Dentina Limited

Parrys Lane Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 30 June 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.

Parrys Lane Dental Practice provides private general and cosmetic dentistry to people living in the Stoke Bishop area of Bristol. The practice has five dentists, an oral surgeon, a specialist endodontist, a specialist orthodontist, a specialist periodontist and a dentist who specialised in dental implants. The majority of the patients at the practice pay for their treatment and there is a range of systems available, such as Denplan, for patients to access.

There is a registered manager in place, 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.

We reviewed 16 comment cards that had been completed by patients and spoke with two patients. The comments made praised the treatment provided and the staff team .Patients said they received professional, caring and compassionate care in a very friendly and clean environment. They used comments such as 'first class service' and 'excellent' to describe their experience of the practice.

Our key findings were:

- There were effective systems in place to reduce the risk and spread of infection.
- We found all treatment rooms well planned and equipped, with good light and ventilation.
- There were systems in place to check all equipment had been serviced regularly, including the air compressor, autoclave, fire extinguishers, oxygen cylinder and the X-ray equipment.

Summary of findings

- We found the dentists regularly assessed each patient's gum health and took X-rays at appropriate intervals.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- The practice kept up to date with current guidelines and was led by a proactive and forward thinking management team.
- During our visit we observed staff were kind, caring, competent and put patients at their ease.

We found two areas for improvement and these were allied to recruitment records and medicines storage and records of antibiotics and medicine used for conscious sedation. The provider and practice manager began to address these issues as they were raised during the inspection and confirmed to us that antibiotics were no longer dispensed by the practice.

In addition the provider should:

- Review its recruitment policy and procedures to ensure the recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.
- Review the practice's protocols for conscious sedation, giving due regard to guidelines published by The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015.

You can see full details of the regulations not being met at the end of this report.

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 systems in place for the management of infection control, clinical waste segregation and disposal, management of medical emergencies and dental radiography. Staff had received training in safeguarding and whistleblowing and knew the signs of abuse and who to report them to. We found the equipment used in the practice was well maintained and in line with current guidelines. There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. The staffing levels were appropriate for the provision of care and treatment with an excellent staff skill mix across the whole practice. The equipment used in the dental practice was well maintained and in safe working order. There were robust systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. Risk management processes were in place to manage and prevent harm. The practice could make improvements to the record keeping of medicines used for conscious sedation, and ensure robust recruitment procedures were in place.

Are services effective?

We found that this practice was providing effective care in accordance withthe relevant regulations.The practice provided evidence based dental care which was focussed on the needs of the patients. Consultations were carried out in line with best practice guidance from the National Institute for Health and Care Excellence (NICE). Patients received a comprehensive assessment of their dental needs including taking a medical history. We saw examples of effective collaborative team working. The staff were up-to-date with current guidance and received professional development appropriate to their role and learning needs. Staff who were registered with the General Dental Council (GDC) had frequent continuing professional development (CPD) and were meeting the requirements of their professional registration. Staff understood the Mental Capacity Act and offered support when necessary. Staff were aware of Gillick competency in relation to children under the age of 16.

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations as feedback from patients through comment cards and interviews was positive about their experiences of dental care provided at the practice. Patients told us they were listened to, treated with respect and were involved with the discussion of their treatment options which included any risks, benefits and costs. Patients were contacted after receiving treatment to check on their welfare. Patients who required emergency dental treatment were responded to in a timely manner and always on the same day. We observed the staff to be caring and committed to their work. Patients told us about the positive experiences of the dental care provided at the practice such as being involved in decisions about their treatment and were provided with sufficient information to make an informed choice. Patients said staff displayed empathy, friendliness and professionalism towards them. We found staff spoke with knowledge and enthusiasm about their work and the team work at the practice which contributed to good outcomes for patients.

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 friendly and personalised dental care. Patients could access routine treatment and urgent or emergency care when required. The practice offered dedicated emergency slots each day enabling effective and efficient treatment of patients with dental pain. Patients told us through comment cards and interviews the practice staff were

Summary of findings

very responsive in supporting those patients who were particularly anxious or nervous to feel calm and reassured. The practice had made reasonable adjustments to accommodate patients with a disability or impaired mobility. The practice handled complaints in an open and transparent and way and apologised when things went wrong. The complaints procedure was readily available for patients to read in the reception area and on the practice website.

Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations. There was a management structure in place and staff understood about their responsibilities. The provider and practice manager were always approachable and the culture within the practice was open and transparent. Staff were aware of the practice ethos and philosophy and told us they felt well supported and could raise any concerns with the provider or the practice manager. The dental practice had effective clinical governance and risk management structures in place. There was a pro-active approach to identify safety issues and make improvements in procedures. The practice assessed risks to patients and staff and audited areas of their practice as part of a system of continuous improvement and learning. The practice sought the views of staff and patients. The practice manager and provider ensured policies and procedures were in place to support the safe running of the service. Regular staff meetings took place and these were recorded. All staff told us they enjoyed working at the practice and would recommend it to a family member or friends.

Parrys Lane Dental Practice

Detailed findings

Background to this inspection

The inspection was carried out on 30th June by a CQC inspector and a dental specialist advisor.

We asked the practice to provide a range of policies and procedures and other relevant information before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas.

On the day of our inspection we looked at practice policies and protocols, dental patient records and other records relating to the management of the service. We spoke to practice owner who was also the provider; three dentists, four dental nurses, the practice manager and a receptionist. We also reviewed 16 comments cards completed by patients and spoke with two patients.

We informed NHS England area team / Healthwatch that we were inspecting the practice; however we did not receive any information of concern from them.

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 an effective system in place to learn from and make improvements following any accidents or incidents. Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). We found incidents were reported, investigated and measures put in place where necessary to prevent recurrence. Patients were told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding adults. This included contact details for the local authority safeguarding team, social services and other agencies including the Care Quality Commission. Staff had completed safeguarding training and demonstrated to us their knowledge of how to recognise the signs and symptoms of abuse and neglect. There was a documented reporting process available for staff to use if anyone made a disclosure to them.

Staff demonstrated knowledge of the whistleblowing policy and were confident they would raise a concern about another staff member's performance if it was necessary.

A risk management process had been undertaken for the safe use of sharps (needles and sharp instruments) and the practice routinely used safety needles to minimise the risk of inoculation injuries to staff. We observed the risk management process in action for small items of equipment used for dental implants. These had dental floss attached to them to enable the dentist to keep account of them.

Medical emergencies

The practice had suitable emergency resuscitation equipment in accordance with guidance issued by the Resuscitation Council UK. This included face masks for both adults and children. Oxygen and medicines for use in an emergency were available. Records completed showed regular checks were done to ensure the equipment and emergency medicine was safe to use.

Records showed all staff had recently completed training in emergency resuscitation and basic life support including the use of the automatic external defibrillator (AED). [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]. Staff we spoke with demonstrated they knew how to respond if a person suddenly became unwell.

Staff recruitment

We reviewed the employment files for newly recruited staff members. The files did not contain all of the evidence to meet the requirements of schedule 3 of the Health and Social Care Act, 2008. We saw CVs were used to demonstrate suitability, experience and employment history, copies of qualifications certificates, immunisation status and evidence of professional registration with the General Dental Council. Where required, checks with the Criminal Records Bureau (now the Disclosure and Barring Service) had been carried out. The Disclosure and Barring Service (DBS) 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 may be vulnerable. The practice did not have photographic evidence of identity although this had been checked as part of the application for a DBS check; the practice had not recorded the telephone references they had taken for new employees.

The practice did not have a written recruitment protocol; however the practice manager was able to explain verbally the process of personal interviews and 'trial' days for potential staff. The qualification, skills and experience of each employee had been fully considered as part of the interview process. We also saw the practice had a pre-employment checklist and specific induction for staff. When we spoke with staff they confirmed this had been followed.

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies. We found the practice had been assessed for risk of fire. A fire marshal had been appointed, fire safety equipment had been recently serviced and staff were able to demonstrate to us they knew how to respond in the event of a fire.

