The Dental And Cosmetic Clinic Ltd

The Dental and Cosmetic Clinic

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 16 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

The Dental and Cosmetic Clinic is located in the suburbs of Leicester in South Wigston. It is outside the city boundary, forming part of the Oadby and Wigston district of Leicestershire. There are good public transport links within the area and a railway station a short walk away from the clinic. The clinic has ample car parking to the rear of the premises for its patients to use.

The practice provides only private dental services and treats both adults and children. The practice serves a population of approximately 3,000. This includes around 50 children.

There are eight members of staff working within the practice team. This consisted of one dentist, four dental nurses and two dental hygienists. In addition the clinic has a practice manager who is also qualified as a dental nurse. There is a receptionist employed who is supported by the practice manager and one of the dental nurses when the reception desk requires manning.

The practice opening hours are Monday to Friday 9.00am to 5.30pm.

We received feedback from 41 patients. All feedback included extremely positive comments about the practice and the majority made particular reference to the staff. Comments supported that the practice was able to meet the needs of nervous patients and those with special

Summary of findings

needs including physical and learning difficulties. One person commented that it was the best service a patient could ever have. Remarks were also made regarding the cleanliness of the practice. We did not receive any negative comments about the practice.

Our key findings were:

- The practice had a system for recording and analysing significant events and complaints and sharing learning with staff.
- Staff had received safeguarding and whistle blowing training and knew the procedures to follow to raise any concerns.
- There were sufficient numbers of suitably qualified staff to meet patients' needs.
- All but one member of staff we spoke with had been trained to handle emergencies and we found that most of the appropriate equipment and medicines were readily available. However, we found that the practice did not have an AED (defibrillator) in place. An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. When this was raised with the practice manager, they made a decision to purchase an AED there and then. We were provided with assurance following our inspection that the defibrillator had arrived at the practice and was ready for use.
- Robust infection control procedures were in place and the practice followed national guidance.
- Patients' care and treatment was planned and delivered in line with evidence based guidelines, best practice and current legislation.
- Patients received clear and detailed explanations about their proposed treatment, costs, options and risks. Patients were therefore able to make informed decisions about their choice in treatments.
- We observed that patients were treated with dignity and respect and confidentiality was maintained.
- The appointment system met patients' needs whether they wanted to be seen urgently or for more routine appointments.
- The practice was well-led and staff worked as a team. There was an open culture in place whereby staff felt able to raise any issues or concerns.
- Governance systems were effective and there was a range of clinical and non-clinical audits to monitor the quality of services.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had procedures in place to investigate and respond to significant events and complaints.

The practice had a safeguarding vulnerable adults and children policy and procedures. Staff demonstrated an awareness of the signs of abuse and knew their duty to report any concerns about abuse.

Latex free rubber dams were used when carrying out root canal treatments in line with guidance from the British Endodontic Society.

We saw evidence that medical alerts were flagged to clinicians when treatments took place.

The practice had a whistle blowing policy for staff to raise concerns in confidence. Staff knew the procedure for whistleblowing and who they could speak with about any concerns.

The practice had procedures and equipment for dealing with most medical emergencies. At the time of the inspection the practice did not have an AED (defibrillator) as recommended by the UK resuscitation council. However, during the inspection we observed the practice manager order an appropriate AED with adult and children's pads and arrange for staff training in its use.

On the day of our inspection, we found staff recruitment procedures required some improvement. Following our discussion with practice management changes to these procedures were immediately implemented and an updated policy and procedure were provided to us after the inspection.

The practice followed national guidance from the Department of Health in respect of infection control.

X-rays were carried out in line with the Ionising Radiation Regulations 1999 (IRR 99) and in line with the Faculty of General Dental Practitioners (FGDP) guidelines.

Are services effective?

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

Patients were assessed at the start of each consultation and updated their medical history. The results of assessments were discussed with patients and treatment options and costs were explained.

Dentists and clinical staff were aware of National Institute for Health and Care Excellence (NICE) guidelines particularly in respect of recalls of patients and anti-biotic prescribing.

Advice was given to patients on how to maintain good oral hygiene and the impact of diet, tobacco and alcohol consumption on oral health.

There were enough suitably qualified and experienced staff to meet patients' needs. Staff were encouraged to update their training, and maintain their continuing professional development (CPD).

