at showed all staff had received basic life support training. Meeting minutes we looked at also supported staff training within this area.

Emergency medicines 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 which was checked during our inspection. The principal dentist was the appointed first aider and had completed appropriate training.

Staff recruitment

We looked at the recruitment files for four members of staff. The practice had a recruitment policy for the employment of new staff, last reviewed in August 2015. This identified the checks that should be undertaken during recruitment. The policy stipulated the requirement for two references to be provided and proof of registration with professional bodies where relevant. The policy stated that applicants may be requested to produce a passport but did not state that proof of identity would be sought in any case prior to appointment. The policy did not make reference to the requirement for potential employees to undergo a Disclosure Barring Service (DBS) check. DBS checks identify whether a person had a criminal record or was on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

From looking at the staff files, we found evidence of DBS checks undertaken when staff had been appointed. Staff had been employed for a number of years and had not been subject to any further formal DBS scrutiny. The practice had asked its staff to sign an annual self-declaration to confirm whether there had been any changes in criminal record status since the original DBS check had been undertaken.

The practice had an induction system for new staff. We looked at the detailed induction documentation which was contained on each staff member's file. Staff were required to sign that they had understood the induction process undertaken.

There were sufficient numbers of suitably qualified and skilled staff working at 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 health and safety and discussions of these matters took place in staff meetings.

The practice had a fire risk assessment that identified fire risks. Fire extinguishers were also serviced annually and fire drills undertaken regularly.

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 staff had 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 document HTM01-05. This demonstrated the practice was compliant with essential requirements.

We found that there was an adequate supply of liquid soaps and hand towels throughout the practice. Sharps bins were signed and dated and did not pass their identified capacity. A clinical waste contract was in place and waste matter was appropriately sorted and stored until collection. We saw waste consignment notes from an approved contractor.

We were shown the procedures the practice used for the decontamination of used or 'dirty' dental instruments by the appointed decontamination lead. The practice had a specific decontamination room that had been been arranged according to the Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.'

Are services safe?

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.

The practice had two autoclaves, one for general use and one as a backup. This type of autoclave was designed to sterilise non wrapped or solid instruments. 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 all had an expiry date that met the recommendations from the Department of Health (HTM01-05).

The equipment used for cleaning and sterilising was maintained and serviced in line with the manufacturer's instructions. Daily, weekly and monthly records were kept of decontamination cycles 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. Records showed that the equipment was in good working order and being effectively maintained.

Staff said they wore personal protective equipment when cleaning instruments and treating people who used the service. Our observations supported this view. Staff files 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 Hepatitis B. We saw that the practice had a needle stick injury policy which the staff were aware of.

We found that clinical staff were re-sheathing needles after their use and the practice had not implemented a written risk assessment to show why they considered this safe practice. Re-sheathing of needles can lead to injury of the person holding a needle.This contravened the European Council Directive 2010/32/EU (the Sharps Directive). When we spoke to the practice manager, they made a decision there and then to order equipment which would allow them to comply with legislation in place. We were provided with evidence of the order details placed.

There was a Legionella risk assessment in place which was last reviewed in July 2015. 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 found in all potable water and can contaminate dental units and the hot and cold water supply in a dental practice if effective controls are not in place).

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 dental instruments 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)

X-ray equipment was situated in individual treatment rooms. Each surgery had an intraoral X-ray unit. Intraoral X-rays are the most common type of X-ray taken where the X-ray film is inside the mouth. The practice also had an orthopantomograph machine (OPG) which externally takes a full mouth X-ray and moves around the head. X-rays were carried out in line with local rules that were relevant to the practice and equipment and appropriately posted.This complied with the Ionising Radiation (Medical Exposure) Regulations (IRMER) regulations1999.

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.