There were effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH)

Are services safe?

regulations. We looked at the COSHH file and found risks (to patients, staff and visitors) associated with substances hazardous to health had been identified and actions taken to minimise them.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included server failure and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the alternate practice to send patients for emergency treatment.

Infection control

There were effective systems in place to reduce the risk and spread of infection. There was a written infection control policy which included minimising the risk of blood-borne virus transmission and the possibility of sharps injuries, decontamination of dental instruments, hand hygiene, segregation and disposal of clinical waste.

The practice had followed the guidance on decontamination and infection control issued by the Department of Health, the 'Health Technical Memorandum 01-05 decontamination in primary care dental practices (HTM 01-05)'. This document and the service's policy and procedures on infection prevention and control were accessible to staff.

We saw the facilities for cleaning and decontaminating dental instruments. We found there was a dedicated decontamination area in each treatment room with a clear flow from 'dirty' to 'clean.' A dental nurse with responsibilities for the decontamination of instruments explained to us how they were decontaminated and sterilised. They wore suitable protective clothing whilst instruments were decontaminated and rinsed prior to being placed in an autoclave (sterilising machine). We saw an illuminated magnifier was used to check for any debris or damage throughout the cleaning stages. This was in accordance with the procedure for decontamination of instruments written by the practice. We observed that instruments were placed in pouches after sterilisation and dated to indicate when they should be reprocessed if left unused. A vacuum type autoclave was used for sterilising implant and surgical equipment in line with guidance. We found daily, weekly and monthly tests were performed to check the steriliser was working efficiently and a log was kept of the results. We saw evidence the parameters (temperature and pressure) were regularly checked to ensure equipment was working efficiently in between service checks.

We found that one surgery did not have its own autoclave and instruments were cleaned initially in the treatment room and then transported to another treatment room for sterilisation. The provider was aware this was not best practice however we observed there was an instrument transportation system, using lidded boxes, in place to ensure the safe movement of instruments between surgeries. This ensured the risk of infection spread was greatly minimised.

We observed how waste items were disposed of and stored. The practice had an on-going contract with a clinical waste contractor. We saw the differing types of waste were appropriately segregated and stored at the practice. This included clinical waste and safe disposal of sharps.

Staff confirmed to us their knowledge and understanding of single use items and how they should be used and disposed of according to the guidance.

We looked at the treatment rooms where patients were examined and treated. All rooms and equipment appeared clean, well lit with good ventilation.

Staff told us the importance of good hand hygiene was included in their infection control training. A hand washing poster was displayed near to the sink to ensure effective decontamination. Patients were given a protective bib to wear each time they attended for treatment. There were good supplies of protective equipment for patients and staff members.

The practice followed infection control guidance when carrying out dental implant procedures. This included the use of sterile solution for irrigation, surgical drapes, clinical gowns and ensuring instruments were reprocessed in a vacuum type autoclave.

Records showed a risk assessment process for Legionella. This process ensured the risks of Legionella bacteria developing in water systems within the premises had been identified and preventive measures taken to minimise risk of patients and staff developing Legionnaires' disease. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings).

Are services safe?

There was a good supply of cleaning equipment which was stored appropriately. The practice had a cleaning schedule in place that covered all areas of the premises and detailed what and where equipment should be used. This took into account national guidance on colour coding equipment to prevent the risk of infection spread.

Equipment and medicines

There were systems in place to check all equipment had been serviced regularly, including the air compressor, autoclave, fire extinguishers, AED, oxygen cylinder and the X-ray equipment. We were shown the annual servicing certificates which showed the service had had an efficient system in place to ensure all equipment in use was safe, and in good working order.

There was a system in place for the reporting and maintenance of faulty equipment such as dental drill hand pieces. Records showed and staff confirmed repairs were carried out promptly which ensured there was no disruption in the delivery of care and treatment to patients.

We reviewed the system in place for the prescribing, recording, dispensing, use and stock control of the medicines used in clinical practice such as the anaesthetics used for conscious sedation (midazolam) and antibiotics. The electronic patient record system provided an account of medicines used and prescribed for each patient, and demonstrated medicines were given appropriately. The quantity, batch numbers and expiry dates for anaesthetics were recorded. We found the anaesthetic medicines were stored safely for the protection of patients.

