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Key Dental Practice - Willenhall

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 8 March 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

Key Dental Practice is a mixed dental practice providing NHS and private dental treatment for both adults and children. The service is provided by six dentists. They are supported by a practice manager and six dental nurses (two of whom are trainees). The dental nurses also carry out reception duties.

The practice is located in a busy shopping precinct and is all on the ground floor so can accommodate patients with restricted mobility. The premises consist of a reception area, waiting room, toilet facilities, three treatment rooms and a decontamination room. There is free parking and dedicated parking bays for patients with disabilities. Opening hours are from 9am to 6pm on Monday to Thursday and from 9am to 1pm on Fridays. The practice is also open on Saturdays from 9am to 4.30pm.

Summary of findings

The provider is registered with the Care Quality Commission (CQC) as an individual. 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.

Twenty-eight patients provided feedback about the practice. We looked at comment cards patients had completed prior to the inspection and we also spoke with patients on the day of the inspection. Overall the information from patients was complimentary. Patients were positive about their experience and they commented that staff were gentle, kind and professional.

Our key findings were:

- The practice had systems to assess and manage risks to patients, including infection prevention and control, health and safety, safeguarding and the management of medical emergencies. We identified some areas of improvement and these were actioned promptly.
- Patients told us they found the staff helpful and friendly. Patients commented they felt involved in their treatment and that it was fully explained to them.
- Patients were able to make routine and emergency appointments when needed.
- Patients' care and treatment was planned and delivered in line with evidence based guidelines, best practice and current legislation.
- The practice had a structured plan in place to audit quality and safety.
- Staff received training appropriate to their roles.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- The practice had an effective complaints system in place and there was an openness and transparency in how these were dealt with.
- Staff told us they felt well supported and comfortable to raise concerns or make suggestions.
- The practice demonstrated that they regularly undertook audits in infection control, radiography and dental care record keeping.

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

- Review the practice's recruitment policy and procedures to ensure character references for new staff are requested and recorded suitably.
- Review the storage of dental care products and medicines requiring refrigeration to ensure they are stored in line with the manufacturer's guidance and the fridge temperature is monitored and recorded.
- Regularly carry out staff appraisals so that learning needs, concerns and aspirations can be formally discussed.

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). Accidents and incidents in the previous 12 months prior to our inspection had been documented.

The practice had systems to assess and manage risks to patients, whistleblowing, complaints, safeguarding, health and safety and the management of medical emergencies. It had a recruitment policy to help ensure the safe recruitment of staff; however, not all of the staff files contained two references as stated in their own policy.

Patients' medical histories were obtained before any treatment took place. The dentist was aware of any health or medicines issues which could affect the planning of treatment. Staff were trained to deal with medical emergencies. Emergency equipment and medicines were in date and mostly in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines. One emergency medicine was missing and this was ordered promptly.

The practice was carrying out infection control procedures as described in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary dental practices'.

Are services effective?

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

The practice monitored any changes to the patients' oral health and made referrals for specialist treatment or investigations where indicated. Explanations were given to patients in a way they understood and risks, benefits and options were explained. Record keeping was in line with guidance issued by the FGDP (Faculty of General Dental Practice).

The dentists followed national guidelines when delivering dental care. These included FGDP and National Institute for Health and Care Excellence (NICE). We found that preventative advice was given to patients in line with the guidance issued in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Are services caring?

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

On the day of the inspection we observed privacy and confidentiality were maintained for patients using the service. Patient feedback was positive about the care they received from the practice. They commented they were treated with kindness and respect while they received treatment. Patients commented they felt involved in their treatment and it was fully explained to them.

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. They were usually able to see patients requiring urgent treatment within 24 hours. There were clear instructions for patients requiring urgent care when the practice was closed.

Summary of findings

There was an effective procedure in place for acknowledging, recording, investigating and responding to complaints made by patients. This system was used to improve the quality of care.

The practice offered access for patients with disabilities but no accessible toilet facilities.

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 staff we spoke with felt supported in their own particular roles.

There were several systems in place to monitor the quality of the service including various audits. The practice used various methods to successfully gain feedback from patients. Staff meetings took place on a regular basis and the practice used several methods to obtain feedback from its patients and staff.

Key Dental Practice - Willenhall

Detailed findings

Background to this inspection

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

We inspected Key Dental Practice on 8 March 2016. The inspection team consisted of one CQC inspector and a dental specialist advisor.