We saw evidence in the audit file the practice had carried out a recent audit of radiographs taken in the practice.The documentation we examined at the practice however, did

Are services safe?

not support that the Faculty of General Dental Practitioners (UK) (FGDP-UK) guidance was complied with. This was in relation to the type of X-ray required and when they should be taken. For example, bitewing X-rays were not taken routinely to monitor gum disease and dental decay. Bitewing X-rays show the upper and lower back teeth and how the teeth touch each other in a single view. They are used to check for decay between the teeth. In the 40 dental records we looked at, there was no recording of why the X-rays had been taken (justification). We found the X-rays had not been quality assured and we did not see a report on what was seen on each X-ray. We also found that a number of X-rays were not labelled with the patient's name.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentist that we spoke with told us that at the start of each patient consultation patients were assessed. He told us that the assessment included taking a medical history from new patients and updating information for returning patients. This included health conditions, treatment options and costs. The sample of records we looked at was not detailed or legible to support whether this process was robust. The dentist acknowledged that others would not necessarily understand his recording of information. This presented a risk that should a patient see a different dentist at the practice, their clinical records may not be understood and this may impact on the patient's care and further treatment.

Patients we spoke with however, said they were involved in those discussions, and were able to ask questions.

We received limited assurance that patients were monitored through follow-up appointments in line with National Institute for Health and Care Excellence (NICE) guidelines. This was because the sample of record cards we examined did not contain any information that patients recall interval was assessed using NICE guidance. The dentist told us that he had adopted a patient recall system and gave an example where he may choose to see an infant at risk every three months.

The dentist we spoke with had not implemented the Department of Health (DH) document 'Delivering Better Oral Health'. This document now in its 3rd edition (2014) has provided evidence based advice for how dentists can improve oral health including advice on oral cancer and alcohol use.

Documentation we looked at indicated that antibiotic prescribing guidelines had not been followed. This was because when antibotics had been prescribed, there was no justification recorded in the patient records we examined. This was not in accordance with Antimicrobial prescribing for general dental practitioners (FGDP-UK) guidance.

From looking at a sample of dental records we found that basic periodontal examination (BPE) information was incomplete. BPE is a screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment required for gums. We found that records indicated that a BPE had been undertaken but did not see information regarding any treatment that patients were receiving for gum disease if this was identified.

We looked at feedback left by patients in comment cards. Feedback was positive with patients expressing their overall satisfaction with their treatment received. Patients spoke positively about the staff, and the dentists. In two reviews left on NHS Choices website, both comments included dissatisfaction with treatment options provided or treatment received.

Health promotion & prevention

The waiting room and reception area at the practice contained a limited range of literature that explained the services offered at the practice. We did not see information about effective dental hygiene and how to reduce the risk of poor dental health. We did not see information about how to maintain good oral hygiene and the impact of diet, tobacco and alcohol consumption on oral health.

The dentist we spoke with told us that he did undertake oral health checks and would record this in patients'dental records. The sample of 40 dental records we examined did not contain this information. The dentist we spoke with told us that there was a high incidence of poor dental hygiene within the local population including with children and the general diets of the local population tended to consist of a higher sugar intake. We did not evidence that fluoride was being promoted or oral health checks as described in 'Delivering Better Oral Health. The dentist did however describe his use of fluoride varnish and high concentration of fluoride toothpaste. We did not find supporting evidence in the records we examined that patients were advised of the importance to have regular dental check-ups as part of maintaining good oral health.

Staffing

The practice had four dentists working within the practice including the principal dentist. Two of the dentists were on long term absence at the time of our inspection. There were also four dental nurses which included the decontamination lead. In addition, the practice had a receptionist and a practice manager who was also qualified as a dental nurse.

Dental staff had appropriate professional qualifications and were registered with their professional body. Prior to

Are services effective?

(for example, treatment is effective)

our inspection we checked the status of all dental professions with the General Dental Council (GDC) website. We saw that all registrations 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 hours 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 infection control. Staff said they were supported in their learning and development and to maintain their professional registration.

The practice had a system for appraising staff performance. The records showed that appraisals had taken place. Staff we spoke with said they felt supported and involved in discussions about their personal development.

Working with other services

The dentist we spoke with informed us they would refer patients to other practices or specialists if the treatment required was not provided by the practice. For example, we were told that orthodontic referrals would be made following discussions held with the patient. The dentist we spoke with was unable to recall details of any particular referrals made to other services and the sample of dental records we looked at did not include details of potential referrals made or discussed with the patient.

