Leagrave Clinic Limited

Leagrave Dental Sedation Clinic

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 25 November 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

Leagrave Dental Sedation Clinic has seven dentists and a medically qualified sedationist. There are also nine qualified dental nurses registered with the General Dental Council (GDC) and two dental nurses in training.

Leagrave Dental Sedation Clinic provides a mix of NHS and private dental treatment including conscious sedation, minor oral surgery and the placement of dental implants. The practice has a contract to provide conscious sedation and minor oral surgery services with NHS England and currently provides 2500 episodes of conscious sedation annually.

The premises are housed in a converted and extended domestic property and consist of four general dental treatment rooms and a well-equipped sedation suite where conscious sedation is provided by a medically qualified sedationist. There is a separate decontamination room for sterilising dental instruments, a room housing a specialised X-ray machine and CT scanner. There is also a reception area and waiting rooms on each floor. Two of the dental treatment rooms and the sedation suite were on the ground floor enabling disabled access.

The clinical lead is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like

Summary of findings

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. Supporting the Registered Manager is a practice manager, deputy manager, a senior administration assistant and clinical governance lead, a receptionist administrator and receptionist. The company has a Managing Director and a Clinical Director.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice. We collected 15 completed cards. These provided a very positive view of the services the practice provides. All of the patients commented that the quality of care was very good.

We carried out an announced comprehensive inspection on 25 November 2015 as part of our planned inspection of all dental practices. The inspection was carried out by a lead inspector and a dental specialist adviser.

Our key findings were:

- We received feedback from 15 patients which was all very positive. Common themes were patients felt they received excellent service from kind and caring staff in a welcoming environment.
- We observed staff to be very friendly and empathetic to the needs of patients.
- Staff had been trained to handle emergencies and appropriate medicines and equipment to deal with medical emergencies was available in accordance with current guidelines.
- Conscious sedation was delivered safely in accordance with current guidelines.
- Infection control procedures were robust and the practice followed published guidance. The practice was visibly clean and well maintained.
- All equipment used in the practice was well maintained in accordance with the manufacturer's instructions.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Staff demonstrated knowledge of the practice's whistleblowing policy and were confident they would raise a concern about another staff member's performance if it was necessary.
- Patients' needs were assessed and care was planned and delivered in line with current professional guidelines.
- The practice placed an emphasis on the promotion of good oral health and provided regular oral health instruction to patients.
- The practice had enough skilled and competent staff to deliver the service safely and effectively.
- Staff had received training appropriate to their roles and were supported in their continued professional development (CPD).
- The practice took into account any comments, concerns or complaints and used these to help them improve the practice.
- There were effective systems in place to assess, monitor and improve the quality of service provided. The practice is a member of the British Dental Association (BDA) Good Practice scheme. This is a quality assurance programme that allows its members to communicate to patients an ongoing commitment to working to standards of good practice on professional and legal responsibilities.
- There were effective systems in place to assess, monitor and mitigate risks to patients, staff and visitors to the practice.

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 robust arrangements for essential topics such as conscious sedation, infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found that all the equipment used in the dental practice was well maintained. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents. There were sufficient numbers of suitably qualified staff working at the practice. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance to guide their practice. The staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

Are services caring?

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

We collected 15 completed cards. These provided a completely positive view of the service; all of the patients commented that the quality of care was very good.

Are services responsive to people's needs?

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

The service was aware of the needs of the local population and took those these into account in how the practice was run. Patients could access treatment and urgent care when required. The practice provided patients with written information about how to prevent dental problems and on the indicative costs of dental treatment. Two dental treatment rooms and the sedation suite were on the ground floor enabling ease of access into the building for patients with mobility difficulties.

Are services well-led?

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

The Registered Manager provided effective leadership for the other clinical staff working in the practice. The practice had clinical governance and risk management structures in place. Staff told us that they felt well supported and could raise any concerns with the Registered Manager and practice manager. All the staff we met said that the practice was a good place to work.

