U Dentistry Limited

U Dentistry

Inspection Report

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Date of inspection visit: 18 February 2016
Date of publication: 23/03/2016

Overall summary

We carried out an announced comprehensive inspection on 18 February 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

U Dentistry is situated in Ilkley, West Yorkshire. It offers private dental treatments including dental implants, endodontics, cosmetic dental treatment, conscious sedation and periodontal treatments.

The practice has two surgeries, a decontamination room, a large waiting area and a reception area. All facilities are located on the ground floor of the premises.

There are five dentists, two dental hygienists, one dental nurse, a receptionist and a practice manager.

The opening hours are Monday to Friday from 8-45am to 5-00pm. Appointments were also available outside these hours by prior arrangement.

The practice manager 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.

During the inspection we received feedback from 32 patients. The patients were positive about the care and treatment they received at the practice. Comments

Summary of findings

included that the staff were friendly and caring and the surgery was immaculate. They also commented that the treatment provided was of the highest standards and the service is excellent.

Our key findings were:

- The practice had systems in place to assess and manage risks to patients and staff including infection prevention and control, health and safety and the management of medical emergencies.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Staff had been trained to manage medical emergencies.
- Infection control procedures were in accordance with the published guidelines.
- Treatment was well planned and provided in line with current best practice guidelines.
- Patients received clear explanations about their proposed treatment, costs, benefits and risks and were involved in making decisions about it.
- Patients were treated with dignity and respect and confidentiality was maintained.
- The appointment system met patients' needs.
- The practice was involved in the local community and charities.
- The practice was well-led and staff felt involved and supported and worked well as a team.
- The governance systems were effective.
- The practice sought feedback from staff and patients about the services they provided.

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.

Staff told us they felt confident about reporting incidents, accidents and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Staff had received training in safeguarding at the appropriate level and knew the signs of abuse and who to report them to.

Staff were suitably qualified for their roles and the practice had undertaken the relevant recruitment checks to ensure patient safety.

Patients' medical histories were obtained before any treatment took place. The dentists were aware of any health or medication issues which could affect the planning of treatment. Staff were trained to deal with medical emergencies. All emergency equipment and medicines were in date and in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines.

The decontamination procedures were effective and the equipment involved in the decontamination process was regularly serviced, validated and checked to ensure it was safe to use.

Are services effective?

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

Patients' dental care records provided comprehensive information about their current dental needs and past treatment. The practice monitored any changes to the patient's oral health and made referrals for specialist treatment or investigations where indicated.

The practice followed best practice guidelines when delivering dental care. These included Faculty of General Dental Practice (FGDP), National Institute for Health and Care Excellence (NICE) and guidance from the British Society of Periodontology (BSP).

Staff were encouraged to complete training relevant to their roles and this was monitored by the registered provider. The clinical staff were up to date with their continuing their professional development (CPD).

The practice liaised with the referring practitioner effectively to keep them informed of treatment decisions which had been made and also any after care which would be required.

Referrals were made to other services if the dentist felt that the treatment required was beyond their capabilities.

Are services caring?

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

During the inspection we received feedback from 32 patients. The patients were positive about the care and treatment they received at the practice. Comments included the staff were friendly, polite and caring. Patients also commented that they were involved in treatment options and everything was explained thoroughly.

We observed the staff to be welcoming and caring towards the patients.

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection. The layout of the waiting area was conducive for maintaining confidentiality.

Summary of findings

Staff explained that enough time was allocated in order to ensure that the treatment and care was fully explained to patients in a way which they understood.

Are services responsive to people's needs?

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

The practice had an efficient appointment system in place to respond to patients' needs. Any patients requesting an emergency appointment would be seen the same day.

Patients commented they could access treatment for urgent and emergency care when required. There were clear instructions for patients requiring urgent care when the practice was closed.

There was a procedure in place for responding to patients' complaints. This involved acknowledging, investigating and responding to individual complaints or concerns. Staff were familiar with the complaints procedure.

The practice was fully accessible for patients with a disability or limited mobility to access dental treatment. The practice had an arrangement with an adjoining building for the use of their accessible toilet.

Are services well-led?

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

There was a clearly defined management structure in place and all staff felt supported and appreciated in their own particular roles. The practice manager was responsible for the day to day running of the practice.

The practice regularly audited clinical and non-clinical areas as part of a system of continuous improvement and learning.