Referrals were made to other services in a timely manner when further treatment or treatment outside the scope of the practice was required.

Staff were aware of the Mental Capacity Act (MCA) 2005, and consent was carried out in line with relevant legislation including the MCA.

Summary of findings

Are services caring?

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

All comments from patients at the practice were extremely positive about the care and treatment they received. Patient's confidentiality was maintained at all times. Staff treated patients with privacy, dignity and respect.

Patient electronic records were password protected on the computer. However we observed the paper records were stored on open shelving albeit to the side and behind the reception desk. We told the provider that they needed to ensure that this storage area was closed with secure shuttering or the documentation moved to a secure area. We were provided with evidence following our inspection that this area had since been secured.

Are services responsive to people's needs?

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

The practice provided patients with detailed information about the services they offered on their website and within the practice. The appointment system responded promptly to patients' routine needs and when they required urgent treatment.

Longer appointment times were available for patients who required extra time or support. Feedback we received from patients supported this.

The practice building was suitable for those who had impaired mobility and the practice had conducted an Equality Act 2010 audit to ensure access for patients who had impairments.

There was a complaints policy and procedure in place. There was assurance regarding the process to be followed in the event of complaints received and how staff learning would be disseminated.

Are services well-led?

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

The practice manager took an active lead in the day to day running of the practice. The practice had arrangements in place for monitoring and improving the services provided for patients. There were governance arrangements in place which were evidenced during our review of documentation held.

The practice had an open and honest culture. We were told that there was a focus at the practice of delivering high quality care and this was evidenced in staff continuous professional development, technological equipment used, and national recognition awards received.

The practice's philosophy put the patient first, and they were at the heart of everything the practice did. If a patient required urgent treatment out of hours, they could contact their dentist on his personal mobile telephone number. We saw that the dentist reviewed his clinical practice and introduced changes to make improvements.

The comments in the Care Quality Commission (CQC) comment cards we received and the patients we spoke with said that they were delighted with the care and treatment they received. We noted feedback was received from a number of patients who had been registered at the practice for a considerable number of years.

Patients were invited to give feedback at any time they visited the practice as well as through the provider's website which contained a page dedicated to providing a feedback mechanism.

The Dental and Cosmetic Clinic

Detailed findings

Background to this inspection

We carried out an announced comprehensive inspection on 16 November 2015. The inspection took place over one day. The inspection team consisted of one CQC inspector and dentist specialist advisor.

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

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

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

Prior to the inspection we asked the practice to send us some information which we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, 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 as well as information available to the public. We found there were no areas of concern.

During the inspection we spoke with the dentist, the practice manager, receptionist and two dental nurses. We reviewed policies, procedures and other documents held which included some staff files. We reviewed feedback from 41 patients. This included CQC comment cards completed and patients we spoke with on the day.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had procedures in place to investigate, respond to and learn from significant events and complaints. We saw evidence of one complaint received which was ongoing. We reviewed the complaint which demonstrated that the practice had followed due process and procedure in responding to complaints. For example, the complainant received an initial acknowledgement to their complaint within timescales set by the practice for its response, as outlined in its complaint handling policy.

Weekly staff team meeting minutes reflected an open culture amongst the practice to discuss any issues such as complaints and customer feedback received. Standing items on the agenda included staff discussion on what had gone well and anything that could be improved. This provided an open forum for staff and management to engage, provide opinion and share any lessons learned.

The system for managing incidents provided a framework for reporting and learning from incidents. There was a separate system to record details of accidents. In addition there was a system for reporting Injuries under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013. Staff we spoke with were aware of these reporting systems. No incidents had been reported in the last twelve months.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts via the practice manager. These alerts identify any problems or concerns relating to a medicine or piece of medical equipment, including those used in dentistry. Alerts were shared with staff at the weekly staff meetings when considered relevant. We saw evidence of MHRA alerts which had been checked by the practice manager.

Reliable safety systems and processes (including safeguarding)

The practice had a safeguarding vulnerable adults and children policy and procedures which contained key information and contact details for the local authority to raise any concerns.

The staff members we spoke with demonstrated an awareness of the signs of abuse and their duty to report any concerns about abuse. Staff discussion over policies took place on a regular basis during practice meetings held. There was an identified lead for safeguarding in the practice who had undertaken level 2 safeguarding training.

