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Cabourne Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 3 February 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

Cabourne Dental Practice opened in 1993 in a purpose built practice alongside other health services such as two GP practices, a physiotherapist and a pharmacy. The practice is a now a private practice and has approximately 1800 registered patients. The practice has a small reception area that is in the waiting room. The practice consists of three treatment rooms (two in use, the third is used as a room to discuss treatment or for any other confidential conversations), a decontamination room and an office which is also the staff room. There is free parking available in a large car park that is shared with the other buildings. The building is accessed from the car park and once in the practice all areas are accessible to people who use wheelchairs.

There is one dentist that works full time alongside two full time dental nurses, one part time dental nurse and the practice manager. The dental nurses have dual roles and also work on reception.

The practice provides private dental treatment to adults and to children. The practice is open Monday to Thursday from 8am to 4pm.

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

Summary of findings

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

We received feedback from 47 patients about the services provided. The feedback reflected positive comments about the staff and the services provided. Patients commented that the practice was clean and tidy and had a welcoming atmosphere. They said that they found the staff offered a friendly, professional and efficient service and were polite, helpful and caring. Patients said that explanations about their treatment were clear and that they were always informed of what was happening which made the dental experience as comfortable as possible. Patients who were nervous commented how the dentist was understanding and patient; they were made to feel at ease and that any questions were answered.

Our key findings were:

- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Infection control procedures were in place and staff had access to personal protective equipment.
- Patients' care and treatment was planned and delivered in line with evidence based guidelines and current legislation.
- Patients received clear explanations about their proposed treatment, costs, benefits and risks.
- Patients were treated with dignity and respect and confidentiality was maintained.
- The appointment system met the needs of patients and waiting times were kept to a minimum where possible.
- The practice was well-led and staff felt involved and worked as a team.
- Staff had been trained to deal with medical emergencies and appropriate medicines and life-saving equipment were readily available and accessible
- Governance systems were effective and policies and procedures were in place to provide and manage the service.
- Staff had received formal safeguarding training and knew the processes to follow to raise any concerns.
- All staff were clear of their roles and responsibilities with a structured chart to refer to.
- The practice had a whistleblowing policy in place which gave staff the option of contacting a neighbouring practice manager if they had any concerns that they wished to discuss.

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

- Review published guidance (HTM 01-05) in relation to hand washing.
- Review the British National Formulary (BNF) guidance for medical emergencies in dental practice and the recommended equipment.
- Review Public Health England document: 'Delivering better oral health: an evidence based toolkit for prevention'.

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 care which was safe in accordance with the relevant regulations.

The practice had effective systems and processes in place to ensure all care and treatment was carried out safely. The practice had procedures in place for reporting and learning from accidents and significant events including near misses.

Staff had received training in safeguarding vulnerable adults and children and staff were able to describe the signs of abuse and were aware of the external reporting process and who was the safeguarding lead for the practice.

Infection control procedures were in place; followed published national guidance and staff had been trained to use the equipment in the decontamination process. The practice was operating an effective decontamination pathway, with robust checks in place to ensure sterilisation of the instruments. The practice did not however have a separate sink in the decontamination room that could be used for handwashing.

Are services effective?

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

Explanations were given to patients in a way they understood and risks, benefits and options available to them. The interval between consultations was in line with guidance from the National Institute for Health and Care Excellence (NICE).

There were clear procedures for referring patients to secondary care (hospital or other dental professionals). Referrals were made in a timely way to ensure patients' oral health did not suffer. There was a thorough tracking system for referrals made and the practice followed up on all referrals.

Patients with a high risk of dental decay were not prescribed fluoride varnish and higher concentration fluoride toothpaste which was not in accordance with current guidance. Discussions with the dentist showed they were not aware of the 'Delivering better oral health' document; however, we saw evidence in dental records to show that much of the guidance had been implemented their practice.

Not all staff had received formal training in the Mental Capacity Act (MCA) 2005 however they were able to explain to us how the MCA principles applied to their roles.

Are services caring?

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

Patients were treated with dignity and respect and their privacy maintained. Patient information and data was handled confidentially. Patients provided positive feedback about the dental care they received, and had confidence in the staff to meet their needs.

Patients said they felt involved in their care. Patients told us that explanations and advice relating to treatments were clearly explained and that they were able to ask any questions that they had. They said that the dentist was patient and understanding especially to the more nervous patients.

