

Charnwood Research Centre Limited

East Midlands Orthodontics

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 19 April 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

East Midlands orthodontics is located in a Victorian town house close to Nottingham city centre.

The practice was registered with the Care Quality Commission (CQC) in April 2014. The practice provides orthodontic services to mostly NHS patients. Services provided include: teeth straightening and fixed and removable braces.

The practice's opening hours are: Monday to Friday: 8:15 am to 4 pm, with the practice closed for lunch 12:30 pm to 1 pm. The practice was not open at weekends.

Access for urgent treatment outside of opening hours is by telephoning the 111 NHS service. This information was on the practice answerphone message.

The principal orthodontist 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'. 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.

The practice has one orthodontist; one orthodontic therapist; three dental nurses; one practice manager; a business support; one receptionist and a decontamination technician.

Summary of findings

We received positive feedback from 23 patients about the services provided. This was through CQC comment cards left at the practice prior to the inspection and by speaking with patients in the practice.

Our key findings were:

- Patients spoke positively about their experiences of the orthodontic services they received, and said they were treated with dignity and respect.
 - Patients' confidentiality was maintained.
 - There were systems in place to record accidents, significant events and complaints, and learning points were identified and were shared with staff.
 - There was a whistleblowing policy and procedures and staff were aware of these procedures and how to use them. All staff had access to the whistleblowing policy.
 - Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.
 - There were training opportunities for staff which allowed personal development within their dental role.
- The practice had the necessary equipment for staff to deal with medical emergencies, and staff had been trained how to use that equipment. This included oxygen and emergency medicines.
 - The practice followed the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control.
 - Patients were involved in discussions about the care and treatment on offer at the practice.
 - Governance arrangements were in place for the smooth running of the practice.

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

- Review its responsibilities to the needs of people with a disability and the requirements of the Equality Act 2010 and ensure an access audit is undertaken for the premises. In addition consider purchasing a portable hearing induction loop to assist patients' who wear a hearing aid.

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.

All staff had received up-to-date training in safeguarding vulnerable adults and children. There were clear guidelines for reporting concerns and the practice had a lead member of staff to offer support and guidance over safeguarding matters. Staff knew how to recognise the signs of abuse, and how to raise concerns when necessary.

The practice had emergency medicines, an automated external defibrillator (AED) and oxygen available.

Recruitment checks were completed on all new members of staff. This was to ensure staff were suitable and appropriately qualified and experienced to carry out their role.

The practice had infection control procedures to ensure that patients were protected from potential risks. Regular audits of the decontamination process were as recommended by the current guidance. Equipment used in the decontamination process was maintained by a specialist company and regular checks were carried out to ensure equipment was working properly and safely.

X-ray equipment was regularly serviced. X-rays were carried out in line with published guidance, the Ionising Radiation Regulations 1999 (IRR 99).

Are services effective?

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

All patients were clinically assessed by an Orthodontist before any treatment began. This included completing a health questionnaire. Patients were given the opportunity to ask questions, and staff used models, photographs and literature to explain the procedures.

Staff took a positive attitude with regard to health promotion, providing advice and assistance with maintaining good oral hygiene.

The practice recorded patients' consent before any treatment was started.

Are services caring?

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

There were systems in place to help maintain patient confidentiality. Staff were able to demonstrate how they achieved this.

Patients said they were well treated, and staff were friendly, polite and caring. Feedback identified that the practice treated patients with dignity and respect.

Patients said they received good orthodontic treatment and they were involved in discussions about their orthodontic care.

Patients said they were able to express their views and opinions.

Are services responsive to people's needs?

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

Patients said they had no problem getting an appointment.

Summary of findings

The patient areas of the practice were not located on the ground floor. There was limited access for patients with restricted mobility. However, alternative arrangements were in place.

The practice had not completed an Equality Act (2010) access audit, and did not have a hearing loop, to assist patients who used a hearing aid.

There were systems and processes to support patients to make formal complaints. Where complaints had been made these were acted upon, and apologies given when necessary.

Are services well-led?

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

There was a clear management structure. Staff were aware of their roles and responsibilities within the dental team, and knew who to speak with if they had any concerns.

There were regular audits carried out at the practice and documentation showed they were effective.

Patients were able to express their views and comments, and the practice listened to those views and acted upon them. Regular feedback was given to patients following surveys to gather patients' views.

Staff said the practice was a friendly place to work, and they could speak with the dentists if they had any concerns.

