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The Crown Street Dental Group

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 28 July 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

The practice was registered with the Care Quality Commission in May 2014 but has only been open for patients since September 2014. This means that some of the processes we would expect to see were not in place on the day of our inspection because the practice had been operating for less than 12 months. However they had been planned. This included annual appraisals and an audit timetable.

The practice employs three dentists who undertake mainly private treatments with a small amount of NHS dental treatment. They are supported by three dental nurses. There is one receptionist working at the practice who also undertakes other administrative functions. Other clinicians also attend the practice but are not employed there. These included a hygienist and a periodontist. The practice has three surgeries and a dedicated decontamination room.

The lead dentist is the responsible person. This is a person who is registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

providers, they are 'responsible persons' and have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

The practice is open Monday to Thursday between the hours of 8.30am and 5.45pm and Fridays between the hours of 8.30am and 4pm. They are also open on one Saturday each month.

On the day of the inspection we spoke with three patients who told us that they were satisfied with the services provided at the practice. They told us that they were treated with kindness, dignity and respect and their privacy was maintained. They said that explanations and costs were clear and they were involved in the decisions about their care and treatment.

We viewed CQC comment cards that had been left for patients to complete, prior to our visit, about the services provided. There were 49 completed comment cards and all of them reflected positive comments about the staff and the services provided, describing the clinical and support staff as kind and caring. The comments made in the CQC cards reflected that patients were extremely satisfied overall with the services provided at the practice.

Our key findings were:

- There were systems in place to manage safety incidents and complaints and to cascade any learning from them to staff.
- There were sufficient supplies of emergency medicines and equipment and staff had been trained in their use. One recommended medicine was not available in the event of an emergency.
- Risks to patients and staff had been assessed and managed effectively. National patient safety and medicine alerts were monitored and acted upon.
- Infection control procedures were being followed but minor improvements were required.
- Radiation protection documentation was incomplete to reflect that X-rays were being safely taken but this was rectified immediately after our inspection.
- Emergency medicines were being checked regularly to ensure they did not expire. One recommended item was not being kept.
- Recruitment processes were generally robust but some supporting documentation was absent from some staff records. There was no written induction process for new members of staff to follow.
- Staff were being appropriately supported and trained and an annual appraisal process was in place.
- Treatments and consultations followed guidance from the National Institute for Health care Excellence.
- The appointment system met the needs of patients including access to emergency dental care.
- The practice was well-led and the lead dentists set standards for staff to follow and monitored them.
- Patient and feedback was sought and monitored through the use of a continuous patient survey. Staff feedback was sought informally, at staff meetings and at appraisals.

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

- Improve recruitment procedures to ensure that employment records contain the necessary documentation to reflect robust recruitment processes and that structured inductions take place. This includes ensuring that health care professionals attending the practice and not employed there have appropriate skills and qualifications.
- Review the emergency medicines to ensure that those recommended by the BNF and Resus Council are available in the event of a medical emergency and review having immediate access to an AED as per Resus Council recommendations
- Review infection control procedures in order to more fully comply with the recommendations of HTM 01-05 for the cleaning and sterilising of used dental instruments.
- Implement a system to provide an audit trail for action when areas for improvement are identified through audit or other monitoring of the services provided.
- Monitor and record fridge temperatures to ensure dental equipment and medicines remain effective.
- Improve the content of patient notes to better reflect consent and that risks and patient involvement with their care and treatment.
- Provide a list of external contacts that staff can contact for safeguarding concerns.

Summary of findings

- Ensure dentists are aware of the “Delivering Better Oral Health Toolkit” and how to apply it to patients. Ensure all staff are aware of Gillick consent in relation to children under the age of 16.