Patients with urgent dental needs or pain were responded to in a timely manner with appointment slots kept each day for emergencies.

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 was well equipped. The waiting area was in reception and had music playing to help maintain confidentiality and provide a relaxed atmosphere. The practice was accessible for people that used a wheelchair and the treatment rooms and other areas were accessible to those with limited mobility.

The practice had surveyed the patients and the results showed high satisfaction with little room for improvement.

Are services well-led?

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

Staff were involved in leading the practice to deliver effective care. Care and treatment records had been audited to ensure standards had been maintained. The practice staff had also audited their own checks, such as tests carried out on equipment used for decontamination to ensure that they were following the correct process and to identify if improvements could be made.

Staff were supported to maintain their professional development and skills. There was an appraisal process in place; however, it had been recognised that staff had not received an annual appraisal in 2015. All staff had been booked for an appraisal in September 2016.

The practice had systems in place to involve, seek and act upon feedback from patients using the service.

Cabourne Dental Practice

Detailed findings

Background to this inspection

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

The inspection took place on 3 February 2016 and was conducted by a CQC inspector and a specialist dental 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 reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, and 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 and found there were no areas of concern.

During the inspection we spoke with a number of staff working on the day. We reviewed policies, procedures and other documents. We viewed 47 Care Quality Commission (CQC) comment cards that had been completed by patients, about the services provided at the practice.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had procedures in place to investigate, respond to and learn from incidents and complaints.

Serious incidents were reported on an incident form which would be reviewed by the practice manager. There had been two incidents recorded in the last 12 months and staff that we spoke with were able to describe action taken and new processes that had been put in place following the incident reviews. Staff were also able to tell us the process that they would follow for reporting incidents and accidents and examples of both. There was an accident book where staff recorded incidents such as needle stick injuries. The last accident reported was in May 2105 where a jet of steam had escaped from the distiller; this was also recorded and reviewed as an incident. Staff were encouraged to bring safety issues to the attention of the management. Staff would raise concerns with the practice manager. The practice had a no blame culture and policies were in place to support this.

The practice had received one complaint in the last 12 months. The practice had a process in place which included complaints being investigated and outcomes and lessons learned would be shared at a practice meeting with all staff.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for recognising and responding to concerns about the safety and welfare of patients. Staff we spoke with were aware of these policies and were able to explain who they would contact and how to refer to agencies outside of the practice should they need to raise concerns. They were able to demonstrate that they understood the different forms of abuse. The practice had information at reception and on the staff room notice board of who to contact if they had any concerns in relation to safeguarding of children or adults. From records viewed we saw that staff at the practice had completed level two safeguarding training in safeguarding adults and children. The staff had all read the safeguarding policy each year and signed to say that they had done this and understood it. The practice manager was the lead for safeguarding to provide support and advice to staff and to oversee safeguarding procedures within the practice. No safeguarding concerns had been raised by the practice.

The practice had a whistleblowing policy and the staff we spoke with where clear on different organisations they could raise concerns with for example, the General Dental Council, NHS England or the Care Quality Commission if they were not able to go directly to the dentist or the practice manager. The policy also stated that staff could speak with a practice manager at another practice locally. The dentist and the practice manager had an agreement with this practice that enabled staff, if they wanted to, the opportunity to discuss concerns with the 'buddy' manager. Staff that we spoke with on the day of the inspection told us that they felt confident that they could raise concerns without fear of recriminations.

Discussions with the dentist and examination of patients' dental care records identified the dentist was using a rubber dam routinely when completing root canal treatments in line with best practice guidelines from the British Endodontic Society. A rubber dam is a thin rubber sheet that isolates selected teeth and protects the rest of the patient's mouth and airway during treatment.

The practice had an up to date employer's liability insurance certificate which was due for renewal August 2016. Employers' liability insurance is a requirement under the Employers' Liability (Compulsory Insurance) Act 1969.

Medical emergencies

The practice had procedures in place for staff to follow in the event of a medical emergency. All staff had received basic life support training including the use of the defibrillator (a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). Staff we spoke with were able to describe how they would deal with a number of medical emergencies including anaphylaxis (severe allergic reaction) and cardiac arrest. The practice did not have an automated blood glucose measurement device as recommended in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.

Staff recruitment

Are services safe?