Leagrave Dental Sedation Clinic

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 25 November 2015. The inspection was carried out by a lead inspector and a dental specialist adviser.

During our inspection visit, we reviewed policy documents and staff records. We spoke with nine members of staff, including the management team. We conducted a tour of the practice and looked at the facilities for providing conscious sedation, dental radiography, storage arrangements for medicines used in the provision of conscious sedation, emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the computer system that supported the patient treatment records. We reviewed comment cards completed by patients. Patients gave very positive feedback about their experience 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

There was a system in place to learn from and make improvements following any accidents, incidents or significant event.

Staff understood the process for accident and incident reporting including the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). We found incidents were reported, investigated and measures put in place where necessary to prevent recurrence.

Staff we spoke with had a very clear understanding of their duty of candour. Patients were told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result (such as referral to a specialist consultant where appropriate).

Reliable safety systems and processes (including safeguarding)

The practice had a nominated individual, the Registered Manager, who acted as the practice safeguarding lead. The Registered Manager acted as a point of referral should members of staff encounter a child or adult safeguarding issue. We discussed with two dentists the different types of abuse that could affect a vulnerable child or adult patient and who to report them to if they encountered any such instances. They were able to describe in detail the types of behaviour a child would display that would alert them if there were possible signs of abuse or neglect. They also had a good awareness of the issues around vulnerable elderly patients who presented with dementia and required dental care and treatment.

Training records showed that all staff had received appropriate safeguarding training for both vulnerable adults and children. There were accessible policies for staff to refer to if they had any concerns. Information was available that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities.

A risk management process had been undertaken for the safe use of sharps (needles and sharp instruments). Only dentists were permitted to re-sheath needles where necessary and needle guards had been introduced in order to minimise the risk of inoculation injuries to staff.

We asked the practice about the use of rubber dam. Staff explained that root canal treatment carried out by the dentists using a rubber dam where practically possible at all times. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). Patients could be assured that the practice followed appropriate guidance by the British Endodontic Society in relation to the use of the rubber dam.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. On the ground floor in the sedation suite was a 'crash trolley'. This contained all the necessary emergency medicines and associated equipment used in the resuscitation of a patient in a dental emergency. The practice had an automated external 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. On the first floor a second fully stocked emergency medicines kit was also available. Oxygen cylinders were also available on each floor. This was in line with the guidance set out by the British National Formulary and Resuscitation Council UK for dealing with common medical emergencies in a dental practice.

All emergency medicines, oxygen and equipment were in date. The expiry dates of medicines and equipment were monitored using a check sheet which enabled the staff to replace out of date drugs and equipment in a timely manner. The practice held training sessions on an annual basis in first aid, immediate life support and paediatric life support for the whole team to maintain their competence in dealing with medical emergencies. We saw that these sessions had been carried out during 2015. Staff we spoke with clearly demonstrated that they knew how to respond if a person suddenly became unwell.

Staff recruitment

There were effective recruitment and selection procedures in place. We reviewed the employment files for five staff members. Each file contained evidence that satisfied the

requirements of relevant legislation. This included application forms, employment history, evidence of qualifications and photographic evidence of the employee's identification and eligibility to work in the United Kingdom where required. The qualification, skills and experience of each employee had been fully considered as part of the interview process.

Appropriate checks had been made before staff commenced employment including evidence of their professional registration with the General Dental Council (where required) and checks with the Disclosure and Barring Service had been carried out. The Disclosure and Barring Service carries out 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 might be vulnerable.

Monitoring health & safety and responding to risks

The practice had a health and safety risk management process in place which enabled them to assess, mitigate and monitor risks to patients, staff and visitors to the practice. There was a business continuity plan in place.