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. There were systems in place to record and analyse significant events and complaints. All staff spoken with were aware of the procedures to follow and encouraged to report incidents if they became aware of them. There was a system in place to manage national patient safety and medicines alerts. Staff had received training that met the needs of patients and an effective system was in place to monitor that it was being undertaken. The systems for cleaning and sterilising dental instruments met Department of Health guidelines but minor improvements were required. Documentation for the safe use of radiation equipment was unsatisfactory but was rectified immediately after our inspection. X-ray equipment was used by trained staff only. Emergency medicines in use at the practice were stored safely and checked to ensure they did not go beyond their expiry dates. Fridges in use were not being monitored to ensure medicines in use were stored at the correct temperatures. Sufficient quantities of equipment were in use at the practice and serviced and maintained at regular intervals.

Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations. Consultations were carried out in line with best practice guidance from the National Institute for Health and Care Excellence (NICE). The dentists were all up to date with current dental guidelines but were not following published guidance in relation to the oral health tool kit. Patients received a comprehensive assessment of their dental needs including updating their medical history. Explanations were given to patients in a way they understood and treatment options were discussed and supported by written treatment plans. Some patient records did not reflect consent from patients and the explanations about the proposed care and treatment. Staff were supported through training and an appraisal system. Patients were referred to other services in a timely way.

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 told us they were listened to, given time to decide upon treatment options and that treatment was clearly explained. Patients who had dental emergencies were seen in a timely manner, often on the same day. CQC comment cards completed by patients rated the practice highly for their caring attitude. Patients felt involved in the decisions about their care and treatment.

Are services responsive to people's needs?

We found that this practice was providing responsive care in accordance with the relevant regulations.Appointment times met the needs of patients and waiting time was kept to a minimum. The practice responded to patients in need of emergency dental treatment and saw them the same day wherever possible. The practice had made reasonable adjustments to accommodate patients with a disability or lack of mobility. The practice had a system in place to manage complaints effectively. The practice were in the process of undertaking a patient survey.

Summary of findings

Are services well-led?

We found that this practice was providing care which was well led in accordance with the relevant regulations. The lead dentist provided clear leadership and involved staff in their vision and values. Regular staff meetings took place and staff felt involved in the running of the practice. Meetings were minuted and copied to individual staff members. Staff were encouraged to develop and supported to maintain their training. The practice sought the views of staff. Health and safety risks had been identified which were monitored and reviewed.

The Crown Street Dental Group

Detailed findings

Background to this inspection

The inspection took place on 28 July 2015 and was conducted by a CQC inspector and a specialist dental advisor.

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

We also reviewed the information we held about the practice and consulted with other stakeholders, such as NHS England area team / Healthwatch, however we did not receive any information of concern from them.

During the inspection we spoke with two dentists, two dental nurses and a receptionist. We also spoke with three patients and reviewed comment cards that we had left prior to the inspection, for patients to complete, about the services provided at the practice.

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

The practice had a system in place to manage significant events and complaints but none had been recorded in the last 12 months. Staff we spoke with were aware of the reporting procedures in place and said they were encouraged to bring safety issues to the attention of the lead dentist.

The system in place included recording, investigating and analysing significant complaints then identifying areas for improvement, implementing actions and cascading learning to staff either informally or through team meetings.

We discussed the system with the lead dentist who was aware of the requirement to display a duty of candour, providing explanations and apologies where required.

The practice had a system of managing national patient safety and medicines alerts that affected the dental profession. These were monitored by the lead dentist and cascaded to relevant staff.

Reliable safety systems and processes (including safeguarding)

Some staff at the practice had not received safeguarding training for children and vulnerable adults but this had been booked for September 2015. Clinical staff we spoke with were aware of the procedures to follow, the different types of abuse and how to recognise them. Staff were aware of who to contact at the practice if they had any concerns about children or vulnerable adults but there was no up to date information available about who to contact outside of the surgery, such as the local authority. Staff were also aware of whistle blowing procedures and who to contact at the practice or externally if required. They felt confident that incidents they reported would be dealt with professionally.

The dentists who we spoke with on the day all used rubber dam for endodontic procedures. 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 prevents inhalation of small instruments during treatment. It was practice policy not to re-use rubber dams and dentists spoken with were aware of this requirement.

