Inspired Dental Care Limited

Inspired Dental Care

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 31 March 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Inspired Dental Care is located in Exeter city centre. The practice is situated over two upper floors in a commercial area of the city. There is a passenger lift for access to the practice for patients with limited mobility. There are three treatment rooms, a decontamination room, a 'Chompers' Club' lounge for educating children about good oral health care, a reception with a waiting area and a further patient lounge.

The practice provides private dental services and cosmetic dental services to approximately 1500 patients. The majority of patients are adults.

The staff structure of the practice consists of four dentists (two principle dentists, one periodontal specialist dentist and one sessional sedation dental practitioner). There are two dental hygienists, three dental nurses/ receptionists and a practice manager.

The practice is open six days a week from Monday to Saturday. Evening appointments are available on Wednesdays. The practice closes at 3.30pm on Saturdays. There is an answer phone message directing patients to emergency contact numbers when the practice is closed.

The practice manager is the registered manager with the Care Quality Commission (CQC). Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Summary of findings

The inspection took place over one day and was carried out by a CQC inspector and dental practice manager specialist advisor.

Thirteen patients provided feedback directly to CQC about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly, professional and caring attitude of the dental staff.

Our key findings were:

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were effective systems in place to reduce and minimise the risk and spread of infection.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Staff knew how to report incidents and how to record details of these so that the practice could use this information for shared learning.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- The provider had a clear vision for the practice and staff told us they were well supported by the management team.
- Governance arrangements were in place for the smooth running of the practice.
- Patients with children benefitted from the provision of a dedicated 'Chompers' Club' space, which was child friendly and geared to the education and promotion of good oral health care in children. These education sessions were run by the dentists.

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

- Provide a thermometer in the decontamination room for ensuring the correct water temperature is maintained when hand washing and rinsing dental instruments.
- Develop systems for feeding back to patients about action taken as a consequence of surveys, patient suggestions or comments.

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 systems in place to minimise the risks associated with providing dental services. The practice had policies and protocols, which staff were following, for the management of medical emergencies. There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. Staff had good awareness of safeguarding issues, which were informed by and supported by practice policies.

We found the equipment used in the practice was checked for effectiveness. Infection control processes were safely managed, however, it was not possible to check the correct water temperature when hand washing dental instruments.

Are services effective?

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

The practice provided evidence-based care in accordance with relevant, published guidance, for example, from the General Dental Council (GDC). The practice monitored patients' oral health and gave appropriate health promotion advice. Patients with children benefitted from the provision of a dedicated 'Chompers Club' space, which was child friendly and geared to the education and promotion of good oral health care in children. Staff explained treatment options to ensure that patients could make informed decisions about any treatment. The practice worked well with other providers and followed up on the outcomes of referrals made to other providers.

Staff engaged in continuous professional development (CPD) and were meeting the training requirements of the General Dental Council (GDC). New staff had received an induction and were engaged in a probationary process to review their performance and understand their training needs.

Are services caring?

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

We received positive feedback from patients through nine written comment cards and by speaking with four patients on the day of the inspection. Patients felt that the staff were kind and caring; they told us that they were treated with dignity and respect at all times. We found that dental care records were stored securely and patient confidentiality was well maintained.

Are services responsive to people's needs?

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

Patients had good access to appointments, including emergency appointments, which were available on the same day. There was a complaints policy in place. The practice had not received any complaints in the past year. Systems were in place for receiving more general feedback from patients, with a view to improving the quality of the service. This included commenting via the practice website, a comments book in the practice reception area and patient surveys. Systems had not yet been developed to promote a response from the practice to what had been done as a result of patient feedback.

Summary of findings

The culture of the practice promoted equality of access for all. The practice staff told us that if patients visited with support dogs, for assistance with a visual or a hearing impairment, that the dogs would be welcomed. The facilities for people with limited mobility were good, with wide corridor spaces and large treatment rooms. There was an accessible toilet and a passenger lift to the practice from the street level entrance.

Are services well-led?

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

The practice had clinical governance and risk-management structures in place. Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the management team (practice manager and two principle dentists). They were confident in the abilities of the managers to address any issues as they arose.

Inspired Dental Care

Detailed findings

Background to this inspection

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

We carried out an announced, comprehensive inspection on 31 March 2016. The inspection took place over one day and was carried out by a CQC inspector and a dental practice manager specialist advisor.