We asked how the practice treated the use of instruments which were used during root canal treatment. The dentist explained that these instruments were single use only. They also explained that root canal treatment was carried out using a latex free rubber dam. (A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth). Patients could be assured that the practice followed appropriate guidance by the British Endodontic Society in relation to the use of the rubber dam.

We saw evidence that medical alerts were flagged to clinicians when treatments took place. This included alerts regarding patients who had a latex or antibiotic allergy. We saw a patient attend an appointment with the dentist who had an allergy. This was highlighted on the patient's electronic notes prior to any treatment taking place.

The practice had a whistle blowing policy for staff to raise concerns in confidence. Staff told us that they felt confident that they could raise concerns and knew the procedure for whistleblowing and who they could speak with about those concerns.

The practice had procedures in place to assess the risks in relation to the control of substances hazardous to health (COSHH). This included any chemical which could cause harm if accidentally spilt, swallowed, or came into contact with the skin. For example, cleaning materials and all dental materials used in the practice. Each of these had been risk assessed and recorded in the COSHH file which all staff were aware of. Staff and patients were provided with personal protective equipment (PPE) (gloves, aprons, masks and visors to protect the eyes). We found sufficient PPE available for practice staff and patients. Hazardous materials were stored safely and securely. The practice kept data sheets from the manufacturers in the COSHH file to inform staff what action to take in the event of a spillage, accidental swallowing or contact with the skin. We found that staff had signed the COSHH controls checklist between February 2015 to July 2015 to show their awareness and understanding.

Medical emergencies

Are services safe?

The practice had procedures and equipment in place for dealing with most medical emergencies. We found however, that the practice did not have an AED (defibrillator) at the time of our inspection. An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. When we discussed this with the practice manager, they made a decision to purchase an AED there and then. The order included both child and adult pads and provision of training in its use for all staff.

Emergency medicines and oxygen were available if required. This was in line with the Resuscitation Council UK guidelines. We checked the emergency medicines and all medicines were in date. We saw records which demonstrated that staff had checked medicines and equipment to monitor stock levels, expiry dates and to make sure that equipment was in working order.

Three of the four staff recruitment files we reviewed included training records of staff who had received basic life support training. Staff knowledge of emergency procedures was demonstrated when we asked them to describe how they would deal with an urgent situation if it arose. We found that all but one member of staff had received training in emergency procedures. The member of staff who told us they had not received this training worked one day a week at the practice. They told us that they would need to call for help if a patient became unwell. We were provided with assurance from the practice that the member of staff would have assistance on hand from other staff if required.

The practice had a first aid kit available within the practice, and we were informed that all members of staff could administer First Aid – having completed appropriate first aid training.

Staff recruitment

We reviewed staff recruitment files for four members of staff. The practice had a recruitment policy for the employment of new staff. This was last reviewed in August 2015. This identified the checks that should be undertaken during the recruitment process. They included obtaining proof of identity, checking skills and qualifications, registration with professional bodies where relevant, references and whether a Disclosure and Barring Service (DBS) check was necessary. DBS checks identify whether a person had a criminal record or was on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

DBS certificates were included in all of the staff files we reviewed. We did find however that the practice had accepted some certificates supplied by staff where the checks had been made by other employers. The acceptance of portable DBS certificates did not provide robust assurance for the practice. The practice did not have a process where it would reapply for staff DBS checks after a period of time had lapsed. Following our inspection, we were informed of new measures deployed by the practice. This included updating the existing certificates and we were passed evidence to support this.

The practice had an induction system for new staff. We reviewed the induction documentation for the newest member of staff and saw that the documentation was complete and detailed.

There were sufficient numbers of suitably qualified and skilled staff working within the practice. A system was in place to ensure that where absences occurred staff would cover for their colleagues. We were told that there was a local agreement for cover in place with other practices when the dentist took annual leave.

Monitoring health & safety and responding to risks

There were arrangements in place to deal with potential emergencies. There was a health and safety policy to guide staff. Staff were aware of the policy and discussions of policies took place regularly in staff meetings.

The practice had a fire risk assessment that identified fire risks. Fire extinguishers were also serviced annually and fire alarms were checked regularly.

The practice also undertook environmental risk assessments and checks of equipment and the premises. Policies included infection control and a legionella risk assessment. Processes were in place to monitor and reduce these risks so that staff and patients were safe.