Patients attending for their consultation had their medical history reviewed on each occasion to ensure that any health conditions or medicines being taken could be considered before receiving care or treatment. Updated records were then transferred to the computerised patient record. New patients were required to complete medical history forms and these were checked by the dentist during their consultation.

Medical emergencies

Emergency medicines, a first aid kit and oxygen were readily available if required. The practice did not have a defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm) but they were aware of a local premises that could be used in an emergency. The emergency equipment in use was in line with the 'Resuscitation Council UK' and 'British National Formulary' guidelines.

All staff had been trained in basic life support and were able to respond to a medical emergency. All emergency equipment was readily available and staff knew how to access it.

We checked the emergency medicines and found that they were in date and monitored monthly to ensure they did not expire or that stocks ran low. Records were being kept of expiry dates and checks to ensure that the emergency oxygen was in working order.

Emergency medicines in use at the practice were of the recommended type and stored in line with published guidance. We checked the medicines in use and found them to be in date and in sufficient quantity. The practice did not store buccal midazolam which is used on patients who experienced a seizure and is a recommended medicine for dental practices to stock. We were told that this would be purchased. Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities.

Staff recruitment

The practice had a recruitment policy that described the process when employing new staff. This included obtaining proof of identity, checking skills and qualifications, registration with professional bodies where relevant and the taking of references. The practice had decided to

undertake Disclosure and Barring checks on all of their staff and these were available to view. (These are checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

We looked at the files of the two newest members of staff and found that there was an inconsistent approach to obtaining references for them. The practice agreed to review their processes to ensure that recruitment procedures were robust.

The practice often used the services of visiting dental health care professionals and the occasional use of locums. We found some evidence that their skills, qualifications and experience had been checked but this was not consistent. The practice agreed to review their procedures when using the services of these dental professionals. We did find however that their competency was assessed and they were satisfactorily supervised to ensure that could meet the requirements of the role.

Monitoring health & safety and responding to risks

A health and safety policy and risk assessment was in place at the practice. This identified the risks to patients and staff who attended the practice.

There were a range of other policies in place at the practice to manage risks. These included infection prevention and control, a legionella risk assessment, fire evacuation procedures and the risks associated with Hepatitis B. The practice also had a risk assessment in relation to the Control of Substances Hazardous to Health (COSHH). Processes were in place to monitor and reduce these risks so that staff and patients were safe.

The practice had a business continuity plan that outlined the procedures to follow in the event that services were disrupted. This identified the steps to take so that the practice could maintain a level of service for the patients.

Infection control

The practice and surgeries were visibly clean, tidy and uncluttered. The flooring was of the recommended type and easy to clean. An infection control policy was in place to support staff. The policy included guidance on needle stick injuries, inoculations against Hepatitis B and the handling of clinical waste.

The general cleaning of the practice was carried out by a contract cleaner. Check lists were made available to ensure that each area of the practice was cleaned appropriately and this also identified the frequency and type of cleaning required. Records held reflected that the quality of the cleaning was being monitored and feedback given accordingly.

During our inspection we visited two surgeries and found them to be visibly clean and tidy. The daily cleaning of each surgery was the responsibility of the dental nurses and they completed checklists to reflect that appropriate tasks had been undertaken. Dental nurses spoken with were aware of the infection control procedures in place and had received training. Sufficient quantities of personal protective equipment were available for clinical staff and we were told that clean surgical gloves and masks were worn for each patient.

An infection control lead had been appointed and this was one of the dental nurses. They had received training for the role. An infection control audit had been carried out in June 2015 and this identified some minor areas for improvement. There was no audit trail to reflect that these had been actioned. Other staff had received infection control training relevant to their role.

We found that there were adequate supplies of liquid soaps and hand towels throughout the premises and hand washing techniques were displayed. Sharps bins were properly located, signed and dated and not overfilled. A clinical waste contract was in place and this was stored securely until collection.