East Midlands Orthodontics

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 19 April 2016. The inspection team consisted of two Care Quality Commission (CQC) inspectors and a dental specialist advisor.

Before the inspection we asked the practice for information to be sent, this included the complaints the practice had received in the last 12 months; their latest statement of purpose; and the details of the 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 five members of staff. We reviewed policies, procedures and other documents. We received feedback from 23 patients about the dental service.

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 maintained records and investigated accidents, significant events and complaints. This allowed them to be analysed and any learning points identified and shared with the staff. Documentation showed the last recorded accident had occurred in March 2015 this being a minor injury to a patient. An ambulance was summoned and the patient was able to go home after being checked by the paramedics. Accident records went back over several years to demonstrate the practice had recorded and addressed issues relating to safety at the practice.

The practice had a policy for RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) which had been updated in July 2015. RIDDOR is managed by the Health and Safety Executive, although since 2015 any RIDDORs related to healthcare have been passed to the Care Quality Commission (CQC). Staff said there had been no RIDDOR notifications made.

The practice recorded significant events. The records showed there had been no significant event in the 12 months up to the inspection visit. The last recorded significant event had been an abusive patient in June 2012. We saw that the significant event had been analysed and discussed in a staff meeting.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts. These were sent out centrally by a government agency (MHRA) to inform health care establishments of any problems with medicines or healthcare equipment. Alerts were received by the practice. The alerts were analysed by the practice manager and information shared with staff if and when relevant. The practice manager said all MHRA alerts are shared with staff via e mail.

Reliable safety systems and processes (including safeguarding)

The practice had a policy for safeguarding vulnerable adults and children. The policy had been reviewed in December 2015. The policy identified how to respond to any concerns and how to escalate those concerns. Discussions with staff showed that they were aware of the safeguarding policies, knew who to contact and how to refer concerns to agencies outside of the practice when

necessary. The relevant contact telephone numbers were on display in the staff room and in the safeguarding file. Safeguarding contact details were also in the patient information folder in the waiting room.

The practice had an identified lead for safeguarding in the practice and this was the principal orthodontist. The lead had received enhanced training in child protection to support them in fulfilling that role. We saw the practice had a safeguarding file which contained all of the relevant information and the action plan should the practice have any concerns relating to safeguarding.

Staff training records showed that all staff at the practice had undertaken training in safeguarding adults and children. This had been completed on-line and dates for refresher training had been identified during 2016 and 2017.

There was a policy, procedure and risk assessment to assess risks associated with the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. This policy directed staff to identify and risk assess each chemical substance at the practice. Steps to reduce the risks included the use of personal protective equipment (gloves, aprons and masks) for staff, and the safe and secure storage of hazardous materials. There were data sheets from the manufacturer on file to inform staff what action to take if an accident occurred for example in the event of any spillage or a chemical being accidentally splashed onto the skin.

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 29 November 2016. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

The practice had a sharps policy which directed staff how to handle sharps (particularly orthodontic wire and sharp dental instruments) safely. We saw the practice used a recognised system for handling sharps safely in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, and practice policy.

There were sharps bins (secure bins for the disposal of needles, blades or any other instrument that posed a risk of injury through cutting or pricking.) We saw the bins were

Are services safe?

attached to the wall and had instructions for use located close by as identified in the Health and safety Executive (HSE) guidance: 'Health and Safety (Sharp Instruments in Healthcare) Regulations 2013'.

Copies of the practice's sharps policy and how to deal with sharps injuries were displayed in the clinical areas of the practice.

Medical emergencies

The dental practice had equipment in preparation for any medical emergencies that might occur. This included emergency medicines and oxygen which were located in a secure central location. We checked the medicines and found they were all in date. We saw there was a system in place for checking and recording expiry dates of medicines, and replacing when necessary.

There was a first aid box in the practice and we saw evidence the contents were being checked regularly. Two dental nurses had completed a first aid at work course which was within date. There were two designated first aiders for the practice, one dental nurse and the practice manager. There was a poster in the reception area to inform patients of the first aid arrangements at the practice.

The practice had an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.

Resuscitation Council UK guidelines suggest the minimum equipment required and includes an AED and oxygen which should be immediately available. Staff at the practice had completed basic life support and resuscitation training in September 2015 and we saw a refresher course was booked for 6 June 2016. Discussions with staff identified they understood what action to take in a medical emergency. Staff said they had received training in medical emergencies.