Infection control

The practice had an infection control policy, which was scheduled for regular review. The policy identified cleaning schedules at the practice including the treatment rooms and the general areas of the practice. The practice manager

Are services safe?

told us that the practice employed an environmental cleaner but dental nurses had set cleaning responsibilities in each treatment room which they recorded daily. The practice had systems for testing and auditing the infection control procedures. We saw records of an Infection Prevention Society (IPS) infection control audit that had been completed in line with recommendations in the Department of health document HTM01-05. The practice scored 99% on this latest IPS audit.

We found that there was an adequate supply of liquid soaps and hand towels throughout the practice. Sharps bins were signed and dated and did not pass their identified capacity. A clinical waste contract was in place and waste matter was appropriately sorted, and stored until collection. We saw waste consignment notes from an approved contractor.

We looked at the procedures the practice used for the decontamination of used or dirty dental instruments. The practice had a specific decontamination room that had been arranged according to the Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.'

We observed the dedicated decontamination room was not secured with a security lock meaning patients or members of the public could gain unauthorised access to this room. The provider advised that a suitable security lock would be ordered and fitted. Following our inspection, we were passed evidence of the lock which had been fitted to the room.

Within the decontamination room there were clearly defined dirty and clean areas to reduce the risk of cross contamination and infection. Staff wore appropriate personal protective equipment during the process and these included heavy duty gloves, aprons and protective eye wear.

The practice had two autoclaves, a vacuum autoclave for general use and one as a backup. This type of autoclave was designed to sterilise non wrapped or solid instruments. At the end of the sterilising procedure the instruments were dried on racks, packaged, sealed, stored and dated with an expiry date. We looked at the sealed instruments in the surgeries and found that they all had an expiry date that met the recommendations of HTM01-05.

We observed the main autoclave was not able to be validated automatically by means of a data reader or printer port and required manual validation. The provider in discussion during the inspection advised that the manufacturers of the autoclave had been contacted and identified that a USB output into a computer was available for this autoclave and had been ordered.

The practice's website contained a video for the general public to view which demonstrated the decontamination process used. This was provided to patients to assure them of the safety measures adopted by the practice.

The equipment used for cleaning and sterilising was maintained and serviced in line with the manufacturer's instructions. Daily, weekly and monthly records were kept of decontamination cycles to ensure that equipment was functioning properly. This allowed the clinical staff (the dentists and dental nurses) to have confidence that the equipment was sterilising the dental instruments effectively and patients were not exposed to cross infection. Records showed that the equipment was in good working order and being effectively maintained.

Staff said they wore personal protective equipment (PPE) when cleaning instruments and treating patients who used the service. Our observations supported this. Staff files showed that staff had received inoculations against Hepatitis B. People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections. We saw evidence in the practice files that the provider had a needle stick injury policy which the staff were aware of. A member of staff was able to describe what action they would take if they had a needle stick injury and this reflected the practice policy. A needle stick injury is the type of injury received from a sharp instrument or needle.

There was a legionella risk assessment in place dated August 2015 and we saw evidence that the recommendations of this risk assessment had been implemented. This ensured the risks of Legionella bacteria developing in water systems within the premises had been identified and steps taken to reduce the risk of patients and staff developing Legionnaires' disease. (Legionella is a bacterium found in water systems and can contaminate dental units if effective controls are not in place). Additional measures were also in place. This included the use of dip slides which were used for measuring and monitoring microbial activity within water systems.

Are services safe?

Equipment and medicines

Medical equipment was monitored to ensure it was in working order and in sufficient quantities. Records of checks carried out were available for audit purposes.

Medicines in use at the practice were stored and disposed of in line with published guidance. There were sufficient stocks available for use. Emergency medicines were checked and were in date. Emergency medicines were located centrally but securely for ease of use in an emergency.

An AED was not present during the inspection but an order was placed and staff training arranged before the end of our visit.

Radiography (X-rays)

Intra-oral X-ray equipment was situated in both the treatment rooms. The term Intra-oral comes from the image receptor being inside the patient's mouth (oral). Intra-oral imaging is used for a variety of different tasks and produces a wide range of clinically relevant dental views. We also saw a central Ortho Pantomograph (OPG) machine. This is a name for a panoramic radiograph which is a panoramic scanning dental X-ray of the upper and lower jaw. X-rays were taken in line with local rules that were relevant to the practice and equipment. The local rules were posted in each area where X-rays were carried out. This complied with the Ionising Radiation (Medical Exposure) Regulations (IRMER) regulations1999.