Prior to the inspection we reviewed information we held about the provider from various sources. We informed NHS England and Healthwatch that we were inspecting the practice and we did not receive any information of concern from them. We also requested details from the provider in advance of the inspection. This included their latest statement of purpose describing their values and objectives and a record of patient complaints received in the last 12 months.

During the inspection we toured the premises, spoke with the practice manager, the provider, one dentist, one receptionist and two dental nurses. We spoke with patients and reviewed CQC comment cards which patients had completed. We reviewed a range of practice policies and practice 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 arrangements for staff to report incidents and accidents. We were told they were discussed informally with staff members at the earliest opportunity. We reviewed an incident that had taken place in February 2016 and found that it had been documented appropriately.

Staff members we spoke with all understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any RIDDOR reportable incidents in the last 12 months.

The practice responded to national patient safety and medicines alerts that affected the dental profession. We were told that the practice had registered with the MHRA (Medicines and Healthcare products Regulatory Agency). There was a folder in place with all relevant alerts and these were discussed with staff at staff meetings for shared learning. The practice also had arrangements in place for staff to report any adverse drug reactions.

Reliable safety systems and processes (including safeguarding)

The practice had child protection and vulnerable adult 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 provider was the safeguarding lead in the practice. Staff members we spoke with were knowledgeable about safeguarding and all had completed safeguarding training. There had not been any safeguarding referrals to the local safeguarding team; however staff members were confident about when to do so.

The British Endodontic Society recommends the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a rectangular sheet of latex used by dentists for effective isolation of the root canal, operating field and airway. We were told that rubber dam kits were available at the practice and that all dentists used them when carrying out root canal treatment whenever practically possible. If they were unable to place the rubber dam in certain situations, the dentist risk assessed and used alternative measures to protect the airway.

The practice had a policy for raising concerns. All staff members we spoke with were aware of the whistleblowing process within the practice. All dental professionals have a professional responsibility to speak up if they witness treatment or behaviour which poses a risk to patients or colleagues.

Never events are serious incidents that are wholly preventable. Staff members we spoke with were aware of never events and had processes to follow to prevent these happening. For example, they had a process to make sure they did not extract the wrong tooth.

There was a policy in place on the duty of candour and all staff members had signed it to state they had read and understood its contents. The intention of this regulation is to ensure that staff members are open and transparent with patients in relation to care and treatment.

Medical emergencies

Within the practice, the arrangements for dealing with medical emergencies were mostly in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). The practice had access to emergency resuscitation kits, oxygen and emergency medicines. There was an Automated External defibrillator (AED) present. 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.

We noted that the practice did not have any buccal midazolam; this is an emergency medicine used to treat a number of conditions including seizures. The practice did have some midazolam in the correct dose but it was not available in the buccal form (it was for other routes such as intravenous, intramuscular and rectal). This was discussed with the practice manager and they emailed us on the same day as our visit to state they had placed an order for the appropriate midazolam and this would arrive within 48 hours.

Staff received annual training in the management of medical emergencies. The practice took responsibility for ensuring that all of their staff received annual training in this area.

The practice undertook regular checks of the equipment and emergency medicines to ensure they were safe to use; however they were not regularly checking the AED. We

Are services safe?

discussed this with the practice manager and were told they would begin to do this immediately. They were already checking and documenting daily checks of the emergency oxygen and monthly checks of the emergency medicines. The emergency medicines were all in date and stored securely. Glucagon (one type of emergency medicine) was stored in the fridge but the temperature was not monitored. The practice manager assured us they would do this with immediate effect.

Staff recruitment

The practice had a policy for the safe recruitment of staff. We looked at the recruitment records for seven members of the practice team. The records we saw contained evidence of immunisation status, staff identity verification, dental indemnity and copies of their GDC registration certificates. Some of these did not apply to the trainee dental nurses (for example, their immunisation course was under progress). Some of the files also contained curricula vitae and induction plans. We were told that the employment contracts were kept off-site. Their recruitment policy stated that two references for each prospective employee must be sought; however, not all staff members had two references. There were Disclosure and Barring Service (DBS) checks present for all of the staff files we viewed. The 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 vulnerable adults.

The practice had a system in place to monitor professional registration of its clinical staff members. We reviewed a selection of staff files and found that certificates were present and had been updated to reflect the current year's membership.