The practice had a recruitment policy which described the process when employing new staff. This included obtaining proof of their identity, checking their skills and qualifications, registration with professional bodies where relevant, references and whether a Disclosure and Barring Service check was necessary. We saw that all staff had received a Disclosure and Barring Service check.

The practice had a formal induction system for new staff which was documented within the staff files of new staff that we reviewed. This included the practice's policies in relation to health and safety, and infection control.

There were sufficient numbers of suitably qualified and skilled staff working at the practice. The practice used cover from a neighbouring dental practice if necessary to cover holidays or emergencies. The practice manager tried to arrange it so that other staff in the practice took annual leave when the dentist was on leave.

Monitoring health & safety and responding to risks

A health and safety policy and risk assessment was in place at the practice which was reviewed annually. There was a comprehensive risk assessment log covering risks such as autoclave burns, biological agents, fire and manual handling. This was reviewed annually and amended if there had been any changes. There were also risk assessments for trainee dental nurses, and pregnant and nursing mothers. The risks had been identified and control measures put in place to reduce them.

The practice had an organised system where policies and procedures were in place to manage risks at the practice. Each year the policies were reviewed and any amendments were made. There was a cover sheet at the front of each folder that stated the policies that were included.This also showed the date of the review, any changes if applicable and the comments relating to the changes, for example, telephone number changes. There was also a signing sheet which was completed by staff each year to say that they had read and were aware of any updates or amendments; we saw this had happened since 2009. The policies included infection prevention and control, control of substances hazardous to health, legionella policy and sharps policy.

Processes were in place to monitor and reduce these risks so that staff and patients were safe. Staff told us that fire detection and firefighting equipment such as fire alarms and emergency lighting were regularly tested and we saw records that confirmed these checks were completed weekly. All staff had been trained in fire safety and the practice had regular update and drills were every six months.

The practice had a business continuity plan to deal with any emergencies that might occur which could disrupt the safe and smooth running of the service. All practice staff had been given a paper copy that they held at their home address should the need arise. This included full contact details for staff and for the relevant personnel or organisation. For example, gas company, electricity and suppliers and also included any account numbers that would be required.

Infection control

The practice was visibly clean, tidy and uncluttered. An infection control policy was in place, which clearly described how cleaning was to be undertaken at the premises including the treatment rooms and the general areas of the practice. The practice employed a cleaning company for the general areas and staff were responsible for cleaning and infection control in the treatment rooms and there were schedules in place for what should be done and the frequency. There was also a check list in the surgery to show that the tasks had been completed. The practice had systems for testing and auditing the infection control procedures.

We found that there were adequate supplies of liquid soaps and paper hand towels in dispensers throughout the premises. Posters describing proper hand washing techniques were displayed in the dental treatment room, the decontamination room and the toilet facilities.

The practice had a sharps' management policy which was clearly displayed and understood by all staff. The practice used sharps' bins (secure bins for the disposal of needles, blades or any other instruments that posed a risk of injury through cutting or pricking.) The bins were located out of reach of small children. The practice had a clinical waste contract in place and waste matter was stored in a non-public area prior to collection by an approved clinical waste contractor.

We looked at the procedures in place for the decontamination of used dental instruments. The practice had a dedicated decontamination room that was set out according to the Department of Health's guidance, Health Technical Memorandum 01-05 (HTM 01-05):

Are services safe?

Decontamination in primary care dental practices. We found good access from one treatment room to the decontamination room which was adjoining and had two doors, one 'in' and one 'out'; this ensured a hygienic environment was maintained. The second treatment room was not connected and meant that access was across the corridor. The decontamination room had defined dirty and clean zones in operation to reduce the risk of cross contamination. There was a clear flow of instruments through the dirty to the clean area. Clean instruments were stored in the decontamination room with minimal stock in the clinical areas. Staff wore personal protective equipment during the process to protect themselves from injury which included heavy duty gloves, aprons and protective eye wear. The worktops in the treatment rooms appeared cluttered at the time of the inspection with patient notes.