The practice carried out a number of risk assessments including a well maintained Control of Substances Hazardous to Health (COSHH) file. Other assessments including fire safety, health and safety and water quality risk assessments were maintained on a well-managed spread sheet which gave details of when assessments had been carried out along with their review dates. For example fire safety testing and electrical wiring had been carried out during 2015 and were to be reviewed again in 2016 and 2018 respectively.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. It was demonstrated through direct observation of the cleaning process and a review of practice protocols that HTM 01 05 (national guidance for infection prevention control in dental practices') Essential Quality Requirements for infection control were being met. We observed that a current audit of infection control processes confirmed compliance with HTM 01 05 guidelines. The most recent audit was carried out in September 2015.

We observed that all dental treatment rooms, sedation suite, waiting areas, reception and toilet were visibly clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms (including the sedation suite) and the decontamination room. Hand washing facilities were available including liquid soap and paper towels in each of the treatment rooms and toilets.

The clinical governance lead was responsible for infection control and a dental nurse described the end to end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. We were shown how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

The drawers and cupboards of a treatment room were inspected in the presence of the lead dental nurse. These were well stocked, clean, well ordered and free from clutter. All of the instruments were pouched and it was obvious which items were single use and these items were clearly new. Each treatment room had the appropriate personal protective equipment available for staff and patient use, such as gloves and masks. The practice carried out the placement of dental implants and other oral surgery procedures. We noted that the practice used sterile single use irrigant packs during these procedures and surgical drapes to minimise the risk of infection spreading.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings) they described the method they used which was in line with current HTM 01 05 guidelines. A Legionella current risk assessment had been carried out by an appropriate contractor in December 2014. The report contained recommendations which the practice had followed up. The next assessment was due to be carried out in December 2016. We noted that the sentinel tap water temperatures were monitored as specified in the risk assessment and documentary evidence was available for inspection. These measures ensured that patients and staff were protected from the risk of infection due to Legionella.

A dental nurse demonstrated to us the decontamination process from transporting the dirty instruments through to cleaning them and making them ready for use again. The process followed a well-defined system of zoning from dirty through to clean. The practice used a system of manual scrubbing in each treatment room as part of the initial cleaning process. Following this, instruments were then transported to a separate decontamination room for

instrument inspection and sterilisation. This decontamination room was organised clean, tidy and clutter free. Displayed on the wall were protocols to remind staff of the processes to be followed at each stage of the decontamination process. Dedicated hand washing facilities were available.

Following inspection with an illuminated magnifier, instruments were placed in an autoclave (a machine used to sterilise instruments). When instruments had been sterilized they were then appropriately transported back to the treatment rooms where they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines. The dental nurse also demonstrated that systems were in place to ensure that the autoclaves used in the decontamination process were working effectively. These included the automatic control test and steam penetration tests for the autoclave. It was observed that the data sheets used to record the essential daily validation checks of the sterilisation cycles were always complete and up to date.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained and was in accordance with current guidelines. The practice used an appropriate contractor to remove dental waste from the practice and was stored in a separate locked location adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection. Patients could be assured that they were protected from the risk of infection from contaminated dental waste.

Equipment and medicines

We found the medicines used for intravenous sedation (including the reversal agent) were stored safely for the protection of patients. The practice had a very secure system in place with medicines stored in a lockable and alarmed wall mounted metal cabinet. The practice also stored prescription pads in this cupboard to prevent loss due to theft. There was a robust written system of stock control for the medicines used in intravenous sedation which was demonstrated to us. The sedation suite had appropriate equipment used for the monitoring of patients during and after conscious sedation. We also noted that the equipment used to deliver relative analgesia was well maintained and was regularly calibrated and checked. We also observed that active scavenging equipment was in place to remove excess nitrous oxide from the atmosphere to prevent occupational health problems in staff carrying out this type of sedation. All electrical appliances had undergone a Portable Appliance Test (PAT) to ensure that they were safe to use. This had been undertaken in December 2012 and was due to be reviewed in 2015.