The practice conducted patient satisfaction surveys, post-treatment questionnaires there was a comments box in the waiting room for patients to make suggestions to the practice.

The practice held monthly staff meetings which were minuted and gave everybody an opportunity to openly share information and discuss any concerns or issues.

U Dentistry

Detailed findings

Background to this inspection

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

The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

During the inspection we received feedback from 32 patients. We also spoke with one dentist, the dental nurse, one dental hygienist and the practice manager. To assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the 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 had clear guidance for staff about how to report incidents and accidents and staff were knowledgeable about the process. We reviewed an incident which had occurred in the last year and this had been documented, investigated and reflected upon by the dental practice. We saw evidence that the patient involved had been informed of the incident and had been given an apology. It was clearly evident the practice had been open and transparent about the incident and that the duty of candour had been followed. We saw that as a result of this incident a process had been implemented to prevent this from occurring again. Any incidents would be discussed at staff meetings in order to disseminate learning.

The registered provider understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR) and provided guidance to staff within the practice's health and safety policy.

The practice received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) that affected the dental profession. These would then be discussed with staff and actioned if necessary.

Reliable safety systems and processes (including safeguarding)

The practice had child and vulnerable adult safeguarding policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff. Staff had access to contact details for both child protection and adult safeguarding teams. The practice manager was the safeguarding lead for the practice and all staff had undertaken level two safeguarding training. The practice manager had undertaken level three safeguarding training. There had not been any referrals to the local safeguarding team; however staff were confident about when to do so.

The practice had safety systems in place to help ensure the safety of staff and patients. These included clear guidelines about responding to a sharps injury (needles and sharp instruments), the use of re-sheathing devices and a policy that only the dentists handle sharps.

Rubber dam (this is a square sheet of latex used by dentists for effective isolation of the root canal and operating field and airway) was used in root canal treatment in line with guidance from the British Endodontic Society.

We saw that patients' clinical records were computerised, and password protected to keep people safe and protect them from abuse. Any paper documentation relating to dental care records were stored securely in a locked area of the practice.

Medical emergencies

The practice had procedures in place which provided staff with clear guidance about how to deal with medical emergencies. This was in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). Staff were knowledgeable about what to do in a medical emergency and had completed training in emergency resuscitation and basic life support within the last 12 months.

The emergency resuscitation kits and oxygen were stored in the decontamination room and the emergency medicines were stored in the room just off the waiting area. Staff knew where the emergency kits were kept and they had a procedure for which staff member got the equipment in the case of a medical emergency. The practice had an Automated External Defibrillator (AED) to support staff in a medical emergency. (An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). This was stored on the reception desk because the practice was a local contact in case it was needed outside of the practice.

Records showed weekly checks were carried out on the AED, emergency medicines and the oxygen cylinder. These checks ensured that the oxygen cylinder was sufficiently full, the AED was fully charged and the emergency medicines were in date. We saw that the oxygen cylinder was serviced on an annual basis.

Staff recruitment

The practice had a policy and a set of procedures for the safe recruitment of staff which included seeking references, proof of identity, checking relevant qualifications and professional registration. We reviewed a sample of recruitment files and found the recruitment procedure had

been followed. The practice manager told us they carried out Disclosure and Barring Service (DBS) checks for all newly employed staff. These 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 reviewed records of staff recruitment and these showed that all checks were in place.

All clinical staff at this practice were qualified and registered with the General Dental Council (GDC). There were copies of current registration certificates and personal indemnity insurance (insurance professionals are required to have in place to cover their working practice).

Monitoring health & safety and responding to risks

A health and safety policy and risk assessment was in place at the practice. This identified the risks to patients and staff who attended the practice. The risks had been identified and control measures put in place to reduce them. Where issues had been identified, remedial action had been taken in a timely manner.

There were policies and procedures in place to manage risks at the practice. These included infection prevention and control, fire evacuation procedures and risks associated with Hepatitis B.

The practice maintained a file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including substances such as disinfectants, and dental materials in use in the practice. The practice identified how it managed hazardous substances in its health and safety and infection control policies and in specific guidelines for staff, for example in its blood spillage and waste disposal procedures. The COSHH folder was reviewed every year by the practice manage to ensure all substances used within the practice were included.

Infection control

There was an infection control policy and procedures to keep patients safe. These included hand hygiene, safe handling of instruments, managing waste products and decontamination guidance. The practice followed the guidance about decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 -Decontamination in primary care dental practices (HTM 01-05)'.