We reviewed information received from the provider prior to the inspection. During our inspection we reviewed policy documents and spoke with four members of staff (one dentist, the practice manager, one dental nurse and one receptionist/dental nurse). We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. A dental nurse demonstrated how they carried out decontamination procedures of dental instruments.

Nine patients had provided written feedback about the service. We also spoke with four patients during our inspection. Patients were positive about the care they received from the practice. They were complimentary about the friendly, professional and caring attitude of the dental staff.

The practice conducted patient surveys. We saw 66 responses over the last 12 months. Patients who responded were satisfied with the service and commented that they were likely to recommend the practice. Comments made in the practice comments book echoed these sentiments.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There was a system in place for reporting and learning from incidents. There had been no significant events related to patients in the past year.

We discussed the investigation of incidents with the practice manager. They confirmed that if patients were affected by something that went wrong, they were given an apology and informed of any actions taken as a result. Practice staff were aware of their responsibilities under the Duty of Candour.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any such incidents in the past 12 months.

A monthly management team meeting was held. We saw minutes of meetings over the last 12 months, demonstrating that learning from incidents was a standing agenda item

Reliable safety systems and processes (including safeguarding)

The practice manager was the named practice lead for child and adult safeguarding. They were able to describe the types of behaviour a child might display that would alert them to possible signs of abuse or neglect. They also had a good awareness of the issues around vulnerable elderly patients who presented with dementia.

The practice had a safeguarding policy reviewed in July 2015 and March 2016. The policy referred to national guidance. Information about the local authority contacts for safeguarding concerns was held in a file in the practice manager's office and at the reception desk. The staff we spoke with were aware of the location of this file and found it promptly. There was evidence in staff files showing that staff had been trained in safeguarding adults and children to an appropriate level. Additional recommended training for the two lead dentists and the practice manager in child protection to level three was booked for May 2016.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, we asked staff about the prevention of needle stick injuries. Staff explained that following administration of a local anaesthetic to a patient, needles were not re-sheathed using the hands. A rubber needle guard was used instead which was in line with current guidelines. The staff we spoke with demonstrated a clear understanding of the practice policy and protocol with respect to handling sharps and needle stick injuries.

The practice followed other national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments in line with guidance from the British Endodontic Society. (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).

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. The practice had an oxygen cylinder, and other related items, such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. An automated external defibrillator (AED) was situated in the decontamination room. This was available for the dental practice to use; the staff were aware of its location and how to use it. (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).

The practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. The emergency medicines were all in date and stored securely with emergency oxygen in a location known to all staff. Notice of oxygen storage was signposted in the case of an emergency. On the day of the inspection there was no guidance available concerning the varied doses for use with adrenaline ampoules. We raised this to the practice manager who took immediate action to ensure this information was stored with this medicine.

Staff received annual training in using the emergency equipment. The staff we spoke with were all aware of the location of the emergency equipment. This equipment was checked for safe use each day the practice was open.

Staff recruitment

Are services safe?

The staff structure of the practice consisted of four dentists (two principle dentists, one periodontal specialist dentist and one sessional sedation dental practitioner). There were two dental hygienists, four dental nurses/receptionists and a practice manager.

Many of the staff had been in post for a number of years. One member of staff had been recruited within the past year on an apprentice scheme with a local college. There was a recruitment policy in place which stated that all relevant checks would be carried out to confirm that any person being recruited was suitable for the role. This included the use of an application form, interview, review of employment history, evidence of relevant qualifications, the checking of references and a check of registration with the General Dental Council. We reviewed six of the staff recruitment files and saw that records had been kept in relation to these checks.

It was practice policy to carry out a Disclosure and Barring Service (DBS) check for all members of staff prior to employment and periodically thereafter. We saw evidence that all members of staff had a DBS check. (The DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety policy in place, reviewed in January 2015. The practice had considered the risk of fire, had clearly marked exits and an evacuation plan. There were also fire extinguishers situated in the reception area. The last fire risk assessment of the premises had been completed by an outside contractor during 2011. The practice was in the process of arranging for this to be reviewed and updated.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. The file was reviewed during March 2016. COSHH products were securely stored.

The practice had a system in place for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS).

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. There was an infection control policy reviewed in July2015, which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. Hand washing training was evidenced in staff recruitment files we examined.

We observed that the premises appeared clean, tidy and clutter free. Clear zoning demarked clean from dirty areas in all of the treatment rooms. Hand-washing facilities were available, including wall-mounted liquid soap, hand gels and paper towels in each of the treatment rooms, decontamination room and staff toilet. Hand-washing protocols were also displayed appropriately in the practice.