The records for the stock control of antibiotic medicines and midazolam (used for conscious sedation) did not provide a clear audit of when stock was obtained and dispensed or administered. We undertook a spot check of antibiotics and found the record provided by the practice to be inaccurate. We also found the antibiotics were stored in an unlocked drawer. These observations were brought to the attention of the provider and practice manager who moved the medicines to a lockable facility and planned to undertake an immediate stock check. The provider and practice manager confirmed to us that they would no longer dispense antibiotics directly from the practice and stock would be disposed of according to the waste management policy.

Radiography (X-rays)

We checked the provider's radiation protection file as X-rays were taken at the practice. We also looked at X-ray equipment at the practice and talked with staff about its use. We found there were suitable arrangements in place to ensure the safety of the equipment. We saw local rules relating to each X-ray machine were displayed. We found procedures and equipment had been assessed by an independent expert within the recommended timescales. The practice had a radiation protection adviser and had appointed a radiation protection supervisor. We were shown how the practice monitors the quality of radiographs so that patients did not receive unnecessary exposure to radiation.

Patients were required to complete medical history forms to assess whether it was safe for them to receive X-rays. This included identifying where patients might be pregnant. Patient records indicated reasons for radiographs being taken.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We found patient assessments were carried out in line with recognised guidance from the National Institute for Health and Care Excellence (NICE) and General Dental Council (GDC) standards. This assessment included an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. The assessment was recorded alongside use of alcohol and tobacco. These measures demonstrated a comprehensive process of risk assessment was undertaken for oral disease. We were given examples of when the dentists would not undertake treatment, for example, patients who were heavy smokers would not be treated for implants.

The dentists assessed each patient and took X-rays at appropriate intervals, as informed by guidance issued by the Faculty of General Dental Practice standards. They also recorded the justification, findings and quality assurance of X-ray images taken.

Patients requiring specialised treatment such as conscious sedation were treated within the practice by staff appropriately trained to do so. We reviewed the practice's protocols for conscious sedation, giving due regard to guidelines published by The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015. We found evidence that when intravenous (IV) sedation was carried out the standards were implemented. Specifically there was evidence of additional patient checks prior to sedation of medical and dental history, Patient Physical Status Classification (ASA), weight and psychological status to ensure the patient was fit and well. Patients were attended during sedation by two suitably trained members of staff and monitored for blood pressure, heart rate and oxygen levels in blood. We saw that there was sufficient equipment in place which had been serviced and calibrated. The practice used midazolam for sedation and kept the medicine to reverse its effects in stock (naloxone).We saw there was comprehensive guidance and post operative information given to each patient which included emergency contact details.

The practice kept up to date with current guidelines and research in order to continually develop and improve their system of clinical risk management. We were told about the regular clinical meetings at the practice to cascade training which individuals had attended such soft tissue grafting and infection control updates.

Health promotion & prevention

The practice promoted the maintenance or good oral health as part of their overall philosophy and had considered the Department of Health publication 'Delivering Better Oral Health; a toolkit for prevention' when providing preventive oral health care and advice to patients. [Delivering Better Oral Health is an evidence based toolkit to support dental practices in improving their patient's oral and general health].

The practice asked new patients to complete a new patient health questionnaire which included further information for health history, consent and data sharing guidance. The practice invited patients in for consultation with one of the dentists for review. Records showed patients were given advice appropriate to their individual needs such as smoking cessation or dietary advice.

Information displayed in the waiting area promoted good oral and general health. This included information on healthy eating, diabetes and tooth sensitivity.

Staffing

Practice staffing included clinical, managerial and administrative staff. Training records showed 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 topics such as responding to medical emergencies and infection control. We found staff were up to date with their yearly continuing professional development requirements and they were encouraged to maintain their continuing professional development (CPD), to maintain their skill levels.

There was an induction programme for new staff to follow which ensured they were skilled and competent in delivering safe and effective care and support to patients. Staff were able to relate to the induction process during the course of our discussions with them. All staff had undergone an appraisal to identify training and development needs and confirmed to us that training for professional development was supported by the provider.