Records we viewed reflected that equipment in use at the practice was regularly maintained and serviced in line with manufacturers guidelines. We observed the maintenance schedules ensuring that the autoclaves were maintained to the standards set out in the Pressure Systems Safety Regulations 2000, the most recent service being carried out in September 2015.The dental compressor, a piece of equipment to produced compressed air was serviced regularly and was last carried out in November 2015 which was in line with the regulations. X-ray machines and the CT scanner were the subject of regular visible checks and records had been kept. A specialist company attended at regular intervals to calibrate and review all X-ray equipment and the CT scanner to ensure they were operating safely. The most recent reports was dated March and May 2015 respectively which was in accordance with the Ionising Radiation Regulations 1999.

Radiography (X-rays)

We were shown a well maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor, Health and Safety Executive (HSE) notification and the necessary documentation pertaining to the maintenance of the X-ray equipment and CT scanner. Included in the file were the critical examination packs for each X-ray set along with the three yearly maintenance logs and a copy of the local rules. The maintenance logs were within the current recommended interval of three years.

The dental care records we reviewed showed that dental X-rays and CT scans were justified and reported on every time. X-rays and CT scans were taken in line with current guidelines by the Faculty of General Dental Practice of the Royal College of Surgeons of England and national radiological guidelines and were of a high quality. These findings showed that practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists working in the practice carried out consultations, assessments and treatment in line with recognised general professional guidelines. A dentist we spoke to described to us how they carried out their assessment. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained in detail. Details of the treatment were also documented and included (where relevant) local anaesthetic type, the site of administration, batch number and expiry date.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general dental hygiene procedures such as brushing techniques or recommended mouth care products. Each patient's dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient which included the costs involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

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

The practice carried out intra-venous and relative analgesia sedation for children and adults who were very nervous of dental treatment and required a range of routine and complex dental treatment. The practice used a medically qualified sedationist to provide conscious sedation for children and adult patients who had more complex medical histories. Two other dentists in the practice were appropriately qualified and experienced and provided intra venous sedation to fit and well adult patients.

We found that there were robust governance systems in place to underpin the provision of conscious sedation. The systems and processes we observed were in accordance with the new guidelines recently published by the Royal College of Surgeons and Royal College of Anaesthetists in April 2015. This included pre and post sedation treatment checks, emergency equipment requirements, medicines management, sedation equipment checks, personnel present, patients' checks including consent, monitoring of the patient during treatment, discharge and post-operative instructions and staff training.

We found that patients were appropriately assessed for sedation. We saw clinical records that showed that all patients undergoing sedation had important checks made prior to sedation. This included a detailed medical history, blood pressure and an assessment of health using the American Society of Anaesthesiologists classification system in accordance with current guidelines. The records demonstrated that during the sedation procedure important checks were recorded at regular intervals which included pulse, blood pressure, breathing rates and the oxygen saturation of the blood. This was carried out using specialised equipment including a pulse oximeter which measures the patient's heart rate and oxygen saturation of the blood. Blood pressure was measured using a separate blood pressure monitor. The medically qualified sedationist and dentists carrying out sedation were supported by appropriately trained dental nurses on each occasion. This was also recorded in the dental care records with details of their names. The measures in place ensured that patients were being treated safely and in line with current standards of clinical practise.

The dental nurses supporting the dentist demonstrated to us that they were confident and assured about their roles and responsibilities during sedation. This reflected the high quality of the ongoing training, supervision and mentoring that the dental nurses received from the sedationists. Dental nurses supporting sedation procedures had undertaken additional qualifications in conscious sedation by the National Examining Board for Dental Nurses.

Are services effective?

(for example, treatment is effective)

Health promotion & prevention

The waiting area on the first floor contained literature in leaflet form that explained about how to reduce the risk of poor dental health including signposting to local smoking cessation services, how to maintain healthy gums and how to manage sensitive teeth. The practice's website also contained details about how to maintain healthy teeth and gums. We saw dental care records that showed that patients attending the practice were advised during their consultation of steps to take to maintain healthy teeth. Tooth brushing techniques were explained to them in a way they understood; smoking and alcohol advice was also given to them. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'.