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):

Decontamination in primary care dental practices.

We found that instruments were being cleaned and sterilised in line with published guidance (HTM 01-05), but some minor improvements were required. On the day of our inspection, a dental nurse demonstrated the decontamination process to us.

The practice transported their dirty instruments from the surgeries to the decontamination room in suitable

containers. The instruments were not being kept damp after use and allowed to dry which makes cleaning more problematic. The instruments were manually cleaned in the container with cleaning solution then examined with a magnifying glass. Although we found that this cleaning process was satisfactory we discussed the advantages of cleaning instruments in a deeper container, or the sink, to reduce the risk of splashing and cross contamination. This was accepted by the practice. We did not find that the process in use was putting patients at risk of unsafe care or treatment.

Once cleaned the instruments were allowed to dry, sterilised in an autoclave and then stored in sealed, dated packages for later use. We looked at the packaged instruments in the surgeries and found that they all contained an expiry date that met the recommendations from the Department of Health. Instruments designed for single use only were disposed of after use.

The decontamination room had been set up to reduce the risk of cross contamination. There were clear zones in place to distinguish between clean and dirty areas. Staff wore appropriate personal protective equipment during the process and these included disposable gloves and protective eye wear.

The equipment used for cleaning and sterilising was maintained and serviced as set out by the manufacturers. Daily, weekly and monthly records were kept of decontamination cycles and tests and when we checked those records it was evident that the equipment was in good working order and being effectively maintained. The practice used bottled water for their dental unit water lines (used for connecting the dentist's drills and other devices to the dental unit on a dental chair). These were being used in line with guidance and appropriate protocols were being followed.

Clinical staff were well presented and told us they wore clean tunics daily. They also told us that they wore personal protective equipment when cleaning instruments and treating people who used the service. Staff files reflected that staff had received inoculations against Hepatitis B and received blood tests to check the effectiveness of that inoculation. A needle stick injury procedure was in place and this was displayed on surgery walls to support staff in the event that an injury was received.

Patients we spoke with always said that the dentist and the dental nurse always wore protective glasses, visors and gloves while undertaking treatment or examinations.

The practice had undertaken a legionella risk assessment in October 2014 and appropriate control measures were in place and recorded. Legionella is a term for particular bacteria which can contaminate water systems in buildings.

Equipment and medicines

Records we viewed reflected that equipment in use at the practice was regularly maintained and

serviced in line with manufacturers guidelines. Fire extinguishers were in place throughout the practice and they had been checked and serviced in August 2014. Staff had been trained in the use of equipment and evacuation procedures.

All equipment used for the cleaning and sterilising of medical instruments had been serviced and maintained regularly. Records reflected that it was in working order at the time of the inspection.

Electrical equipment in use had undergone portable appliance testing in 2015 to ensure it was safe to use. Local anaesthetic for use on patients were being stored appropriately.

A fridge was in use at the practice for the storage of dental materials and some medicines. The temperature of the fridge was not being monitored. The practice have agreed to undertake this in the future and keep records to reflect that the fridge is working correctly and materials and medicines are stored at the recommended temperatures.

Radiography (X-rays)

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. However radiation protection documentation was incomplete and we were not assured that prior risk assessments had been undertaken or that critical examination testing had taken place at appropriate intervals on the equipment in use.

As a result of this we asked the practice to stop taking X-rays until this was in place. They agreed to do so and within two days we were sent evidence that the X-ray equipment had been correctly registered with the Health

Are services safe?

and Safety Executive and that all equipment had been tested and was in working order. We were sent confirmation of this from a qualified radiation protection adviser and were satisfied that X-rays were now being taken safely.

This information demonstrated that 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 rules described the safe use of X-rays and the procedures to follow if the X-ray equipment failed to operate properly.

All staff who were involved in taking X-rays were suitably trained and qualified and had received up to date training in relation to dental radiography. Dental nurses and other staff we spoke with were aware of the safety procedures to follow and where to stand when a patient received an X-ray. Local rules were being displayed near to each X-ray machine in use.