Additional emergency equipment available at the practice included: airways to support breathing, manual resuscitation equipment (a bag valve mask) and portable suction.

Staff recruitment

We saw the practice had a staff recruitment policy which had been reviewed in December 2015. We looked at the

staff recruitment files for three staff members to check that the recruitment procedures had been followed. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (schedule 3) identifies information and records that should be held in all staff recruitment files. This includes: proof of identity; checking the prospective staff members' skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed). 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.

We found that all members of staff had received a DBS check. We discussed the records that should be held in the recruitment files with the practice manager, and saw the practice recruitment policy and the regulations had been followed.

Monitoring health & safety and responding to risks

The practice had a health and safety policy which was dated December 2015. There were also environmental risk assessments which had been updated in January 2016. Risks to staff and patients had been identified and assessed, and the practice had measures in place to reduce those risks. For example: fire safety, radiation, and manual handling.

Records showed that fire detection and firefighting equipment such as fire alarms and emergency lighting were regularly tested. The fire risk assessment had been reviewed in January 2016. All staff had attended a practical fire safety training course in December 2015. The fire extinguishers had last been serviced in July 2015. Records showed the last fire drill for staff had been on 11 January 2016.

The practice had a health and safety law poster on display one at the back of reception. Employers are required by law (Health and Safety at Work Act 1974) to either display the Health and Safety Executive (HSE) poster or to provide each employee with the equivalent leaflet.

Infection control

Dental practices should be working towards compliance with the Department of Health's guidance, 'Health

Are services safe?

Technical Memorandum 01-05 (HTM 01-05):

Decontamination in primary care dental practices' in respect of infection control and decontamination of equipment. This document sets out clear guidance on the procedures that should be followed, records that should be kept, staff training, and equipment that should be available.

The practice had an infection control policy which had been reviewed in December 2015. The policy was readily available to staff working in the practice. Dental nurses had set responsibilities for cleaning and infection control in each individual treatment room. The practice had systems for testing and auditing the infection control procedures.

Records showed that regular six monthly infection control audits had been completed as identified in the guidance HTM 01-05. The last audit had been on 5 February 2016. The practice scored 100% on this audit for infection control.

The practice had a clinical waste contract and waste matter was collected regularly. Clinical waste was stored securely away from patient areas while awaiting collection. The clinical waste contract also covered the collection of sharps boxes. The practice had a spillage kit for bodily fluids, which was within its use by date.

There was a dedicated decontamination room that had been split into two rooms with a clean and a dirty side. The decontamination room had been organised in line with HTM 01-05. Staff wore personal protective equipment during the process to protect themselves from injury. This included the use of heavy duty gloves, aprons and protective eye wear.

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 policy.

The practice used both manual cleaning and a washer disinfectant (a machine for cleaning dental instruments similar to a domestic dish washer) to clean dental instruments. We saw the water temperature was being monitored during manual cleaning as this was crucial to the effectiveness of the cleaning. After cleaning the dental instruments were rinsed and examined using an illuminated magnifying glass. Finally the instruments were sterilised in one of the practice's two autoclaves (a device

for sterilising dental and medical instruments). At the completion of the sterilising process, instruments were dried, packaged, sealed, stored and dated with an expiry date.

We checked the equipment used for cleaning and sterilising the dental instruments was maintained and serviced regularly in accordance with the manufacturers' instructions. There were records to demonstrate the decontamination processes to ensure that equipment was functioning correctly. Records showed that the equipment was in good working order and being effectively maintained.

We examined a sample of dental instruments that had been cleaned and sterilised using the illuminated magnifying glass. We found the instruments to be clean and undamaged.

We saw records to demonstrate that staff had received inoculations against Hepatitis B and had received regular blood tests to check the effectiveness of that inoculation. Health professionals who are likely to come into contact with blood products, or are at increased risk of sharps injuries should receive these vaccinations to minimise the risk of contracting this blood borne infection.

The practice had a Legionella risk assessment dated 6 November 2015. The practice was monitoring the water quality to assess for the risk of Legionella. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The practice was aware of the risks associated with Legionella, and was testing and recording water temperatures.

The practice was flushing the dental unit water lines used in the treatment rooms. This was done for two minutes at the start of the day, and for 30 seconds between patients, and again at the end of the day. A concentrated chemical was used for the continuous decontamination of dental unit water lines to reduce the risk of Legionella bacterium developing in the dental unit water lines. This followed the published guidance for reducing risks of Legionella developing in dental water lines.