Staff received training in infection prevention and control. We saw evidence that staff were immunised against blood borne viruses (Hepatitis B) to ensure the safety of patients and staff.

We observed the treatment rooms and the decontamination room to be clean and hygienic. Work surfaces were free from clutter. Staff told us they cleaned the treatment areas and surfaces between each patient and at the end of the morning and afternoon sessions to help maintain infection control standards. We observed the dental nurse cleaning up after a procedure and setting up for a dental implant to be placed and we found the technique to be highly effective to ensure the appropriate sterility for a surgical procedure. There was a cleaning schedule which identified and monitored areas to be cleaned. This cleaning schedule had been put together by the dental nurse and had been discussed at a staff meeting to ensure all staff were aware of the process involved.

There were hand washing facilities in the treatment rooms and staff had access to supplies of personal protective equipment (PPE) for patients and staff members. Patients confirmed that staff used PPE during treatment. Posters promoting good hand hygiene and the decontamination procedures were clearly displayed to support staff in following practice procedures. Sharps bins were appropriately located, signed and dated and not overfilled. We observed waste was separated into safe containers for disposal by a registered waste carrier and appropriate documentation retained.

Decontamination procedures were carried out in a dedicated decontamination room in accordance with HTM 01-05 guidance. An instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which minimised the risk of the spread of infection.

The dental nurse showed us the procedures involved in disinfecting, inspecting and sterilising dirty instruments; packaging and storing clean instruments. The practice routinely used an ultrasonic bath to clean the used instruments, examined them visually with an illuminated magnifying glass, and then sterilised them in a validated autoclave. The decontamination room had clearly defined

Are services safe?

dirty and clean zones in operation to reduce the risk of cross contamination. Staff wore appropriate PPE during the process and these included disposable gloves, aprons and protective eye wear.

The practice had systems in place for daily and weekly quality testing the decontamination equipment and we saw records which confirmed these had taken place. There were sufficient instruments available to ensure the services provided to patients were uninterrupted.

The dental nurse had carried out an Infection Prevention Society (IPS) self- assessment audit in September 2015 relating to the Department of Health's guidance on decontamination in dental services (HTM01-05).This is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. The audit showed the practice was meeting the required standards.

We saw that staff uniforms were washed on site. The practice manager was responsible for washing the uniforms and ensured that they were washed at the correct temperature and that dirty uniforms were not taken outside of the practice.

Records showed a risk assessment process for Legionella had been carried out in August 2014 (Legionella is a term for particular bacteria which can contaminate water systems in buildings). The dental nurse undertook processes to reduce the likelihood of legionella developing which included running the water lines in the treatment rooms at the beginning and end of each session and between patients, monitoring cold and hot water temperatures each month and also fortnightly tests on the on the water quality to ensure that Legionella was not developing. If the water testing identified any Legionella developing then an intensive dental unit water line treatment to eradicate the Legionella was used.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as X-ray sets, the autoclave and the compressor. We saw evidence of validation of the autoclave and the compressor. Portable appliance testing (PAT) had been completed annually (PAT confirms that portable electrical appliances are routinely checked for safety).

The practice dispensed antibiotics and painkillers for patients where indicated. They also kept drugs used in the provision of conscious sedation. These were stored securely in a locked area of the practice. We saw a log was kept of these medicines to ensure there was sufficient stock available, medicines were in date, and to ensure the medicines were not being abused.

Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. Records we viewed demonstrated the X-ray equipment was regularly tested and serviced. A Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure that the equipment was operated safely and by qualified staff only. We found there were suitable arrangements in place to ensure the safety of the equipment. Local rules were available in all surgeries, in the X-ray room and within the radiation protection folder for staff to reference if needed. We saw that a justification, grade and a report was documented in the dental care records for all X-rays which had been taken.

The practice had a cone beam computed tomography (CBCT) machine. CBCT is an X-ray based imaging technique which provides high resolution visualisation of bony anatomical structures in three dimensions. We saw that the appropriate monthly quality assurance tests were conducted on the machine to ensure it remained safe to use. Staff were appropriately trained in the use of the machine.