We asked a dental nurse to describe to us the end-to-end process of infection control procedures at the practice. The protocols described demonstrated that the practice had followed the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05),' with one exception. There was no thermometer in the decontamination room for use to test the correct temperature of the water when hand washing and rinsing dental instruments. We raise this with the practice manager who told us they would arrange for a thermometer to be purchased for this purpose. They also told us that they would arrange for an additional in-house staff training update on decontamination procedures within the next working week.

The dental nurse explained the decontamination of the general treatment room environment following the treatment of a patient. Staff described the process they followed to ensure that the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines. Environmental cleaning was carried out in accordance with the national colour coding scheme by the cleaning staff employed to work throughout the building.

Are services safe?

We checked the contents of the drawers in one of the treatment rooms. These were well stocked, clean, ordered and free from clutter. All of the instruments were pouched. Each treatment room had the appropriate personal protective equipment, such as gloves and aprons, available for staff and patient use.

The practice used a decontamination room for instrument processing. In accordance with HTM 01-05 guidance, an instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which ensured the risk of infection spread was minimised. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

Instruments were manually cleaned in the treatment room then inspected under a light magnification device and then placed in an autoclave (steriliser). When instruments had been sterilised, they were pouched and stored appropriately until required. Pouches were dated with a date of sterilisation and an expiry date in accordance with HTM 01-05.

The practice carried out checks of the autoclave to assure that it was working effectively. Periodic checks included the automatic control test and steam penetration test. A log book was used to record the essential daily validation checks of the sterilisation cycles. Test results were also scanned and stored electronically to assist audit trails of sterilisation processes.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained. The practice used a contractor to remove dental waste from the practice. Waste was stored in a separate, locked location within the practice prior to collection by the contractor. Waste consignment notices were available for inspection.

Staff files showed that staff regularly attended training courses in infection control. Clinical staff were also required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. (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 blood borne infections.)

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a term for particular bacteria which can contaminate water systems in buildings). The practice manager described the method they used which was in line with current HTM 01-05 guidelines. A Legionella risk assessment had been carried out by an external contractor in 2015. The practice was following recommendations to reduce the risk of Legionella, for example, through the regular testing of the water temperatures. A record had been kept of the outcome of these checks on a monthly basis; this had been last completed on the 22 March 2016.

The practice had carried out a practice-wide infection control audits in July 2015 and February 2016. This had identified that good practice was being followed. The practice infection control policy stated audits would be carried out on a six monthly basis.

Equipment and medicines

We found that the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor, fire equipment and X-ray equipment had all been inspected and serviced. Certificates for pressure equipment had been issued in accordance with the Pressure Systems Safety Regulations 2000. Portable appliance testing (PAT) had been completed in accordance with current guidance in July 2014 and was next due by July 2016. PAT is the name of a process during which electrical appliances are routinely checked for safety every two years as a minimum.

The expiry dates of medicines, oxygen and equipment were monitored using daily, weekly and monthly check sheets to support staff to replace out-of-date medicines and equipment promptly. Dental care products requiring refrigeration, were stored in a fridge in line with the manufacturer's guidance.

Radiography (X-rays)

There was a radiation protection file, which was in the process of being completed at the time of the inspection, in line with the Ionising Radiation Regulations (IRR) 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor

Are services safe?

as well as the documentation pertaining to the maintenance of the X-ray equipment. We saw that the X-ray equipment had been serviced in January 2015, within the three yearly recommended maintenance cycle.

We saw evidence that the two principal dentists had completed radiation training in the last 12 months.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Dentists and hygienists carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. We spoke with one dentist and asked them to describe to us how they carried out their assessment. The assessment began with the patient completing a medical history update covering any health conditions, medicines being taken and any allergies suffered. We saw patients being asked to complete a medical history when they booked in for their appointment to give to the dentist. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were made aware of the condition of their oral health and whether it had changed since the last appointment.

The patient's dental care record was updated with the proposed treatment after discussing options with the patient. The dentist used intra-oral photographs of patients' mouths to aid discussions about the condition of the teeth and gums. Treatment plans were printed for each patient, which included information about the costs involved. Patients were referred to the practice information leaflet, or website for cost information on routine treatments. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

We checked a sample of four dental care records to confirm the findings. These showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums and soft tissues lining the mouth were noted using the basic periodontal examination (BPE) scores. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). These were carried out, where appropriate, during a dental health assessment.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. We spoke with one dentist who told us they discussed oral health with their patients, for example, around effective tooth brushing. They were aware of the need to discuss a general preventive agenda with their patients. They told us they held discussion with their patients, where appropriate, around smoking cessation, sensible alcohol use and diet. The dentists also carried out examinations to check for the early signs of oral cancer.