Equipment and medicines

The practice maintained a file of records to demonstrate that equipment was maintained and serviced in line with manufacturer's guidelines and instructions. Portable appliance testing (PAT) had been completed on electrical

Are services safe?

equipment at the practice during July 2015. The fire alarm had been serviced in July 2015. Fire extinguishers were checked and serviced by an external company and staff had been trained in the use of equipment and evacuation procedures.

We saw the gas boiler had been serviced on 11 April 2016. In addition the practice had a new compressor installed in March 2016. The compressor produced the compressed air for operating the dental chairs in the treatment rooms.

The practice had all of the medicines needed for an emergency situation, as identified in the current guidance. Medicines were stored securely and there were sufficient stocks available for use. Medicines used at the practice were stored and disposed of in line with published guidance.

Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities.

Radiography (X-rays)

The dental practice had a radiation protection file which contained all of the information related to the X-ray machines and their use within the practice.

The practice had a specific X-ray room where X-rays were taken. There was one intraoral X-ray machine (intraoral X-rays concentrate on one tooth or area of the mouth). However, staff said this machine was not used. There was also one extra-oral X-ray machine (an orthopantomogram known as an OPG) for taking X-rays of the entire jaw. There was also a cephalometric radiograph machine. This was a machine which produced an image of the skull which the orthodontist used as a treatment planning tool. The image produced allowed the relationships between the dental and skeletal structures to be analysed.

We saw that X-rays were carried out in line with the local rules that were relevant to the practice and each specific piece of X-ray equipment. The local rules for the use of each X-ray machine were available in each area where X-rays were carried out.

The local rules identified the practice had appointed a radiation protection supervisor (RPS) this was the principal orthodontist. There was also a radiation protection advisor (RPA). This was a company specialising in servicing and maintaining X-ray equipment, who were available for technical advice regarding the machinery. The Ionising Radiation Regulations 1999 (IRR 99) requires that an RPA and an RPS be appointed and identified in the local rules. Their role is to ensure the equipment is operated safely and by qualified staff only.

Records showed the X-ray equipment had last been serviced in June 2015. The Ionising Radiation Regulations 1999 (IRR 99) require that X-ray equipment is serviced at least once every three years.

All patients were required to complete medical history forms and the dentist considered each patient's individual circumstances to ensure it was safe for them to receive X-rays. This included identifying where patients might be pregnant. There were risk assessments in place for pregnant and nursing mothers.

Guidance from the Ionising Radiation (Medical Exposure) Regulations 2000 identified that dental care records should include grading of the X-ray, views taken, justification for taking the X-ray and the clinical findings. Patients' dental care records showed that information related to X-rays was recorded.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice held dental care records for each patient. We saw a small number of dental care records to confirm information we had gathered during the inspection. The dental care records contained information about the assessment, diagnosis, treatment and advice given to patients by dental healthcare professionals.

Patients at the practice completed a medical history form, or updated their details. The medical history was checked at every visit. The forms were then checked by the orthodontist, so they could be informed of any changes to the patients' health or medicines which could affect the orthodontic treatment. The medical history was then added to the dental care record. The medical history forms included any health conditions, medicines being taken and whether the patient had any allergies.

The costs for both private and NHS treatments were on display in the practice.

Health promotion & prevention

The practice had a waiting room with information for patients on display. There was assorted literature about the services offered at the practice, as well as health promotion advice. This included photographs to give patients a visual representation of various conditions associated with the mouth. Models were available to demonstrate various treatments and to give patients an idea of how their mouth would look with the braces fitted.

The practice had a qualified oral health educator who had produced personalised oral health programmes for patients. Good oral health is an important factor in orthodontic treatment, and the personalised programmes offered guidance to patients in achieving improved oral health outcomes.

We saw that dental nurses gave advice to children about tooth cleaning and oral hygiene as good hygiene crucial is in orthodontic treatment.

Staffing

The practice had one orthodontist; one orthodontic therapist; three dental nurses; one practice manager; a business support; one receptionist and a decontamination technician. Before the inspection we checked the

registrations of all dental care professionals with the General Dental Council (GDC) register. We found all staff were up to date with their professional registration with the GDC.