The practice had started an audit on the quality of the X-rays but this had not been completed at the time of our inspection.

Patients were required to complete medical history forms to assess whether it was safe for them to receive X-rays. This included identifying where patients might be pregnant so the risk to the patient could be assessed before proceeding.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice carried out consultations and assessments in line with recognised guidance from the National Institute for Health and Care Excellence (NICE) and General Dental Council (GDC) guidelines. The dentists we spoke with were aware of and followed the latest NICE guidelines.

However there was a lack of knowledge about the preventative care and advice known as "Delivering Better Oral Health Toolkit". This involved identifying patients at high risk of tooth decay and then taking appropriate action to improve their oral health. We did find that despite the lack of awareness of this guidance, appropriate prevention treatments were being given to patients and their care and treatment assessed accordingly.

Each patient received an oral examination prior to deciding whether further care and treatment was required. This assessment included an examination covering the condition of a patient's teeth, gums and soft tissue and whether there were any signs of mouth cancer. Patients were then made aware of the condition of their oral health and treatment discussed with them. Where required, smoking cessation advice was provided.

We looked at several patient records on the day of our visit for both dentists we spoke with. We found that generally record keeping was satisfactory but some records lacked detail in relation to consent and discussions about the planning of treatments. Records did containg satisfactory information about the justification for taking X-rays and recording the assessments of patient's oral health. The lead dentist agreed to review the quality of patient notes so that they better reflected the assessment, planning and involvement of patients in the decisions about their treatments.

We found that at each visit, dentists checked the medical history of each patient and recorded any changes in the patient record.

Following a consultation X-rays were taken in line with Faculty of General Dental Practice (FGDP) guidelines. This identifies patient's risk factors and gives suggested intervals to take X-rays in order to diagnose or monitor tooth decay. All X-rays taken were justified, graded and reported on and recorded in the clinical records. A diagnosis was then discussed with the patient and appropriate treatment was planned. Care was taken to ensure X-rays were not taken on any patients who were or maybe pregnant until the risk had been fully assessed.

Patients who required treatment were given a written treatment plan which included details of the treatment required. This also included the costs associated with the treatment.

There was evidence that recall intervals were adjusted to an individual patient's needs. This was in line with NICE guidelines. This recall interval was based on risk factors including tooth decay, gum disease, medical history and soft tissue condition.

Health promotion & prevention

The waiting room and reception area at the practice contained limited information for patients about the services provided. A price list was displayed that explained the costs of treatments and their practice website contained further information to help patients understand the services provided.

We were satisfied that consultaions provided patients with sufficient information in relation to health promotion and prevention of tooth decay. Patients were given advice and guidance on how they could achieve better oral health. This included dietary, alcohol and lifestyle advice and information about effective dental hygiene.

Patients were recalled at appropriate intervals to check on their teeth to ensure that prevention methods were effective.

Patients we spoke with told us that the dentists gave them advice and guidance on the best methods to use to clean their teeth and to maintain better oral health.

Staffing

The practice employed two dentists both supported by dental nurses. The ratio of dentists to dental nurses was one to one.

There was one full-time receptionist at the practice and during their absence reception was covered between the dental nurses. There were sufficient numbers of staff working at the practice to meet the needs of patients.

Are services effective?

(for example, treatment is effective)

The practice had been open for less that 12 months when we conducted our inspection so staff were not due for their annual appraisal but a process was in place. Staff spoken with told us told us that the dentists were supportive and always available for advice and guidance.

We looked at the staff files for the two most recently employed members of staff who had started work within the last 12 months. There was no written induction process in place for them to follow to familiarise themselves with the day to day running of the practice. However as a small practice it was evident that they had been supervised and mentored effectively by the dentists working there but this had not been formalised.

We and found that training was being monitored and staff had been booked on a safeguarding course for children and vulnerable adults for September 2015.