Monitoring health & safety and responding to risks

We saw evidence of a comprehensive business continuity plan which described situations which might interfere with the day to day running of the practice. This included extreme situations such as loss of the premises due to fire. We reviewed the plan and found that it had all relevant contact details in the event of an emergency.

The practice had arrangements in place to monitor health and safety. We reviewed several risk management policies. We saw evidence that a fire risk assessment had taken place and fire extinguishers had been serviced in September 2015. We also reviewed a fire safety certificate from September 2015. Fire alarms were tested regularly and this was documented. Fire drills took place annually and there was clear guidance on what to do in the event of fire.

Information on COSHH (Control of Substances Hazardous to Health 2002) was available for all staff to access. We looked at the COSHH file and found this to be comprehensive where risks (to patients, staff and visitors) associated with substances hazardous to health had been identified and actions taken to minimise them.

Infection control

There was an infection control policy and procedures to keep patients and staff safe. The practice followed the guidance about decontamination and infection control issued by the Department of Health, namely the 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05)'. However, the policy was generic and needed to be updated so that it was more specific to this practice. The practice had a nominated infection control lead that was responsible for ensuring infection prevention and control measures were followed. We saw evidence that staff had carried out training in infection control.

We reviewed a selection of staff files and saw evidence that clinical staff were immunised against Hepatitis B to ensure the safety of patients and staff (the trainee dental nurse's immunisation course was in progress).

We observed the treatment rooms and the decontamination room to be visibly clean and hygienic. Several patients commented that the practice was clean and tidy. Work surfaces and drawers were free from clutter. Patient dental care records were computerised and the keyboards in the treatment rooms were all water-proof, sealed and wipeable in line with HTM 01-05.

The floors were adequately sealed in all clinical areas. In one treatment room, there was a small tear in the dental chair which would make effective cleaning difficult. The provider had sealed this temporarily to assist with cleaning. The provider was aware of this and we saw evidence that they had placed an order for this to be replaced two months before our visit. However, this was on back-order which is why there was a delay.

Are services safe?

There were handwashing facilities in the treatment rooms and staff had access to supplies of personal protective equipment (PPE) for themselves and for patients.

Decontamination procedures were carried out in a dedicated decontamination room. In accordance with HTM 01-05 guidance an instrument transportation system was in place to ensure the safe movement of instruments between the treatment rooms and the decontamination room.

Sharps bins were appropriately located and out of the reach of children. They were wall-mounted and dates recorded on them. We observed waste was separated into safe and lockable containers for fortnightly disposal by a registered waste carrier and appropriate documentation retained. Clinical waste storage was in an area where members of the public could not access it. The correct containers and bags were used for specific types of waste as recommended in HTM 01-05.

We spoke with clinical staff about the procedures involved in cleaning, rinsing, inspecting and sterilising dirty instruments. Clean instruments were packaged, date stamped and stored in accordance with current HTM 01-05 guidelines. There appeared to be sufficient instruments available and staff confirmed this with us.

Staff used manual scrubbing techniques to clean the used instruments; they were subsequently examined visually with an illuminated magnifying glass and then sterilised in an autoclave. The decontamination room had clearly defined clean and dirty zones to reduce the risk of cross contamination. Staff wore appropriate personal protective equipment during the process and these included disposable gloves, aprons and protective eye wear. Heavy duty gloves are recommended during the manual cleaning process and they were replaced on a weekly basis in line with HTM 01-05 guidance.

The practice had systems in place for quality testing the decontamination equipment daily and weekly. We saw records which confirmed these had taken place.

The practice had a protocol which provided assistance for staff in the event they injured themselves with a contaminated sharp instrument. This was clearly displayed in the treatment rooms and it had contact details.

The practice manager informed us that environmental cleaning of all clinical and non-clinical areas were carried out daily by an external cleaner. We reviewed cleaning logs which helped to ensure that all areas were effectively cleaned.

The Department of Health's guidance on decontamination (HTM 01-05) recommends self-assessment audits of infection control procedures every six months. It is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. We saw evidence that the practice carried these out every three months. Action plans were documented subsequent to the analysis of the results. By following the action plan, the practice could subsequently assure themselves that they had made improvements as a direct result of the audit findings.