X-ray audits were carried out by the dental nurse every month. This included assessing the quality of the X-rays which had been taken. If an X-ray was not of optimal quality a reason as to why it was not was documented. The results of the most recent audit undertaken confirmed they were compliant with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept up to date detailed electronic and paper dental care records. They contained information about the patient's current dental needs and past treatment. The dentist carried out an assessment in line with recognised guidance from the Faculty of General Dental Practice (FGDP). This was repeated at each examination in order to monitor any changes in the patient's oral health. The dentist used NICE guidance to determine a suitable recall interval for the patients. This takes into account the likelihood of the patient experiencing dental disease. This was documented and also discussed with the patient.

During the course of our inspection we discussed patient care with the dentist and checked dental care records to confirm the findings. Clinical records were comprehensive and included details of the condition of the teeth, soft tissue lining the mouth, gums and any signs of mouth cancer. If the patient had more advanced gum disease then a more detailed inspection of the gums was undertaken. Patients with more advanced gum disease were referred to the dental hygienist for intensive treatment in an attempt to stabilise the patient's oral health.

Records showed patients were made aware of the condition of their oral health and whether it had changed since the last appointment. Medical history checks were updated by each patient every time they attended for treatment and entered in to their electronic dental care record. This included an update on their health conditions, current medicines being taken and whether they had any allergies.

The practice used current guidelines and research in order to continually develop and improve its system of clinical risk management. For example, following clinical assessment, the dentist followed the guidance from the FGDP before taking X-rays to ensure they were required and necessary.

We saw that the process involved in providing conscious sedation was in line with those set out in the Intercollegiate Advisory Committee for Sedation in Dentistry (IACSD). We saw that patients' anxiety was assessed prior to undertaking conscious sedation and alternatives were discussed. We were told that the practice infrequently used conscious sedation as they felt it was a last resort and felt that by providing appropriate care and support the patients could avoid the use of conscious sedation. The dental nurse explained techniques which were used to reduce patients' anxiety. These included using acupressure points on the patient's hand to reduce the pain associated with an injection. We think this simple procedure is notable practice because it demonstrates compassionate care and a positive culture towards improving the patient experience.

Prior to the induction of conscious sedation the dentist recorded the patient's blood oxygen saturation, blood pressure and heart rate (vital signs). Throughout the procedure these vital signs were regularly checked and documented in the sedation record. We saw that the dose of sedative medicines were titrated to effect to ensure that the patient was not over-sedated. These doses were documented in the sedation records. We saw that an antagonist to the sedative medicines was readily available if needed. However, we were told that this had never been needed. After the procedure the patient's escort would be suitably briefed with regards to post-operative care. Patients would be kept at the practice for one hour after to procedure to ensure that they were safe to discharge.

During the inspection we noted that the specialist endodontist used a dental microscope whilst providing endodontic treatment. Dental microscopes provide the dentist with a degree magnification which improves visual acuity which helps in improving the outcome of endodontic treatment for patients.

The practice provided dental implants. The dentist explained the process which patients underwent prior to undertaking implant treatment. This included using X-rays to assess the quality and volume of the bone and whether there were any important structures close to where the implant was being placed. We saw evidence that these X-rays were analysed to ensure the implant work was undertaken effectively. We also saw that patients gum health was thoroughly assessed prior to any implants being placed. If the patient had any sign of gum disease then they were referred to the dental hygienist for a course of treatment. This treatment would also involve an assessment of which particular bacteria were causing the gum problems. Once the particular bacteria had been identified then specific antibiotics could be used as an

Are services effective?

(for example, treatment is effective)

adjunct to treatment to improve the outcome for the patient. After the implant treatment the patient would be followed up at regular intervals to ensure that it was healing and integrating well.

Health promotion & prevention

The practice had a strong focus on preventative care and supporting patients to ensure better oral health in line with the 'Delivering Better Oral Health' toolkit (DBOH). DBOH is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. High fluoride toothpastes were prescribed for patients at high risk of dental decay.

The practice had a selection of dental products on sale in the reception area to assist patients with their oral health.

The medical history form patients completed included questions about smoking and alcohol consumption. We were told by the dentist and saw in dental care records that smoking cessation advice was given to patients who smoked. Patients were also referred to their own GP for extra smoking cessation advice if appropriate. There were health promotion leaflets available in the waiting room and surgery to support patients. We saw that the orthodontist provided patients undergoing orthodontic treatment with detailed preventative advice sheets.

The practice also referred to in-house dental hygienists for those patients who required extra support in maintaining good levels of oral hygiene.