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. This was as identified in the Ionising Radiation Regulations 1999 (IRR 99). Those authorised to carry out X-ray procedures were clearly identified. This protected patients who required X-rays to be taken as part of their treatment. The practice's radiation protection file contained documentation to demonstrate the X-ray equipment had been maintained at the recommended intervals. Records we viewed demonstrated that the X-ray equipment was regularly tested and serviced with repairs undertaken when necessary.

The practice monitored the quality of its X-ray images on a regular basis by carrying out an annual X-ray audit; the findings of which we found in the comprehensive radiation protection file. This reduced the risk of patients being subjected to further unnecessary X-rays. 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 female patients of child bearing age might be pregnant. Patient's notes showed that information related to X-rays was recorded and followed guidance from the Faculty of General Dental Practice (UK) (FGDP-UK). This included justification, quality assurance and a report on the findings of the X-ray.

We saw that the practice used digital radiography which significantly reduced radiation and the need to use chemicals for developing and processing X-rays. We saw such radiographs were embedded in the patient's electronic records which meant all information contained in them was easily accessible for clinicians.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Discussions with the dentist identified that at the start of each patient consultation, patients were assessed. The assessment included taking a medical history from new patients and updating information for returning patients. This included health conditions, current medicines being taken and whether the patient had any allergies.

The dentist we spoke with told us that the results of each patient's assessment was discussed with them and treatment options and costs were explained. The patient notes were updated with the proposed treatment after discussing the options. Patients said they were involved in those discussions, and were able to ask questions. This was supported by our observations.

Patients were monitored through follow-up appointments in line with National Institute for Health and Care Excellence (NICE) guidelines. The dentist was aware of NICE guidelines, particularly in respect of recalls of patients and anti-biotic prescribing.

We reviewed feedback left by patients in CQC comment cards. All feedback was extremely positive with patients expressing their high levels of satisfaction with their treatment received. Patients spoke highly about the staff, and particularly the dentist.

Health promotion & prevention

The waiting room and reception area at the practice contained a range of literature that explained the services offered at the practice in addition to information about effective dental hygiene and how to reduce the risk of poor dental health. This included information on how to maintain good oral hygiene and the impact of diet, tobacco and alcohol consumption on oral health. Patients were advised of the importance of having regular dental check-ups as part of maintaining good oral health. The practice operated out of the same building as a smoking cessation clinic and we were told that this was useful as patients could be referred into the service.

Staffing

The practice had one dentist working at the practice who was the principle dentist. There were four dental nurses and two dental hygienists. In addition the clinic had a practice manager who was also qualified as a dental nurse. There was also a receptionist employed.

Dental staff had appropriate professional qualifications and were registered with their professional body. Prior to our inspection we checked the status of all dental professionals with the General Dental Council (GDC) website. We saw that all registrations with were up to date. Staff were encouraged to maintain their continuing professional development (CPD) to maintain their skill levels. CPD is a compulsory requirement of registration with the GDC. CPD contributes to the staff members' professional development. Staff files showed details of the number of hour's staff members had undertaken and training certificates were also in place in the files.

Staff training was monitored and training updates and refresher courses were provided. Records we viewed showed that staff were up to date with training, for example infection control. Staff said they were supported in their learning and development and to maintain their professional registration.

The practice had a system for appraising staff performance. The records showed that appraisals had taken place. Staff said they felt supported and involved in discussions about their personal development. They told us that the provider and practice manager were supportive and always available for advice and guidance.

Working with other services

The practice had systems in place to refer patients to other practices or specialists if the treatment required was not provided by the practice. This included referral for specialist treatments such as conscious sedation or referral to the dental hospital if the problem required more specialist attention.

We saw an example of a patient who was told during their consultation that the dentist would need to seek further advice. This was due to the complex nature of their case. The dentist advised them that he was going to consult widely before providing options and costings. We saw that the patient was satisfied and made a further appointment on the day to return.

Consent to care and treatment

The practice had a policy for consent to care and treatment with staff. We saw evidence that patients were presented

Are services effective?