Staff members were following the guidelines on managing the water lines in the treatment rooms to prevent Legionella. Legionella is a term for particular bacteria which can contaminate water systems in buildings. We saw evidence that a Legionella risk assessment was carried out by an external contractor in May 2014 – this was due for a review in May 2016. We saw evidence that the practice recorded water temperature on a monthly basis to check that the temperature remained within the recommended range. We saw evidence of this dating back to 2011. However, the practice was only checking one water outlet for the temperature. The previous risk assessment was comprehensive but did not have specific details regarding the number of water outlets. The practice manager told us they would check this with the contractor and follow their recommendations. They also tested the water quality every three months and we saw records dating back to 2013.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as X-ray equipment, pressure vessels and autoclaves.

Regular Portable Appliance Testing (PAT) is required to confirm that portable electric items used at the practice are safe to use. The practice previously had PAT carried out in January 2016.

The practice kept a log of prescriptions given so they could ensure that all prescriptions were tracked and safely given. Prescriptions were stored securely and stamped only at the point of issue.

Are services safe?

There was a separate fridge for the storage of medicines and dental materials. However, the temperature was not being monitored or recorded. We discussed this with the practice manager and were told they would do this with immediate effect.

We were told that the batch numbers and expiry dates for local anaesthetics were always recorded in patients' dental care records. Stock rotation of all dental materials was carried out on a regular basis by the practice manager and all materials we viewed were within their expiry date. This was also documented.

Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history.

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. Local rules were available in the practice for all staff to reference if needed.

We saw evidence of notification to the Health and Safety Executive (HSE). Employers planning to carry out work with ionising radiation are required to notify HSE and retain documentation of this.

We saw evidence that the practice carried out X-ray audits at least annually since 2011. Audits are central to effective quality assurance, ensuring that best practice is being followed and highlighting improvements needed to address shortfalls in the delivery of care. We saw that the results were analysed and reported on with subsequent action plans. Learning was shared with other team members in staff meetings and individually.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept up to date, detailed electronic dental care records. They contained information about the patient's current dental needs and past treatment. The dentists carried out assessments in line with recognised guidance from the Faculty of General Dental Practice (FGDP).

We spoke with two dentists about the oral health assessments, treatment and advice given to patients and corroborated what they told us by looking at patient dental care records. Dental care records included details of the condition of the teeth, soft tissues lining the mouth, gums and any signs of mouth cancer. Medical history checks were updated by each patient at each visit. This included an update on their health conditions, current medicines being taken and whether they had any allergies.

The Basic Periodontal Examination (BPE) is a screening tool which is used to quickly obtain an overall picture of the gum condition and treatment needs of an individual. We saw that the practice was recording the BPE for all adults. They were also recording the BPE for children with poor oral hygiene but the guidelines recommend that all children above 7 years old have their BPE checked and documented.

The practice kept up to date with other current guidelines and research in order to develop and improve their system of clinical risk management. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to lower wisdom teeth removal and in deciding when to recall patients for examination and review. Following clinical assessment, the dentist told us they followed the guidance from the FGDP before taking X-rays to ensure they were required and necessary. Justification for the taking of an X-ray was recorded and reports on the X-ray findings were available in the dental care records.

Staff told us that treatment options and costs (where applicable) were discussed with the patient and this was corroborated when we spoke with patients.

Health promotion & prevention

The medical history form patients completed included questions about smoking and alcohol consumption. The dentist we spoke with and the patient records showed that patients were given advice appropriate to their individual needs such as smoking cessation, alcohol consumption or dietary advice. There were posters and oral health promotion leaflets available in the practice to support patients look after their health. Examples included information on gum disease, oral cancer, smoking cessation and tooth decay.

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'. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. For example, the practice recalled patients, as appropriate, to receive fluoride applications to their teeth. Where required, toothpastes containing high fluoride were prescribed.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. This covered areas such as infection control, emergency procedures and practice policies.

Staff told us they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, orthodontic therapists, clinical dental technicians and dental technicians. All clinical staff members were registered with the GDC (apart from the trainee dental nurses as only qualified staff can register).

The provider monitored staffing levels and planned for staff absences to ensure the service was uninterrupted. The provider recruited additional staff members so staff shortage was a rare occurrence.

Dental nurses were supervised by the dentists and supported on a day to day basis by the practice manager. Staff told us the practice manager was readily available to speak to at all times for support and advice.

We were told that the dental nurses were encouraged to carry out further training and several of them had already completed training in areas such as taking X-rays and dental impressions.