Patients with children benefitted from the provision of a dedicated 'Chompers Club' space, which was child friendly and geared to the education and promotion of good oral health care in children. These education sessions were run by the dentists. The practice had identified a training development need for dental nurses in oral health education and this had been included in the annual staff development plan.

We observed that there were health promotion materials displayed in the reception area. These could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition.

Staffing

Staff told us they received appropriate professional development and training. We checked the staff recruitment files and saw that this was the case. The training covered the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, safeguarding, infection control and X-ray training.

There was a written induction programme for new staff to follow and evidence in the staff files that this had been used at the time of their employment.

Many of the staff employed had worked at the practice for a number of years. One member of staff had been recruited within the last twelve months. They told us there had been a comprehensive induction course which included training on safeguarding, health and safety, infection control and information governance.

The practice was able to offer conscious sedation on request for anxious patients. (Conscious sedation are techniques in which the use of a medicine or medicines produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation). We were told by the practice manager that they had not received any requests for this service yet. The practice had secured the services of a sessional dentist trained in conscious sedation. The

Are services effective?

(for example, treatment is effective)

practice had in place protocols for conscious sedation, giving due regard to guidelines published by The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015'.

Working with other services

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients.

Staff at the practice explained how they worked with other services, when required. Dentists and hygienists were able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. For example, the practice made referrals to other specialists for complex orthodontic work.

We reviewed the systems for referring patients to specialist consultants in secondary care. A referral letter was prepared and sent to the hospital with full details of the dentist's findings and a copy was stored on the practices' records system. We looked at four examples of referral letters. These were comprehensively completed and referrals took place in a timely way to avoid delay to treatment. The receptionist kept an electronic record noting the dates when referrals were made, when the appointment had been completed and further actions required for follow up. They contacted other providers to check on the progress of their patients and kept the referring dentist informed about the outcomes.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. We spoke to the dentist about their understanding of consent issues. They explained that individual treatment options, risks, benefits and costs were discussed with each patient. Patients were asked to sign formal written consent forms for specific treatments. We looked at four patient electronic records and saw consent to treatment was suitably recorded in the patient dental care records.

All of the staff were aware of the Mental Capacity Act 2005. (The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves). Clinical staff had completed formal training in relation to the MCA in 2016. The dentist could describe scenarios for how they would manage a patient who lacked the capacity to consent to dental treatment. They noted that they would involve the patient's family, check for appropriate lasting power of attorney authorisation to act on a person's behalf, along with other professionals involved in the care of the patient, to ensure that the best interests of the patient were met.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The nine comments cards we received, and the four patients we spoke with, all made positive remarks about the staff's caring, professional and helpful attitude. Patients indicated that they felt comfortable and relaxed with their dentist and that they were made to feel at ease during consultations and treatments. We also observed staff were welcoming and helpful when patients arrived for their appointment or made enquiries over the phone.

Staff were aware of the importance of protecting patients' privacy and dignity. The treatment room was situated away from the main waiting area and we saw that the door was closed at all times when patients were having treatment. Conversations between patients and the dentist could not be heard from outside the rooms, which protected patient's privacy.

Staff understood the importance of data protection and confidentiality and had received training in information governance. Patients' dental care records were stored in a paper format in a dedicated locked room away in an area where patients had no access. There were also electronic records for X-rays and charting. Computers were password protected and regularly backed up.

Involvement in decisions about care and treatment

The practice detailed information about services on the practice website. This gave details of the range of services available, dental charges or fees and payment options (such as membership of private dental schemes).

We spoke with all four of the staff on duty on the day of our inspection. All of the staff told us they worked towards providing clear explanations about treatment and prevention strategies. We saw evidence in the records that the dentists recorded the information they had provided to patients about their treatment and the options open to them.

The patient feedback we received via comments cards, and through speaking with patients on the day of the inspection, confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' dental needs. The dentists decided on the length of time needed for their patient's consultation and treatment according to patient need. The feedback we received from patients indicated that they felt they had enough time with the dentist and were not rushed.