Staffing

There was an induction and training programme for staff to follow which ensured they were skilled and competent in delivering safe and effective care and support to patients. In addition, new staff were assigned mentors throughout their period of training to ensure they had extra support whenever it was required in addition to their line managers.

Staff had undertaken training to ensure they were kept up to date with the core training and registration requirements issued by the General Dental Council. This included areas such as responding to medical emergencies and infection control and prevention. The practice employed a good skill mix of staff; dental nurses had also undertaken additional qualifications such as dental radiography to help support patients' needs effectively.

There was an appraisal system in place which was used to identify training and development needs. Staff told us they had found this to be a useful and worthwhile process; they felt well supported by the practice management team and they were given opportunities to learn and develop.

Working with other services

The practice was a referral centre for complex treatment and services and maintained and monitored the process to ensure patients had access to dental care and treatment in a timely manner. Dentists explained how they would work with other services if they could not provide all the necessary treatment for patients. They were able to refer patients to a range of specialists in secondary and tertiary care services if the treatment required was not provided by the practice. Referral letters were prepared and then sent to the hospital with full details of the dentists' findings and was stored on the practice's computer dental software system. When the patient had received their treatment they would be discharged back to the practice for further follow-up and monitoring.

Consent to care and treatment

We spoke to dentists and dental nurses on the day of our visit who had a clear understanding of patient consent issues. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options. They explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. We observed that these findings were recorded in meticulous detail. We also noted that in instances where treatment plans were more complex the patient was provided with a written statement of the individual findings in language that they could understand.

Dentists we spoke with explained how they would obtain consent from a patient who suffered with any mental impairment which may mean that they might be unable to fully understand the implications of their treatment. They explained that they would involve relatives and carers where relevant to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patients told us they felt they received personalised care and treatment from professional, friendly and caring staff in a clean and safe environment. On the day of our inspection, we observed staff being polite, friendly and very welcoming to patients. In a recent patient survey, 100 per cent of patients (50 in total) had responded that they were very satisfied with the courtesy and friendliness of staff.

Treatment rooms were situated away from the main waiting area and we saw that doors were able to be closed at all times when patients were with dentists and dental hygienists. Conversations between patients and dentists could not be heard from outside the rooms which protected patients' privacy. Patients' clinical records were stored electronically and in paper form. We noted that the paper records were stored in lockable filing cabinets in the administration office preventing unauthorised access by patients or the general public. Computers were password protected and regularly backed up to secure storage and screens at reception were not overlooked which ensured patients' confidential information could not be viewed at reception.

Patients who had received treatment under sedation were supported (when ready) to leave with their escort through the rear exit of the practice. This meant they did not have to walk through a busy reception area in order to access their transport.

Involvement in decisions about care and treatment

The dentists we spoke with stressed the importance of communication skills when explaining care and treatment to patients. They explained that they would not normally provide treatment to patients on the first appointment unless they were in pain or their presenting condition dictated otherwise. The dentists felt that patients should be given time to think about the treatment options presented to them. This made it clear that a patient could withdraw consent at any time and that they had received a detailed explanation of the type of treatment required, including the risks, benefits and options. Costs were made clear in the treatment plan. Dental care records we saw confirmed this approach had taken place.

In a recent patient survey, 100 per cent (50 patients) of respondents said they were very satisfied with the range of treatment options they had been offered.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided care and treatment that supported patients' individual needs. Several patients reported they felt safe and at ease when attending the practice. One person said they had not seen a dentist for more than twenty years as they had been afraid. They said the staff at this practice were very caring and sensitive to their anxieties and now they would not want to go anywhere else. Staff reported (and we saw from the appointment book) the practice scheduled enough time to assess and undertake patients' care and treatment needs. Staff told us they did not feel under pressure to complete procedures and always had enough time available to prepare for each patient.