The dental nurse told us they provide dental hygiene advice to children in local pre-schools and children centres in more deprived areas. They told us they really enjoyed doing this as they felt it improved knowledge of maintaining good oral hygiene and having a good balanced diet.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. The induction process included getting the new member of staff aware of the location of emergency medicines, arrangements for fire evacuation procedures, the clinical clothing policy and the decontamination procedures.

Staff told us they had good access to on-going training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). Records showed professional registration with the GDC was up to date for all staff and we saw evidence of on-going CPD.

Staff told us they had six-monthly appraisals and training requirements were discussed at these. We saw evidence of completed appraisal documents. Staff also felt they could approach the practice manager or the dentist at any time to discuss continuing training and development as the need arose.

Working with other services

The practice received referrals for endodontics, orthodontics and implants. Upon receiving a referral letter the relevant dentist reviewed the letter and then the patient was contacted. An initial assessment appointment was arranged for the patient and the referring dentist was also made aware of this initial consultation. The referring dentist was made aware of what treatment had been proposed in order to keep them updated. Once treatment had been completed the patient was sent back to the referring dentist for on-going treatment. A letter would be sent back to the referring dentist with advice about what treatment had been provided and advice about on-going treatment which related to the treatment provided.

Consent to care and treatment

Patients were given appropriate verbal and written information to support them to make decisions about the treatment they received. Staff were knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent. Staff described to us how valid consent was obtained for all care and treatment and the role family members and carers might have in supporting the patient to understand and make decisions.

Staff had received training and had a good understanding of the principles of the Mental Capacity Act (MCA) 2005 and how it was relevant to ensuring patients had the capacity to consent to their dental treatment.

Staff ensured patients gave their consent before treatment began and this was signed by the patient. We were told that individual treatment options, risks, benefits and costs were discussed with each patient. We saw copies of

Are services effective?

(for example, treatment is effective)

consent forms for implant treatment which provided detailed information about the other options available for replacing teeth and the risks and complications associated with implant treatment.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Feedback from patients was positive and they commented that they were treated with care, respect and dignity. Staff told us that they always interacted with patients in a respectful, appropriate and kind manner. We observed staff to be friendly and respectful towards patients during interactions at the reception desk and over the telephone.

We observed privacy and confidentiality were maintained for patients who used the service on the day of inspection. The waiting area was conducive to maintaining confidentiality as it was very large, consisted of segregated areas and had music playing in the background. Dental care records were not visible to the public on the reception desk. We observed staff were helpful, discreet and respectful to patients. Staff said that if a patient wished to speak in private, an empty room or a private area of the waiting room would be found to speak with them

Patients' electronic care records were password protected and regularly backed up to secure storage. Any paper records were securely stored in a locked room.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients commented they felt involved in their treatment and it was fully explained to them. Staff described to us how they involved patients' relatives or carers when required and ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood.

There was an area in the surgery where the dentist discussed treatment options with patients. There was a large high definition television which they used to show the patient X-rays and scans to explain the treatment. They would also use study models of teeth to assist with these explanations. The dentist also used an intra-oral camera to take photos of teeth which were then displayed on the television. This allowed the patient to see exactly what the issue with a particular tooth was any why a treatment was needed. For example, the dentist showed us a photo of a tooth with a crack in it and described the treatment options discussed with the patient.

Patients were also informed of the range of treatments available in leaflets and notices in the waiting area and on the practices' website.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We found the practice had an efficient appointment system in place to respond to patients' needs. We saw that the practice offered early morning, late night and weekend appointments if requested.

Staff told us that patients who requested an urgent appointment would be seen the same day. We saw evidence in the appointment book that there were dedicated emergency slots available every day for each dentist.

Patients commented they had sufficient time during their appointment and they were not rushed. We observed the clinics ran smoothly on the day of the inspection and patients were not kept waiting.

Tackling inequity and promoting equality

The practice had equality and diversity, and disability policies to support staff in understanding and meeting the needs of patients. Reasonable adjustments had been made to the premises to accommodate patients with mobility difficulties. There was wheelchair access at the rear of the building and a ground floor toilet. The toilet was not large enough for a wheelchair; however, the practice had an agreement with a neighbouring building to use their accessible toilet facilities. There was an audio loop for those patients with hearing difficulties. Both surgeries were large enough to accommodate a wheelchair or a pram.