Consent to care and treatment

The practice had a policy for consent to care and treatment with staff. Practice records showed that training around issues of consent had taken place in a staff meeting in November 2015. This included Gillick competency and the Mental Capacity (MCA) Act 2005. Gillick competence is used to decide whether a child (16 years or younger) is able to consent to their own medical or dental treatment without the need for parental permission or knowledge. 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. The dentist we spoke with demonstrated understanding of consent.

Our examination of documentation did not support that patients were presented with treatment options and consent recorded.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We saw that staff at the practice were treating patients with dignity and respect. Our observations supported that discussions between staff and patients were polite, respectful and professional. We saw that staff sought to maintain patient's privacy and discussions took place either in a treatment room or away from other patients.

We saw that patient paper dental care records were held securely under lock and key. The practice did not use an electronic dental care records system.

We looked at Care Quality Commission comment cards that had been completed by patients, about the services provided. All comment cards had positive comments about the services provided. Patients said that practice staff were friendly, professional and courteous. We noted one of the patients had been registered at the practice for a considerable number of years.

Involvement in decisions about care and treatment

Patients we spoke with on the day of the visit were all positive about their experience of the practice. Comments supported that patients felt confident in asking questions about their care and treatment and were happy with the treatment received. One comment included that the patient did not need to return for a long time following treatment received. The practice reception area included a notice to patients to ask their dentist to explain anything that they may not understand. We found that treatments and the NHS cost structure were explained clearly on the practice website, although we did not find information which related to the costs of private treatment. We found some information displayed within the practice regarding NHS financial help towards treatment costs.

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.

Services included crowns, bridges, dentures and teeth whitening. We did find however, that the practice website was only accessible when we were informed of the website address by the practice as general searches through the internet did not produce any links to the website.

We found the practice had an appointment system to respond to patients' routine dental care and when they required urgent treatment. For example, patients in pain were offered an emergency appointment during normal working hours if possible. We were informed that the length of appointments and the frequency of visits for each patient were based on their individual needs.Longer appointments were available for patients who needed more time. The practice also advertised that it would offer appointments outside of working hours on their website.

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

Tackling inequity and promoting equality

The practice mainly provided NHS dental treatment and was situated close to Leicester city centre. The majority of patients who used the practice spoke a number of languages. This was because a high number of people with Asian heritage lived within the area. Staff we spoke with told us that they could speak a number of languages and could therefore assist a patient if they presented with a language barrier.

The practice building was partially suitable for those who had impaired mobility. This included level access to the building. Doorways and corridors were wide enough to accommodate those who used wheelchairs. The treatment rooms were on different floors within the practice. However, staff told us that patients with poor mobility were seen in the downstairs treatment room to avoid them having to use the stairs. We noted that only an upstairs toilet was available which would impact on patients who were restricted in their physical movement.

When we discussed with the practice manager whether the practice had been subject to an Equality Act assessment of its premises, we were informed that the practice had previously undertaken its own assessment of accessibility. We did not find that any actions had been taken to improve access as a result of their own assessment. The practice manager made a decision on the day of our inspection to arrange for an independent assessment to be made and we were shown the details of this.

Access to the service

The arrangements for emergency dental treatment outside of normal working hours were through NHS 111. We saw that a notice was displayed in the practice waiting area to advise patients of the out of hours service.

The practice normal opening hours were: Monday, Tuesday, Thursday and Friday: 09:30am to 5:30pm and Wednesdays 09:30am to 12:30pm. The practice did advertise that it offered appointments outside of these hours on its website.

Feedback from patients we spoke with about the appointments system was positive. One comment included that the patient had moved to the practice as they were unable to be seen urgently by their previous practice. We also looked at a total of two comments left on the NHS Choices website. One of the comments stated that the practice did not answer their phone. The practice had not responded to the statements made via the website.

Concerns & complaints

We saw that the reception noticeboard contained information about making a complaint. The practice had a complaints procedure. This was available to patients on request and explained the process, timescales involved for investigation and the person responsible for handling the matter. The procedure also included the details of external organisations that could be contacted should a patient remain unsatisfied with the outcome of their complaint. We found that these contact details required updating as one related to an organisation which no longer existed. Staff we spoke with were aware of the procedure to follow if they received a complaint and showed us the information that would be provided to a patient.