The practice regularly followed up patients who had not completed their course of treatment in order to minimise the risk of them developing further dental disease or pain.

There were effective systems in place to ensure the equipment and materials needed were in stock or received well in advance of the patient's appointment. This included checks for implant fixtures and laboratory work such as crowns and dentures and ensured delays in treatment were avoided.

Tackling inequity and promoting equality

We asked staff to explain how they communicated with people who had different communication needs such as those who spoke another language. Staff told us they treated everybody according to their individual needs and welcomed patients from different backgrounds, cultures and religions. They would encourage a relative or friend to attend who could translate or if not they would contact a translator. Practice staff also spoke a number of languages between them and produced information leaflets in languages as well as English to support the needs of the local community.

Staff told us they supported a number of patients with autism to receive treatment at the practice. It was clear staff were very knowledge about and empathetic to patients' individual physical, mental health, social and cultural needs. The practice was accessible to people using wheelchairs.

Access to the service

Appointments could be made in person or by telephone. During our inspection we looked at examples of information available to people. We saw that the practice waiting area displayed a variety of information including opening hours, emergency 'out of hours' contact details and arrangements, and practice policy documents. This was also explained in the patient information leaflet which was available in the waiting area and the practice web site reinforced this information. We looked at the appointment schedules for varying complexities of treatment and found patients were given adequate appointment lengths.

Concerns & complaints

There was a complaints policy which provided staff with information about handling formal and informal complaints from patients.

Information for patients about how to make a complaint was available in the practice waiting room. This included contact details of other agencies to contact if a patient was not satisfied with the outcome of the practice investigation into their complaint.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was an effective system in place which ensured a timely response. The practice team viewed complaints as a learning opportunity and discussed those received in order to improve the quality of service provided.

Are services well-led?

Our findings

Governance arrangements

The governance arrangements of the practice were developed through a process of continual learning. The practice is a member of the British Dental Association) Good Practice scheme. This is a quality assurance programme that allows its members to communicate to patients an ongoing commitment to working to standards of good practice on professional and legal responsibilities.

The practice had in place a number of risk assessments which helped to underpin their system of clinical governance. These included a robust radiology risk assessment to ensure safe use of radiation and a Legionella assessment to ensure the safety of the water systems. The practice also had a comprehensive 'sedation file' which contained all the necessary systems and processes in place for the provision of safe sedation care. This had been updated to take account of the most recent guidance.

We were shown examples of monthly staff meeting minutes which provided evidence that training took place and that information was shared with practice staff. These were an important method for cascading new information to all members of the dental team. The meetings were used to discuss various aspects of the running of the practice and the care and treatment it provided to patients.

Staff met each morning to discuss the day ahead in order to ensure they were fully prepared to support patients' needs effectively and to reinforce any key issues.

Leadership, openness and transparency

Staff reported there was an open and transparent culture at the practice which encouraged candour and honesty. They confident they could raise issues or concerns at any time with their line manager, the practice manager or the clinical lead without fear of discrimination.

We found staff to be hard working, very caring towards the patients (and each other), were committed to the work they did and worked well as a team. Many staff had worked at the practice for several years. We found the principal dentist, who also acted as the Registered Manager, provided effective clinical leadership to the whole dental team.

Learning and improvement

There were a number of audits undertaken at the practice. These included important areas such as infection prevention control and X-ray quality. These had been carried out during 2015. We also saw audit of other areas of clinical practise including clinical record keeping and conscious sedation. This included an audit of the various types of medicine used in conscious sedation their effects on the patient and a breakdown of the different types of case where sedation is used.

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

There was a system in place to act upon suggestions received from patients using the service.

The practice conducted regular staff meetings. Staff members told us they found these were a useful opportunity to share ideas and experiences which were listened to and acted upon.