(for example, treatment is effective)

with treatment options and consent forms which were signed by the patient. The provider was aware of and understood the use of Gillick competencies in young persons. Gillick competencies are used to decide whether a child (16 years or younger) is able to consent to their own medical or dental treatment without the need for parental permission or knowledge. The practice had a small number of children registered at the practice. We were told that this was around 50 patients approximately. We did not see any examples in dental care records where Gillick competencies had been recorded.

Discussions with four patients identified that consent was discussed and recorded at each patient consultation and treatment.

Documents within the practice demonstrated staff were aware of the need to obtain consent from patients and this included information regarding those who lacked capacity to make decisions. Staff had been provided with Mental Capacity Act 2005 (MCA) training. 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.

We were told that one of the dental nurses had a national vocational qualification (NVQ) in dementia care and information we reviewed in the staff member's file supported this.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We saw that staff at the practice were treating patients with dignity and respect. Discussions between staff and patients were polite, respectful and professional. We also saw that staff maintained patient's privacy, and discussions took place either in a treatment room or a separate reception room.

We saw that patient electronic dental care records were held securely and password protected on the computer. However the paper dental care records were not secure. We discussed this with the practice who informed us that immediate action would be taken to secure the area. We were provided with evidence after our inspection of the measures being sought. This involved the purchase of a lockable roller shutter to secure the records.

We reviewed Care Quality Commission comment cards that had been completed by patients, about the services provided. All comment cards contained extremely positive comments about the services provided. Patients said that practice staff were friendly, professional and the dentistry was of a high standard. The majority of the patients who provided feedback had been registered with the practice for many years.

Involvement in decisions about care and treatment

Patients we spoke with were all very positive about their experience of the practice. Some remarked upon the high quality of the dentistry at the practice and how caring and friendly the staff were. All patients spoken with said that treatment was explained clearly including the cost. We also found that treatments and costs were explained clearly in literature at the practice as well as on the practice's website.

Care Quality Commission (CQC) comment cards completed by patients included comments about how treatment was always explained in a way the patients could understand. Several comment cards made reference to recommending the dentist to other family members who had become patients as a result. Feedback from patients spoken with showed they had been fully involved in all decisions relating to their care and treatment at the practice. In addition, all comment cards specifically stated that patients had been involved in care decisions, discussions or had been able to ask questions or offer an opinion.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided patients with information about the services they offered on their website. In addition we saw a range of patient information was available in the waiting room. We found the practice had an appointment system to respond to patients' routine needs and when they required urgent treatment. For example, patients who required a routine appointment were offered one within four weeks. Those who were in pain were offered a fast emergency appointment during normal working hours. Those patients who required out of hours assistance were able to contact the dentist on his mobile telephone number.

The length of appointments and the frequency of visits for each patient was based on their individual needs and treatment plans. Longer appointments were available for patients who needed more time.

If patients required services that were not provided at the practice, there were established referral pathways to ensure patients' care and treatment needs were met.

Tackling inequity and promoting equality

The practice only provided private dental treatment mainly to adults and was situated in the South Wigston area of Leicestershire which was on the outskirts of Leicester city centre.

The practice building was suitable for those who had impaired mobility. This included level access, a downstairs toilet which was accessible to people with restricted mobility (via a portable ramp). Doorways and corridors were wide enough to accommodate those who used wheelchairs.

Staff members told us that longer appointment times were available for patients who required extra time or support, such as patients who were particularly nervous or anxious. We saw an example of a patient who was anxious being given a longer appointment. This enabled the dentist to take their time whilst reassuring the patient. The practice's website advertised that it catered for nervous patients.

The practice also advertised the use of a pain free anaesthetic. The new technology used in the practice enabled the dentist to administer a needle free dose of anaesthetic which also minimised numbness afterwards.

Access to the service

The arrangements for emergency dental treatment outside of normal working hours were through the provider's mobile number and he told us he always responded to emergency calls twenty four hours a day.

The practice normal opening hours were Monday to Friday 9.00am to 5.30pm.

Feedback from patients about the appointments system was positive. Patients said that appointments were easy to arrange, and emergency treatment was usually on the same day.

Concerns & complaints

The practice had a complaints procedure that explained to patients the process to follow, the timescales involved for investigation and the person responsible for handling the issue. The policy also included the details of other external organisations that a complainant could contact should they remain dissatisfied with the outcome of their complaint or felt that their concerns were not treated fairly. Staff we spoke with were aware of the procedure to follow if they received a complaint.