We found that instruments were being cleaned and sterilised in line with the published guidance (HTM 01-05). A dental nurse demonstrated the decontamination process, and we saw the procedures used followed the practice's policy. Dirty instruments were transported in purpose made containers however these were not clearly marked as dirty. This meant that these instruments could have been mistaken for clean instruments. We spoke to the practice who said they would action this straight away. The dental nurses were knowledgeable about the decontamination process and demonstrated they followed the correct procedures. We checked the equipment used for cleaning and sterilising was maintained and serviced regularly in accordance with the manufacturer's instructions. There were daily, weekly and monthly records to demonstrate the decontamination processes to ensure that equipment was functioning correctly and there were also audits in relation to these tests to ensure completeness and highlight any areas for improvement. Records showed that the equipment was in good working order and being effectively maintained. The decontamination room did not have a separate sink for handwashing. This was being done in the treatment rooms. We spoke with the provider who said that they would look at this for the future. Staff told us that they would use the in and out doors accordingly after hand washing so as not to compromise the decontamination process.

Staff files reflected staff Hepatitis B status. 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 practice had a Legionella risk assessment in place. A Legionella risk assessment is a report by a competent person giving details as to how to reduce the risk of the legionella bacterium spreading through water and other systems in the work place.

(Legionella is a bacterium found in the environment which can contaminate water systems in buildings). The records showed the practice was flushing their water lines in the treatment rooms. Records showed waterlines were flushed for two minutes at the beginning and end of each session, and for 30 seconds between patients. This was in keeping with HTM 01-05 guidelines. These measures reduce the risk of Legionella or any other harmful bacteria from developing in the water systems.

Equipment and medicines

Records we viewed showed that equipment in use at the practice was regularly maintained and serviced in line with manufacturer's guidelines. The records we saw showed us that the equipment had been tested annually for a number of years. Portable appliance testing had taken place annually with the last test in December 2015. Fire extinguishers had been checked and serviced by an external company in February 2016 and staff had been trained in the use of firefighting equipment and evacuation procedures. We were able to view records that showed annual checks of all equipment since 2009.

Emergency medicines, a defibrillator and oxygen were readily available if required. This was in line with the Resuscitation Council UK and British National Formulary Guidelines. We checked the emergency medicines and found that they were of the recommended type and were all in date; however, the practice did not have an automated blood glucose measurement device. Staff told us that they checked medicines and equipment to monitor stock levels, expiry dates and ensure that equipment was in working order weekly.

Radiography (X-rays)

X-ray equipment was situated in suitable areas and X-rays were carried out safely and in line with local rules that were relevant to the practice and equipment. These documents were displayed in areas 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.

Are services safe?

Those authorised to carry out X-ray procedures were clearly named in all documentation. This protected patients who required X-rays to be taken as part of their treatment. The practice's radiation protection file contained the necessary documentation demonstrating the maintenance of the X-ray equipment at the recommended intervals. Records we viewed demonstrated that the X-ray equipment was regularly tested and serviced, and repairs undertaken when necessary.

The dentists monitored the quality of the X-ray images and digital processing on a regular basis and records were being maintained. This ensured that they were of the required standard and reduced the risk of patients being subjected to further unnecessary X-rays. There were records to show that actions were taken following any engineers' recommendations.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice had policies and procedures in place for assessing and treating patients. Patients attending the practice for a consultation received an assessment of their dental health after providing a medical history covering health conditions, current medicines being taken and whether they had any allergies. The patient dental care record contained all the relevant detail and followed guidance provided by the Faculty of General Dental Practice. X-rays were taken at appropriate intervals and in accordance with the patient's risk of oral disease. X-rays were justified, graded for quality and reported.

The dentist we spoke with told us that each patient's diagnosis was discussed with them and treatment options were explained although notes could be more detailed. Patients with a high risk of dental decay were not prescribed fluoride varnish and higher concentration fluoride toothpaste which was not in accordance with current guidance. Public Health England had produced an updated document in 2014: 'Delivering better oral health: an evidence based toolkit for prevention'. Following the guidance within this document would be evidence of up to date thinking in relation to oral healthcare. Discussions with the dentist showed they were not aware of the 'Delivering better oral health' document; however, we saw evidence in dental records to show that much of the guidance had been implemented their practice.

The dental care records were updated with the proposed treatment after discussing and recording the options with the patient. Patients were monitored through follow-up appointments and these were scheduled in line with the National Institute for Health and Care Excellence (NICE) guidelines.

Feedback we received from 47 patients showed that they were satisfied with the service including the assessments, explanations, the quality of the dentistry and outcomes.

Health promotion & prevention

The waiting room and reception area at the practice contained literature that explained the services offered at the practice. The practice also had a notice board where they changed the theme every quarter. Previous themes had included the effects of smoking and the theme at present was showing patients the infection control process that the practice adhered to. This included pictures of the checks and processes that the staff cover.