Working with other services

The practice had systems in place to refer patients to other practices or specialists if the treatment required was not

Are services effective?

(for example, treatment is effective)

provided by the practice. Where a referral was necessary, the type of care and treatment required was explained to the patient and they were given a choice of another healthcare professional who was experienced in undertaking the type of treatment required. A referral letter was then prepared and sent to the practice with full details of the consultation and the type of treatment required. When the patient had received their treatment they would be discharged back to the practice for further follow-up and monitoring.

Where patients had complex dental issues, such as oral cancer, the practice referred them to other healthcare professionals using the NHS referral process.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. Staff confirmed individual treatment options, risks and benefits and costs were discussed with each patient and then documented in a written treatment plan. Patients were given time to consider and make informed decisions about which option they wanted. This was reflected in the comment cards completed by patients. The practice asked patients to sign specific consent forms for some dental procedures to indicate they understood the treatment and risks involved, for example, dental implants.

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Staff demonstrated an understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment. Staff explained how they would consider the best interests of the patient and involve family members or other healthcare professionals responsible for their care to ensure their needs were met.

Clinical and reception staff were aware about consent in relation to children under the age of 16 who attended for treatment without a parent or guardian. They told us children of this age could be seen without their parent/guardian and the dentist told us they would ask them questions to ensure they understood the care and treatment proposed before providing it. This is known as the Gillick competency test. The practice ensured valid consent was obtained for all care and treatment.

Staff confirmed individual treatment options, risks and benefits and costs were discussed with each patient and then documented in a written treatment plan. Patients were given time to consider and make informed decisions about which option they wanted. When we reviewed patient records we found evidence that consent for treatment was clearly recorded.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We also spoke with two patients on the day of our inspection; all of the comments were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful, caring and knowledgeable. They said staff treated them with dignity and respect. All told us they were satisfied with the care provided by the practice.

Staff and patients told us consultations and treatments were carried out in the surgeries. We noted the treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard. We observed patients were dealt with in a kind and compassionate manner. We observed staff being polite, welcoming, professional and sensitive to the different needs of patients. We also observed staff dealing with patients on the telephone and saw them respond in an equally calm professional manner. Staff we spoke with were aware of the importance of protecting patient confidentiality and reassurance for nervous patients. They told us they could access a separate treatment room off the reception area if patients wished to discuss something with them in private or if they were anxious about anything.

The provider and staff explained to us how they ensured information about patients using the service was kept confidential. Patient's clinical records were stored electronically; password protected and regularly backed up to secure storage. Archived paper records were kept securely in a locked cabinet. Staff members demonstrated to us their knowledge of data protection and how to maintain confidentiality. Staff told us patients were able to have confidential discussions about their care and treatment in the surgeries or in another room if they preferred. Patients told us they were always treated with respect by caring and patient staff.

Involvement in decisions about care and treatment

Patients we spoke to on the day of our inspection told us their medical status was discussed with them in respect of decisions about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision. Patient feedback on the CQC comment cards we received was also positive and aligned with these views.

The provider told us they used a number of different methods including tooth models, display charts and pictures and leaflets to demonstrate what different treatment options involved so that patients fully understood. Information leaflets gave information on a wide range of treatments and disorders such as gum disease and good oral hygiene. Information about procedures such as tooth whitening, veneers, crowns and bridges was accessible on the practice website. A treatment plan was developed following examination of and discussion with each patient. Staff told us dentists took time to explain care and treatment to individual patients clearly and were always happy to answer any questions.

We looked at some examples of written treatment plans and found they explained the treatment required and outlined the costs involved. The dentist told us they rarely carried out treatment the same day unless it was considered urgent. This allowed patients to consider the options, risks, benefits and costs before making a decision to proceed. We were told patients who had received more complex treatments were always followed up with a phone call by the relevant clinician to monitor their welfare.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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 needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

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

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback directly from patients. For example appointment times on Saturdays were provided to meet the needs of patients who worked.

Patients with emergencies were assessed and seen the same day if treatment was urgent.