We looked at the staff files for a number of the clinical staff working there and found that they were appropriately trained and registered with their professional body. Staff were encouraged to maintain their continuing professional development (CPD) to maintain their skill levels.

Staff numbers were monitored by the lead dentist and staff shortages were planned for in advance wherever possible. Where it was necessary to obtain staff from a locum agency, there was no system in place to check their registration with their professional body, qualifications, skills and experience before using them.

Staff had ready access to the procedures and policies of the practice which contained information that further supported them in the workplace.

Working with other services

The practice had systems in place to refer patients for specialist treatment if it was required. Specialists were advised of the description of the treatment and they were referred in a timely manner. The practice computerised software system supported the referral process and we were told that referrals were dealt with on the same day in the majority of cases.

The practice did not undertake conscious sedation procedures but referred patients to other practices that carried out this procedure.

Consent to care and treatment

Clinical staff spoken with had an understanding of consent issues in relation to children, adults and vulnerable persons. They understood that consent could be withdrawn by a patient at any time. The practice had a consent policy in place to support staff.

Not all staff were clear about consent in relation to children under the age of 16 years who attended for treatment without a parent or guardian. This is known as Gillick competence. The practice has agreed to update all staff on the action to take if a child or young person under this age prefers to attend the practice without a parent or guardian. Staff spoken with did tell us that if this occurred the patient would be referred to one of the dentists which was the correct course of action.

The dentists we spoke with displayed knowledge of the guidelines of the Mental Capacity Act 2005 and explained how they would take consent from a patient if their mental capacity was such that they might be unable to fully understand the implications of their treatment.

The dentists obtained consent from all patients prior to any procedure taking place. Patients received a written treatment plan which included the costs of the treatment. Patients were made aware that consent could be withdrawn at any time.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We found that staff at the practice treated patients with dignity and respect and maintained their privacy. The reception area was open plan but if a confidential matter arose, a private room was available for use. Staff spoken with were aware of the need to maintain patient confidentiality and a policy was available to support them.

Patients we spoke with told us that practice staff were kind and caring and treated them with dignity and respect. The patients we spoke with told us that they would be happy to recommend the practice to family and friends and that all staff were polite and caring. The comment cards we reviewed reflected that patients were extremely satisfied with the way they were treated at the practice.

We observed the interaction between staff and patients and found that they were being treated with dignity and respect. Staff spoken with told us that they would call patients the next day after treatment to check on their welfare if they had undergone a complex procedure.

Involvement in decisions about care and treatment

The dentists spoken with told us that they gave clear explanations to patients about any proposed treatments. They were then given time to consider the treatments and asked whether they understood the treatments at the next visit to the practice.

Patients we spoke with and comment cards we viewed reflected that patients were satisfied that the dentists listened to them and involved them in the decisions about their care and treatment. They told us that consultations and treatment options were clearly explained to them and they were provided with a written treatment plan that included the costs involved.

We spoke with three patients on the day of our inspection and were told that explanations were clear and they were involved in the decisions about the care and treatment proposed.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice offered private dental treatment only and costs were clearly displayed in the practice. The practice had an effective appointment system and patients confirmed this in the comments they made on CQC comment cards. We were told by the practice that appointments rarely ran late. The practice did not have an issue with patients failing to attend for their appointments.

The practice had recently started a patient survey and patients had been provided with questionnaires when they attended the practice. The results of the feedback were to be considered in the future and used to drive improvement.

Tackling inequity and promoting equality

The practice was accessible for those patients with mobility issues, using wheelchairs or mobility scooters and the practice had made reasonable adjustments to accommodate them.

Surgeries were available on the ground and first floor and a lift for the disabled had been installed so they could access all areas f the practice.

The practice had a toilet that was suitable for use by the disabled and baby changing facilities.

Patients with mobility issues were supported by staff when they needed it.

The practice had a small number of vulnerable patients and they were aware of their support needs when attending the practice. These had been recorded in their patient record system.