Staff told us that they advised patients on how to maintain good oral hygiene both for children and adults. Staff also advised patients on the impact of tobacco and diet on oral health. The practice was able to give patients details of a smoking cessation service if they wished. Patients were advised of the importance of having regular dental check-ups as part of maintaining good oral health. Patients were given free samples of toothpaste when available. Diet sheets would be given for completion in relation to children were concerns around diet were identified.

Staffing

Dental staff were appropriately trained and registered with their professional body. Staff were encouraged to undertake their continuing professional development (CPD) to maintain their skill levels. CPD is a compulsory requirement of registration as a general dental professional and its activity contributes to their professional development. Files we looked at showed details of the number of CPD hour's staff had undertaken and training certificates were also in place.

Staff had accessed training face to face, online and also practice led with staff actively reading policies annually to refresh their knowledge. Formal face to face training had been conducted in relation to basic life support. Staff we spoke with told us that they were supported in their learning and development and to maintain their professional registration. The provider paid for staff to complete any training that they required or any training that was identified that would benefit the practice and the staff member.

The practice had procedures in place for appraising staff performance. The practice had, during the preparation for the inspection identified that the appraisals had not taken place since 2014. This had been highlighted and staff had been booked to have their appraisals in September 2016 after staff holidays had taken place. We saw the appraisals had taken place in 2014 and that there were personal development plans for staff and training was identified. They told us that the practice manager and the dentist were supportive and approachable and always available for advice and guidance.

Are services effective?

(for example, treatment is effective)

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. The records at the practice showed that referrals were made in a timely way and followed NICE Guidelines criteria where appropriate. The practice had a detailed monitoring and tracking system for referrals. Once a referral had been made it was recorded on a monthly log sheet. This recorded details of the referral, the date of the referral, name and date of birth of the patient and where referred to. The patients were offered a copy of the referral letter if they wished. All referrals were then tracked and the practice would record the outcome once received or if no information was received then they would contact the patient. The practice recorded the date of the reply and the outcome or action taken. The practice had a log of all referrals made since 2011.

Consent to care and treatment

We discussed the practice's policy on consent to care and treatment with staff. We saw evidence that patients were presented with treatment options, and verbal consent was received and recorded. The dentist we spoke with was also aware of and understood the assessment of Gillick competency in young patients. 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.

We saw in documents that the practice was aware of the need to obtain consent from patients and this included information regarding those who lacked capacity to make decisions. Not all staff had received formal Mental Capacity Act 2005 (MCA) training but those that we spoke with understood their responsibilities and were able to demonstrate a basic knowledge. MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for them.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The practice had procedures in place for respecting patients' privacy, dignity and providing compassionate care and treatment. We observed that staff at the practice treated patients with dignity and respect, and maintained their privacy. The main reception area was open plan and the patients waiting area was close to the reception desk however confidentiality was maintained by the practice operating a two surgery system which meant that most of the time there would be one person waiting in the waiting area at any one time. Staff members told us that they never asked patients questions related to personal information at reception if there were other patients, and for personal discussions a separate room could be used to maintain confidentiality.

A data protection and confidentiality policy was in place. This policy covered disclosure of, and the secure handling of, patient information. We observed the interaction between staff and patients and found that confidentiality was being maintained. Staff were aware of the need to lock computers, store patient records securely, and the importance of not disclosing information to anyone other than the patient.

Patients told us that they felt that practice staff were kind, helpful and caring and that they were treated with dignity and respect at all times. They also told us that staff listened to them and were attentive to their needs and professional.

Involvement in decisions about care and treatment

Feedback from patients included comments about how they were given good explanations and were listened to. They also said that they were given advice relating to treatments and any questions they had were answered. Patients who were nervous commented how the dentist was understanding and patient and they were made to feel at ease and that any questions were answered.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patient's needs

The practice information displayed in the waiting area described the range of services offered to patients and the complaints procedure. The practice also had a comments book and comments box for patients to express their views.

The practice had surveyed patients at different times and each survey had shown high satisfaction levels and little room for improvement.

The practice had an appointment system which patients said met their needs. Where treatment was urgent, patients would be seen the same day. There an answerphone message when the surgery was closed that gave details of how to access emergency care or a local dental practice that provided cover on a Friday when the practice was closed.