Are services responsive to people's needs?

(for example, to feedback?)

From information received prior to the inspection we saw that one complaint had been received by the practice. We looked at the complaint file but the complaint was within its early stages of being addressed. Learning points had not been noted at this stage.

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

Are services well-led?

Our findings

Governance arrangements

The practice manager took a lead in the day to day running of the practice. The manager was also a registered dental nurse. This ensured the maintenance of service and operations. The practice manager demonstrated they had a thorough understanding of the day to day operation of the practice. We were unable to meet with the principal dentist on the day of the inspection.

The practice could demonstrate that it had made efforts to monitor the services provided for patients. We looked at minutes of staff meetings which identified issues of safety and quality were discussed. For example, storage of dental records, cleaning schedules and waste disposal processes were discussed. Patient feedback was sought last year and a questionnaire issued to patients. Practice meeting minutes dated November 2015 showed that the practice recognised they needed to ensure treatment options and fees were explained clearly prior to dental work being undertaken.

Staff we spoke with said they found meetings beneficial. We asked how staff were encouraged to feedback their views on practice related matters and if in their opinion systems or processes worked well or could be improved. We were informed that the feedback mechanism was informal and could also be given in staff appraisals.

We found that whilst there were some governance arrangements in place, these required strengthening. There was a full range of policies and procedures in use at the practice. These included health and safety, infection prevention control and patient confidentiality. Staff were able to demonstrate some of the policies through their actions which indicated they had read and understood them. We saw that staff were aware of their roles and responsibilities within the practice.

We looked at a random sample of policies and procedures and found them to be in date and subject to annual review. We found however that some policies required further scrutiny, for example, the complaints policy contained outdated contact details for external complaint organisations. The recruitment policy had not incorporated the requirement for DBS checks to be undertaken, stipulated the requirement for photographic identification and checks regarding the applicant's qualifications held.

We found that best practice guidance had not been complied with in relation to a number of areas. A governance and accountability framework had therefore not been established.

Leadership, openness and transparency

We were unable to meet with the principal dentist on the day of our inspection as he was unavailable. We were able to meet with one dentist on the day of our inspection. We found however from discussions with practice staff and looking at practice meeting minutes that there were lines of responsibility and staff understood their roles and responsibilities. Our observations together with comments from staff supported that the receptionist, dental nurses and practice manager were able to discuss professional issues openly.

We found that these practice staff were responsive and had chosen to take decisive action in areas which could be strengthened straight away. For example, the practice organised for an Equality Act audit 2010 to be undertaken on the day of our inspection.

Whilst comments from patients we spoke with and left in CQC comment cards were positive, we noted that two adverse comments left by members of the public on NHS Choices website had not been acknowledged or responded to online.

A response to a patient complaint had been recorded, and showed an open approach. We noted however, that the complaint had been recently received and had yet to be fully investigated and addressed. Documentation we looked at showed a willingness to engage with the complainant.

Management lead through learning and improvement

A key element of the practice's statement of purpose was to promote good oral health to all its patients and to participate in initiatives to promote this to the wider population.The statement also included that the practice would ensure an awareness of current national guidelines affecting the way they cared for their patients. We did not find evidence during our inspection to support these values.

Are services well-led?

We received limited assurance that clinical staff reviewed their clinical practice and introduced changes to make improvements. This was reflected in the absence of regular clinical audit and incorporation of best practice guidelines such as NICE.

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

There was limited evidence to support that the practice ensured that patients were involved in making decisions about their care and treatment as dental records we looked at did not include such information. The dental records examined only recorded the treatment which had been undertaken.

The comments in the Care Quality Commission (CQC) comment cards we received and patients we spoke with said that they were happy with the care and treatment they received. Reviews left on NHS Choices by members of the public did not support this. The practice website did not include a feedback area or contain any patient testimonials.

We did not see any notices around the practice inviting patients to leave feedback, although we did see a notice regarding patient complaints. A process was in place to address complaints received, although staff learning was not evident as the one complaint recently received was ongoing.

The practice held regular staff meetings and staff appraisals had been undertaken. Staff told us that information was shared and that their views and comments were sought informally. Staff we were able to speak with told us that they felt part of a team and well supported.