Tackling inequity and promoting equality

We asked staff to explain how they communicated with patients who had different communication needs such as those who spoke another language. Staff told us they treated everybody equally and welcomed patients from many 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.

The practice had recognised the needs of different groups in the planning of its services. Patients with disabilities and patients with pushchairs were able to access services on the ground floor of the building. Easy access was provided for entry into the building. The practice also had accessible toilet facilities that were available for all patients attending the practice. Parking was available at the back and side of the practice.

Access to the service

Appointments were available from 8.30am – 5.30pm Monday and Thursday, with extended opening until 8pm on Tuesday and 7pm on Thursday. The practice closed at 4pm on Friday. Saturday appointments were available by pre-booked appointment only. These flexible opening times allowed access outside of school hours for children and young people. The length of appointment was specific to the patient and their need, for example, nervous patients could be booked a longer appointment so they could be reassured and not rushed.

We asked the receptionist how patients were able to access care in an emergency or outside of normal opening hours. Where treatment was urgent patients would be seen the same day if necessary. We looked at the appointment diary on the day of our visit and urgent appointment slots were available during the day if needed. Comments received from patients indicated that patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice without exception. Staff told us an answer phone message detailed how to access out of hours emergency treatment. The practice also participated in the out of hours on-call service organised through a group of local dental practices. We saw the website also included contact information as did the treatment plan given to patients.

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 and on the practice website. 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. The designated responsible person who handled all complaints was the practice manager.

We reviewed the practice complaints system and noted that only one patient complaint had been received over the past 12 months. We read the practice procedure for acknowledging, recording, investigating and responding to complainants and found there was an effective system in place which ensured there was a clear response and shared learning disseminated to staff about the event.

Are services well-led?

Our findings

Governance arrangements

The governance arrangements of the practice were evidence based and developed through a process of continual learning. The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. All of the policies and procedures we saw had been reviewed and reflected current good practice.

The practice manager had responsibility for the day to day running of the practice. The provider worked at the practice and was available to lead and contribute as and when necessary. The provider and practice manager held regular meetings with the staff to discuss any issues and identify any actions needed. There was a clear leadership structure with named members of staff in lead roles. For example, a dental nurse lead on infection control and the practice manager was the lead for safeguarding.

Leadership, openness and transparency

We saw from minutes of staff meetings, they were held regularly and staff told us how much they benefited from these meetings. For example, the dentists held a monthly clinical meeting where they could discuss treatment pathways; the nurse team told us they met and discussed opportunities for more effective working or changes in guidance.

Staff reported there was an open and transparent culture at the practice which encouraged candour and honesty. Staff felt confident they could raise issues or concerns at any time with the provider or practice manager and be listened to. We observed and staff told us the practice was a relaxed and friendly environment to work in and they enjoyed coming to work at the practice. Staff felt well supported by the practice management team and worked as a team toward the common goal of delivering high quality care and treatment.

The staff handbook was available to all staff, and included sections on areas such as disciplinary processes and harassment at work.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. The management of the practice was focused on achieving high standards of clinical excellence and provided daily supervision with peer review and support for staff. We found that formal appraisal had been undertaken but was not embedded within the culture of the practice because of the daily dialogue and contact between the staff teams and the provider. However, all of the staff we spoke with told us the practice was supportive of training and professional development, and we saw evidence to confirm this.

The practice carried out regular audits on infection prevention and control in accordance with national guidance -HTM 01-05 standards for decontamination in primary care dental practices. The most recent audit indicated the facilities and management of decontamination and infection control were managed well. A programme of audit ensured the practice regularly monitored the quality of care and treatment provided and made any changes necessary as a result. For example, we found the clinical records were regularly audited and we were told the findings discussed as a team so that any improvement actions needed could be identified and taken.

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. We saw that patients had been consulted about opening the practice on a Saturday in addition to the extended opening hours. Patients had indicated they did not feel this was needed and so Saturday appointments continued on an ad hoc basis to fit individual patient's requirements.

The practice conducted regular scheduled staff meetings as well as daily -unscheduled discussions. Staff members told us they found these were a useful opportunity to share ideas and experiences which were always listened to and acted upon.