Appointment times and availability met the needs of patients. The practice opened Monday to Thursday from 8am to 4pm. The practice closed on a Friday and this day would be used for any staff training. Patients were able to contact a neighbouring dentist in an emergency.

Tackling inequity and promoting equality

The practice had a range of policies around anti-discrimination and promoting equality and diversity. Staff we spoke with were aware of these policies. They had also considered the needs of patients who might have difficulty accessing services due to limited mobility or other physical issues. A disability access audit had taken place at the practice. The practice was aware of patients with limited mobility or wheelchair users and staff on the reception desk would open the practice door for these patients to assist them if necessary. Once inside the practice all areas were easily accessible to patients using a wheelchair or those with limited mobility. There was an assisted toilet, accessible to patients. It did not have a pull cord to alert staff in an emergency however the toilet was next to reception and staff said that they were always aware of who was in the toilet and who was in treatment rooms.

The practice was able to use an interpreting service if required, both via the telephone and by booking interpreters in advance if necessary for any non-English speaking patients.

Access to the service

Patients could access care and treatment in a timely way and the appointment system met the needs of patients. Surveys that had been completed and comment cards confirmed this. There had been feedback that said the opening times could be improved. The practice had considered this however with only one dentist there were limitations to what could be provided. Where treatment was urgent patients would be seen on the day or the next available. On the day the practice was closed patients were able to telephone a neighbouring practice if they needed urgent assistance.

Staff we spoke with told us that patients could access appointments when they wanted them. Patients' feedback confirmed that they were happy with the availability of routine and emergency appointments.

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. It also included the details of external organisations such as the GDC (General Dental Council) that a patient could contact should they remain dissatisfied with the outcome of their complaint or feel that their concerns were not treated fairly. Details of how to raise complaints were accessible in the reception area. Staff we spoke with were aware of the procedure to follow if they received a complaint.

The practice manager told us that there had been one complaint made within the last 12 months. The complaint had been investigated thoroughly and actions had been taken accordingly with an apology to the patient. CQC comment cards reflected that patients were more than satisfied with the services provided.

Are services well-led?

Our findings

Governance arrangements

The practice had arrangements in place for monitoring and improving the services provided for patients. There were governance arrangements in place. Staff we spoke with were aware of their roles and responsibilities within the practice. The practice had a detailed chart in the staff room which gave staff duties that needed to be completed dependant on their role for that day.

Clinical audits had been undertaken in areas such as radiography and infection control. Non clinical audits such as record cards to monitor and improve the quality of care provided had been carried out however the actions following the audits could have been more detailed as not all the actions following the audit had led to improvement. Discussions following audits were cascaded to other staff and discussed at practice meetings.

There was a full range of policies and procedures in use at the practice which had been read by all staff annually as part of informal training. Staff spoken with were able to discuss many of the policies and this indicated to us that they had read and understood them.

Leadership, openness and transparency

The culture of the practice encouraged openness and honesty. Staff told us that they could speak with any of the dentists or the management team if they had any concerns. They told us that there were clear lines of responsibility and accountability within the practice and that they were encouraged to report any safety concerns.

All staff were aware of whom they could raise any issues with and told us that the managers and dentists would listen to their concerns and act appropriately. We were told that there was a no blame culture at the practice.

Management lead through learning and improvement

The management of the practice was focused on achieving high standards of clinical excellence and improving outcomes for patients and their overall experience. Staff were aware of the practice's values and ethos and demonstrated that they worked towards these.

The dentist was mindful of the fact that they were a single handed dentist and was actively involved in a local peer review group which mitigated the risks of sole working. This was an effective means of communication and case reviews. The practice manager had identified a 'buddy' in another practice locally and also another in an NHS practice outside of Lincoln which gave them an increased knowledge and also peers to discuss issues with and look at ways they could improve their practice and serve the patients better.

Practice meetings were held monthly and were minuted. We saw that there were standing agenda items such as significant events and training. These were also used forinformal training sessions, to discuss personal development plans and future training dates.

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

Staff told us that patients could give feedback at any time they visited. The practice completed surveys with patients and also invited feedback via a comments box.

The practice had systems in place to review the feedback from patients including those who had cause to complain. Any complaints or feedback received were discussed at the practice meeting.

The practice held staff meetings each month. As the practice team were small, discussions were also held informally rather than waiting for a meeting. Staff told us that they felt part of a team. A staff member had displayed a chart in the staff room which identified staff roles and responsibilities.