We were also told that the practice organised a weekly get together for ladies for the local community. The group is called the University of the 3rd Age (U3A). The U3A group works on the principle that people of retirement age have a desire to learn new skills. The ladies who meet teach each other new techniques such as tapestry or crochet. The only rule is that whatever they make has to be of use to someone else. Any items which were made during these sessions were sent to charities including the recent Nepal earthquake disaster charity. We felt that this was notable practice as it involved the local community and helped good causes.

Access to the service

The practice displayed its opening hours in the premises, in the practice information leaflet and on the practice website. The opening hours are Monday to Friday from 8-45am to 5-00pm. Appointments were also available outside these hours by prior arrangement.

Patients told us they were rarely kept waiting for their appointment. Patients could access care and treatment in a timely way and the appointment system met their needs. Where treatment was urgent patients would be seen the same day. The practice had a system in place for patients requiring urgent dental care when the practice was closed. Patients were provided with a contact number which was on the practice's answerphone system. The practice manager or the dentist would then provide advice for the patient or arrange to open the practice out of hours. Information about the out of hours emergency dental service was also displayed in the waiting area and in the practice's information leaflet.

Concerns & complaints

The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. There were details of how patients could make a complaint displayed in the waiting room, in the practice information leaflet and on the practice website. The complaints procedure included details of other organisations available for patients to contact if they were not satisfied with the response from the practice.

The practice manager was in charge of dealing with complaints when they arose. Staff told us they would raise any formal or informal comments or concerns with the practice manager to ensure responses were made in a timely manner. Staff told us that they aimed to resolve complaints in-house initially. They had not received any complaints since the practice was opened.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients. We found there was an effective system in place which helped ensure a timely response. This included acknowledging the complaint within three working days and providing a formal response within 10 working days. If the practice was unable to provide a response within 10 working days then the patient would be made aware of this.

Are services well-led?

Our findings

Governance arrangements

The practice manager and the dentist were responsible for the day to day running of the service. There was a range of policies and procedures in use at the practice. We saw there were systems in place to monitor the quality of the service and to make improvements. The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately.

The practice had an effective approach for identifying where quality or safety was being affected and addressing any issues**.** Health and safety and risk management policies were in place and we saw a risk management process to ensure the safety of patients and staff members. For example, we saw risk assessments relating to fire safety, the use of equipment and infection control.

There was an effective management structure in place to ensure that responsibilities of staff were clear. Staff told us that they felt supported and were clear about their roles and responsibilities.

Leadership, openness and transparency

The culture of the practice encouraged candour, openness and honesty to promote the delivery of high quality care and to challenge poor practice. Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. These would be discussed openly at staff meetings when relevant and it was evident the practice worked well as a team.

The practice held a monthly staff meeting. These meetings were minuted for those who were unable to attend. The agenda for the meeting was displayed in the staff room so that all staff members were aware of what was to be discussed. Topics discussed at staff meetings included safeguarding, consent and infection control. Staff were actively encouraged to be involved in the staff meetings. For example, the dental nurse told us they gave a talk about the surgery cleaning schedule which they had formulated.

All staff were aware of whom to raise any issue with and told us that the practice manager was approachable, would listen to their concerns and act appropriately. We were told that there was a no blame culture at the practice and that the delivery of high quality care was part of the practice's ethos.

Learning and improvement

Quality assurance processes were used at the practice to encourage continuous improvement. The practice audited areas of their practice as part of a system of continuous improvement and learning. This included clinical audits such as dental care records, X-rays, implant success and infection control. We looked at the audits and saw that the practice was performing well. It was evident the audit process was used as a tool to encourage continuous improvement to ensure the best possible treatment was being provided to patients.

Staff told us they had access to training and this was monitored to ensure essential training was completed each year; this included medical emergencies and basic life support. Staff working at the practice were supported to maintain their continuous professional development as required by the General Dental Council.

All staff had six-monthly appraisals at which learning needs, general wellbeing and aspirations were discussed. We saw evidence of completed appraisal forms in the staff folders.

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

The practice had systems in place to involve, seek and act upon feedback from people using the service including carrying out annual patient satisfaction surveys and a post-treatment questionnaire. The satisfaction survey included questions about the patients' overall satisfaction, the cleanliness of the premises, whether the appointment time was suitable and whether the dentist listened to their needs. The most recent patient survey showed a high level of satisfaction with the quality of the service provided. We were told that as a result of feedback from patients that the music in the waiting room had been changed.