From information received prior to the inspection we saw that one complaint had been received in the last two years. The practice manager informed us that the complaint was identified and responded to. We reviewed the complaints file and saw evidence of analysis and that the complaint had been responded to in a timely manner. It was also in line with the practice's complaints policy. We saw evidence that the matter had been discussed with staff at a team meeting.

There were several testimonials on the practice website in which patients had shared positive experiences of the practice.

Care Quality Commission (CQC) comment cards reflected that patients were extremely satisfied with the services provided.

Are services well-led?

Our findings

Governance arrangements

The practice manager took an active lead in the day to day running of the practice. The manager was also a registered dental nurse and had a thorough understanding of the day to day operation of the practice.

The practice had arrangements in place for monitoring and improving the services provided for patients. For example, patients were invited to complete satisfaction surveys. Minutes of staff meetings identified that issues of safety and quality were regularly discussed. Staff said they found regular meetings beneficial as learning could be shared and discussed. The frequency of staff meetings had increased to weekly in response to staff feedback regarding their usefulness approximately six months previously.

We found that there were governance arrangements in place although we identified these could be further strengthened. We saw audits of patients' notes, four clinical audits undertaken and regular review and updates of policies and procedures. There was a full range of policies and procedures in use at the practice. These included health and safety, infection prevention and control and patient confidentiality. Staff were able to demonstrate many of the policies through their actions, and this indicated they had read and understood them. The practice also used a dental patient computerised record system and all staff had been trained to use the system. We reviewed a random sample of policies and procedures and found them to be in date and having review dates identified.

We saw that staff were aware of their roles and responsibilities within the practice.

Following our inspection, we were provided with evidence that measures had been deployed to strengthen the governance arrangements in place. This related to staff recruitment procedures. The provider had applied for updated DBS checks for it's members of staff and introduced a review period for when such checks would be made again. The provider updated their policy to reflect changes.

Leadership, openness and transparency

The practice had received national recognition in the form of awards. These included the British Dental Association (BDA) Good Practice Award 2015 which reflected the practice's quality assurance programme, an award in aesthetic dentistry received in 2015 and nomination for a best team award at the Birmingham NEC Dental Awards 2015.

The practice had an open and honest culture which included focus on safety. We found clear lines of responsibility and accountability within the practice. Staff told us that they could speak with the provider and practice manager if they had any concerns. Our observations together with comments from patients and staff supported that clinical staff were able to discuss any professional issues openly.

Staff said they felt well cared for, respected and involved in the practice, with weekly staff meetings in which they were encouraged to participate.

We were told that there was a focus at the practice of delivering high quality care. Response to a patient's complaint had been recorded, and showed an open approach. Documentation showed a willingness to engage with the complainant and resolve matters where possible.

Management lead through learning and improvement

The practice strove to deliver high quality, consistent dental care and this was a key element of their statement of purpose. The practice highlighted patient safety as a priority and encouraged any feedback from patients. We found staff were aware of the practice values and ethos and demonstrated that they worked towards these.

Staff members we spoke with said that the practice put the patient first, and were at the heart of everything the practice did. We saw that clinical staff reviewed their clinical practice and introduced changes to make improvements. This was demonstrated in its complaints procedures, robust clinical audit, consultation with external specialist clinicians where required and reference to best practice NICE guidelines.

We saw innovative new technology used within the practice. This included pain free anaesthesia, equipment designed to light up the mouth area keeping it completely dry and a probe which was used to examine the mouth and highlight any problematic areas.

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

Are services well-led?

The practice ensured that patients were involved in making decisions about their care and treatment and this information was recorded in their records. Comments on the practice website were positive and included comments that they received a professional service and good quality care and treatment.

Feedback from patients to CQC in the comment cards received and the patients we spoke with said that they were extremely happy with the care and treatment they received.

Staff said that patients could give feedback at any time they visited.

The practice had systems in place to review the feedback from patients who had complained. A system was in place to assess and analyse complaints and then learn from them if relevant, acting on feedback when appropriate.

The practice held regular staff meetings and annual staff appraisals had been undertaken. Staff told us that information was shared and that their views and comments were sought informally and generally listened to and their ideas adopted. Staff told us that they felt part of a team and well supported. We found however, that the practice needed to ensure that any staff who could not routinely attend weekly practice meetings were kept abreast of any shared learning and any other management updates.