We looked at staff training records and these identified that staff were maintaining their continuing professional development (CPD). CPD is a compulsory requirement of registration with the GDC. The training records showed how many hours training staff had undertaken together with training certificates for courses attended. This was to ensure staff remained up-to-date and continued to develop their dental skills and knowledge. Examples of training completed included: radiography (X-rays), medical emergencies, and safeguarding.

The practice manager was aiming to introduce monthly one to one meetings with the dental nurses to provide supervision and support.

Staff appraisals for all staff were scheduled for May 2016. Staff said they had had an appraisal in July 2015; however we did not see any documented evidence to support this.

Working with other services

Patients were usually referred to the practice from high street dentists, following diagnosis of issues that required specialist orthodontic input. This was because the patients' own dentists did not offer that service in their own practice. When the practice made referrals it tended to be back to the patient's own dentist. This was for dental treatment that was required before the orthodontic treatment could continue. In addition the practice sometimes made referrals to hospital, usually the Queens Medical Centre in Nottingham. The referrals might include the surgical exposure of teeth which had not erupted, or some other surgical procedure.

Patients' dental care records within the practice contained evidence that referrals had been made and received. During the inspection it became clear that dental hygiene was an issue. A patient with poor dental hygiene would be a poor candidate for orthodontic treatment. In such circumstances the practice was referring back to the patient's own dentist; however consideration was being given to appointing a dental hygienist to join the team to overcome this problem.

Consent to care and treatment

Are services effective?

(for example, treatment is effective)

The practice had a consent policy which had been reviewed in December 2015. The policy made reference to capacity and there was information about the Mental Capacity Act 2005 (MCA) and best interest decisions. The MCA provided a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make particular decisions for themselves.

The practice recorded consent in the patients' dental care record. Patients were given a consent form which identified the treatment plan and options including the costs, and signed copies were retained indicating the patients' consent.

Discussions with the practice manager showed there was awareness of and understanding of the use of Gillick to record competency for young persons. Gillick competence refers to the legal precedent set that a child may have adequate knowledge and understanding of a course of action that they are able to consent for themselves without the need for parental permission.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Throughout the inspection we observed how staff spoke with patients and how patients were treated. We saw that staff were welcoming, friendly and polite. Our observations showed that patients were treated with dignity and respect.

The reception desk was located within the waiting room. We discussed the need for confidentiality with reception staff who explained how this was achieved. Staff said they were aware of the need for confidentiality and if necessary there were areas of the practice where this could happen. Staff said that an unused treatment room could be used, or there was a specific consultation room on the first floor. Staff said all details of patients' individual treatment were discussed in the privacy of the treatment or the consulting rooms.

We observed staff speaking with patients throughout the day. We found that confidentiality was being maintained. We saw that patients' dental care records were held securely.

Involvement in decisions about care and treatment

We received feedback from 23 patients on the day of the inspection. This was through Care Quality Commission (CQC) comment cards, and through talking to patients in the practice. Feedback from patients was wholly positive with many saying the staff provided good explanations, and were friendly and caring. Patients also spoke positively about the orthodontic care they had received. Five patients said they had noticed a marked improvement following their ongoing treatment.

The practice offered mostly NHS orthodontic treatments. The costs of NHS treatment were displayed within the practice and the range of private fees were also available.

We spoke with one orthodontist and two dental nurses who explained that each patient had their diagnosis and orthodontic treatment discussed with them before treatment began. In addition treatment was discussed as it progressed.

Where necessary staff at the practice gave patients information about preventing dental decay and good oral hygiene. This included discussions about the effect of smoking and diet on the patient's teeth.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice was located in a Victorian town house close to Nottingham city centre. There was car parking available on the street at the front of the practice. There were no ground floor treatment rooms.

The practice offered patients' flexible appointment times, with those outside of school hours being particularly popular. Patients were given the choice of which dental professional they saw. On occasions the practice has had patients who had been in prison. These patients attended with a prison escort, and the practice had arranged appointments to protect the patients' dignity and respect.

At the time of the inspection first appointments were taking approximately four months, and treatment commenced within a further two to three months. This was quicker when compared to other orthodontic practices in the area.

The practice had separate staff and patient areas, to assist with confidentiality and security.

We saw there was a good supply of dental instruments, and there were sufficient instruments to meet the needs of the practice.

We spoke with two patients during the inspection. Patients said they had found getting an appointment easy, and there had been no unreasonable delay.