Staff told us that patients could book an appointment in good time to see the dentist. The feedback we received from patients confirmed that they could get an appointment when they needed one, and that this included good access to emergency appointments on the day that they needed to be seen. On the day of our inspection we saw a patient request an urgent appointment and they were seen within 20 minutes of this request.

During our inspection we looked at examples of information available to people. The practice website contained a variety of information, including opening hours and costs. The practice manager told us the printed patient information leaflet was in the process of being revised.

The practice had a treatment coordination room. This was a quiet room used for discussing treatment and was also used to monitor patients following complex procedures, away from the main reception area.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. There was an equality and diversity policy for staff to refer to. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. Reception staff showed us they had could provide written information for people who were hard of hearing and use large print documents for patients with some visual impairment.

The practice was wheelchair accessible. There was a large passenger lift to the practice. We noticed that patients using wheelchairs had to negotiate opening the front door to the practice on the ground floor before getting into the lift. We raised this with the practice manager in terms of promoting accessibility. Following the inspection the practice manager wrote to us to inform us that they had installed a door bell and signage by the front door for the benefit of patients requiring assistance. The doorbell had been connected to the reception desk area on the second floor. The installation of the doorbell took place within 48 hours of our inspection visit.

Facilities for patients with limited mobility included an accessible patient toilet and an area of the reception desk was lowered to enable people using wheelchairs to maintain eye contact with receptionists when holding a conversation. There was also a range of seating at the practice to suit peoples' needs.

Access to the service

The practice opening hours were Monday to Saturday. There were appointments until 7pm on Wednesday evening and the practice opened until 3.30pm on Saturdays.

We asked the receptionist about access to the service in an emergency or outside of normal opening hours. They told us the answer phone message gave details about how to access out-of-hours emergency treatment.

The receptionist told us that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, were seen on the same day that they alerted the practice to their concerns. The feedback we received via comments cards confirmed that patients had good access to the dentist in the event of needing emergency treatment.

Concerns & complaints

Information about how to make a complaint was displayed in the reception area. There was a formal complaints policy describing how the practice handled formal and informal complaints from patients. There had been no complaints recorded in the past year.

Patients were also invited to give feedback through a comments book in the reception area. Patients could also send comments via the practice website. The practice also used patient surveys, in which patients could remain anonymous. However, systems had not yet been developed to publicise the action taken by the practice as a result of patient feedback.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements and a management structure. There were relevant policies and procedures in place. Staff were aware of these and acted in line with them.

There were arrangements for identifying, recording and managing risks through the use of risk assessment processes.

Regular meetings took place at the practice. These included a weekly whole staff meeting and a monthly management meeting. Records showed items discussed included patient safety and staff training.

The practice manager told us about the governance structures and protocols at the practice. A systematic process of induction and staff training was in place which ensured that staff were aware of, and were following, the governance procedures.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said that they felt comfortable about raising concerns with the senior managers at the practice. They felt they were listened to and responded to when they did so.

We found staff to be dedicated in their roles and caring towards the patients. We found the principal dentists provided effective clinical leadership to the dental team.

Staff told us they enjoyed their work and were supported by the senior managers. They understood the systems for staff appraisal and were focused on meeting high standards by the end of their probationary period. Records showed all staff received an annual appraisal.

Learning and improvement

The management had a clear vision for the practice which included plans for improving the premises and equipment. For example, the reception area had very recently been improved through redecoration and purchase of new furnishings.

The practice was rebranded in the last 12 months and was in the process of arranging to offer an additional serviceof conscious patient sedation for nervous patients.

Staff kept up to date with current practice though in-house monthly 'lunch and learn' sessions and by attending external training events. For example, a whole team away day in March 2016 on the theme of oral cancer.

Staff were being supported to meet their professional standards and complete continuing professional development (CPD) standards set by the General Dental Council (GDC). We saw evidence that the clinical staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the GDC.

The practice had completed clinical audits of infection control and dental care records. For example, the recent audit of dental records had identified where improvements could be made in the recording of soft tissue assessments during patient consultations. Additional staff training took place as a result. A re-audit took place and identified that the improvements had been implemented.

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

The practice gathered feedback from patients through the use of a comments book in the waiting area, website and patient surveys. Actions had been taken as a result. For example, the installation of a coffee machine in the patient waiting area.

Staff told us that the management team were open to feedback regarding the quality of the care. The practice carried out an annual staff survey, where anonymity was offered. There were also regular formal staff meetings and informal meetings. The appraisal system also provided appropriate system for staff to give their feedback.