Access to the service

The practice was open Monday to Thursday between the hours of 8.30am and 5.45pm and Fridays between the hours of 8.30am and 4pm. They are also open on one Saturday each month.

Patients and staff spoken with told us that the appointment system was effective. Patients were rarely kept waiting and could obtain emergency treatment on the same day during surgery hours. Patients requiring out of hour's treatments used the emergency 111 service.

Concerns & complaints

The practice had a complaint procedure and a lead had been identified to respond to them. The procedure outlined who was responsible for investigating them and the timescales for reply. There was a system in place to manage clinical and non-clinical matters and the lead dentist had responsibility for oversight. There had been no complaints since the practice opened in September 2014.

Staff spoken with were aware of the procedures to follow and would try and deal with the complaint themselves if they were able and then notify the complaints lead.

Patients we spoke with on the day of our inspection had not had any cause to complain and were satisfied with the services provided. They felt that staff at the practice would treat any matter professionally. CQC comment cards reflected that patients were highly satisfied with the services provided.

Are services well-led?

Our findings

Governance arrangements

The lead dentist was responsible for all matters relating to governance. Other staff working at the practice were clear on the standards that had been set and were following them. A statement of purpose was in place that outlined the aims and objectives of the practice.

There was a full range of policies and procedures. These included health and safety, infection prevention control, patient confidentiality and recruitment. Staff were aware of the policies and they were readily available for them to access. There was a system in place to review policies annually.

Due to the practice being open for less than 12 months we did not find evidence of audit activity. However these had been planned for the future. The practice had purchased a computer software programme specifically designed to undertake audits that were relevant to dental practices. An audit timetable was being planned. An X-ray audit had recently been started but they were not at the analysis and results stage at the time of our inspection.

Leadership, openness and transparency

The practice had a small number of staff members and it was clear that they working as part of a team. The culture of the practice encouraged, openness, honesty and a duty of candour.

The leadership was provided by the lead dentist supported by an associate dentist. All documents we viewed were clear and concise. Staff were being managed effectively and supervised to ensure standards were being maintained.

Staff spoken with told us that they were encouraged to report safety issues or to raise any concerns they had. They were aware of whom to raise any issue they would be listened to and their concerns acted upon appropriately. They felt confident that issues raised would be dealt with professionally.

Team meetings were used to discuss relevant practice issues and their ideas for improvement were sought. Minutes were kept of meetings and each staff member received their own copy so they could be aware of all issues affecting the practice. Staff felt part of a team. We were told that there was a no blame culture at the practice and that the delivery of high quality care was part of the practice ethos. Staff told us that they worked in a happy environment and felt supported.

Staff spoken with were very positive about working at the practice. They said they were supported and that it was a nice place to work. Some staff mentioned that their roles might benefit from greater definition and clarity so that everyone knew what was expected of them.

Management lead through learning and improvement

The practice was focused on achieving high standards of clinical excellence and this was monitored by the lead dentist at the practice. Staff at the practice were all working towards a common goal to deliver high quality care and treatment.

Staff meetings were held regularly and minutes were recorded which reflected that discussions had taken place about practice matters. We were told that significant events, safety issues and complaints would be discussed at these meetings to cascade learning to staff but there had been none since the practice opened in September 2014.

Staff appraisals were due to begin later in 2015 and used to identify training and development needs that would provide staff with additional skills and to improve the experience of patients at the practice. Staff told us that they were encouraged to undertake their continuous professional development and to identify their training needs for development purposes.

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

The practice acted on feedback from staff through staff meetings and informally. Future appraisal meetings were to be used to encourage staff to identify areas for improvement. Staff spoken with confirmed that they were encouraged to provide feedback about the services provided.

The practice had started a patient survey to obtain feedback from their patients. This was in progress and questionnaires were behing handed out to patients for their comments about the services provided. We were told that an analysis would follow once sufficient responses had been received.