Tackling inequity and promoting equality

The practice was located in a town house with treatment rooms on the upper floors. Access to the treatment rooms was via the stairs, as there was no lift. Patients who were unable to manage the stairs could not be seen at the practice.

The practice had not completed an Equality Act (2010) access audit. This would allow the practice to formally consider the needs of patients with restricted mobility. Particularly in respect of them accessing the service and meeting their dental needs. The practice did not have a

portable hearing induction loop. The Equality Act requires where 'reasonably possible' hearing loops are to be installed in public spaces, such as dental practices. Staff acknowledged the practice had older patients who might use a hearing aid.

The practice had access to interpreters via the NHS England area team, and this included the use of sign language. The practice had examples of patients who did not have English as their first language, and where interpreters had come to the practice for the patients' appointments.

Access to the service

The practice's opening hours were: Monday to Friday: 8:15 am to 4 pm, with the practice closed for lunch 12:30 pm to 1 pm. The practice did not open at the weekends.

Access for urgent treatment outside of opening hours was by telephoning the 111 NHS service. This information was on the practice answerphone message.

The practice did not have a text reminder service, but was actively looking into having one.

Concerns & complaints

The practice had a complaints procedure which explained the process to follow for making complaints or raising concerns. The procedure included other agencies to contact if the complaint was not resolved to the patients' satisfaction. This included NHS England and the Parliamentary and Health Service Ombudsman. Information about how to make a complaint was displayed in the practice waiting room.

From information received before the inspection we saw that there had been two formal complaints received in the past 12 months. Both complaints were referred to NHS England. The outcome and learning points for staff were recorded and both complaints were closed and not upheld. With both complaints the practice had arranged a staff meeting to share the learning from the complaint. We saw from documentation in the practice that complaints had been addressed in a timely way, and apologies had been given for any distress caused.

Are services well-led?

Our findings

Governance arrangements

We reviewed a number of policies and procedures at the practice and saw that most had been reviewed and where relevant updated during December 2015.

We spoke with several members of staff who said they understood their roles. Staff also said they could speak with the practice manager or a dentist if they had any concerns. We spoke with three members of staff who said they were happy working at the practice, and felt part of a team.

We saw a selection of dental care records which were complete, legible, accurate, and secure.

Leadership, openness and transparency

There was a practice manager in post who was a qualified dental nurse, with many years' experience. The practice manager also had an NVQ in business management and customer services.

The practice held staff meetings every four to six weeks throughout the year. All staff also met for an informal daily breakfast huddle, where issues of the day were discussed. This ensured good communication across the team.

Staff said there was an open culture, with staff able to voice their views, and raise concerns. Staff also said they understood how the practice worked, and had a working knowledge of policies and procedures.

The practice had an employee handbook. This contained selected policies and procedures and offered staff guidance around key areas of the practice.

The practice had a whistleblowing policy which had been reviewed in July 2015. This policy identified how staff could raise any concerns they had about colleagues' conduct or clinical practice. This was both internally and with identified external agencies. We discussed the whistleblowing policy with two dental nurses who were able to describe the purpose of the procedures, and when and how to use them. The policy was available in the policy file, and on any computer in the practice.

Learning and improvement

The practice had completed a number of audits to monitor quality and identify areas for improvement. For example: An infection control audit had been completed by Nottingham City Care in February 2016 and the practice scored 100%. In addition a record keeping audit had been completed in November 2015, and the Faculty of General Dental Practice (FGDP) guidelines had been followed; a radiography audit including grading reports had been started in April 2016, but had not been completed as the analysis of the data was still ongoing.

Two dental nurses had been accepted at Warwick University to train as orthodontic therapists.

Clinical staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council. Training records at the practice showed that clinical staff were completing their CPD and the hours completed had been recorded. Dentists are required to complete 250 hours of CPD over a five year period, while other dental professionals need to complete 150 hours over the same period. The practice manager was monitoring clinical staff members' CPD on behalf of the organisation.

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

The practice had an NHS Friends and Family (F and F) comment box which was located in the waiting room. The responses within the boxes were analysed on a monthly basis. Feedback from patients by means of the F and F box identified three responses recorded the month before the inspection. All of the responses were positive with respondents saying they would recommend the practice to their family and friends.

The practice had its own suggestion box in the waiting room; however staff said this was of limited success. The practice had its own patient survey which operated on a six monthly basis. The latest survey had been completed in November 2015 with ten responses which all provided positive feedback.