Working with other services

Are services effective?

(for example, treatment is effective)

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. For example, referrals were made to hospitals and specialist dental services for further investigations or specialist treatment. We viewed six referral letters and noted that all were comprehensive to ensure the specialist services had all the relevant information required.

The practice understood the procedure for urgent referrals, for example, patients with suspected oral cancer.

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 ensured patients gave their consent before treatment began. The dentists had recently started to record this in the patients' dental care records. Written information was available for some complex dental procedures such as bridgework.

Staff members were knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent (in accordance with the Mental Capacity Act 2005). The 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. There was a MCA protocol in place and all staff had signed it to state they had read and understood it.

Staff members we spoke with were clear about involving children in decision making and ensuring their wishes were respected regarding treatment. They were familiar with the concept of Gillick competence regarding the care and treatment of children under 16. Gillick competence principles help clinicians to identify children aged under 16 who have the legal capacity to consent to examination and treatment.

Staff confirmed individual treatment options, risks, 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 preferred. We saw evidence of customised treatment plans when reviewing dental care records.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Twenty-eight patients provided feedback about the practice. We looked at comment cards patients had completed prior to the inspection and we also spoke with patients on the day of the inspection. Overall the information from patients was complimentary. Patients were positive about their experience and they commented that staff were helpful and caring. Patients were very pleased with their treatment and said the dentists were very kind and gentle. Many patients would recommend this practice to family and friends. Patients were satisfied with the standard of care and found the staff were respectful and professional.

We observed privacy and confidentiality were maintained for patients who used the service on the day of the inspection. For example, the doors to the treatment rooms were closed during appointments and confidential patient details were not visible to other patients. We observed staff members were helpful, discreet and respectful to patients.

Staff members we spoke with were aware of the importance of providing patients with privacy. We were told that all staff had individual passwords for the computers where confidential patient information was stored.

We were told that the practice appropriately supported anxious patients using various methods. The practice booked longer appointments so that patients had ample time to discuss their concerns with the dentist. For children (especially anxious patients), the dentists used child appropriate language and the tell-show-do technique. The tell-show-do technique is an effective way of establishing rapport as it is very much an **interactive** and communicative approach. They also had the choice of seeing different dentists, including male or female dentists.

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. Patients were also informed of the range of treatments available. Patients commented that the cost of treatment was discussed with them and this information was also provided to them in the form of a customised written treatment plan.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We conducted a tour of the practice and we found the premises and facilities were appropriate for the services that were planned and delivered. Patients with mobility difficulties were able to access the practice as there was a treatment room on the ground floor. There was no wheelchair access to the toilet although the toilet was on the ground floor.

The practice had an appointment system in place to respond to patients' needs. Patients we spoke with told us that they were always seen on time. We were told it was easy to make an appointment.

Staff told us the majority of patients who requested an urgent appointment would be seen within 24 hours. Feedback from patients confirmed that this was the case in their experience.

Patient feedback confirmed that the practice was providing a good service that met their needs. One patient we spoke with told us they travelled 25 miles to this practice due to the excellent service.

Tackling inequity and promoting equality

The practice had an equality and diversity policy to support staff in understanding and meeting the needs of patients. The practice appeared to recognise the needs of different groups in the planning of its services. The practice had an audio loop system for patients who might have hearing impairments.

The practice had access to an interpreting service for patients that were unable to speak fluent English. There was a poster clearly displayed in the waiting room with information about this service.

Access to the service

Patients could access care and treatment in a timely way and the appointment system met their needs.

The practice had a system in place for patients requiring urgent dental care when the practice was closed. Patients were signposted to the NHS 111 service for advice on obtaining emergency dental treatment.

Opening hours were from 9am to 6pm on Monday to Friday. The practice was also open on Saturdays from 9am to 4:30pm.

Concerns & complaints

We saw evidence that complaints received by the practice had been recorded, analysed and investigated. We found that complainants had been responded to in a timely manner. We were told that any learning identified was cascaded personally to team members. We saw examples of changes and improvements that were made as a result of concerns raised by patients.

The practice had a complaints' process which provided staff with clear guidance about how to handle a complaint. Any formal or informal comments or concerns were passed on to the practice manager to ensure responses were made in a timely manner. This information would then be passed on to any relevant staff members. Information for patients about how to make a complaint was displayed clearly at the practice.

Patients had made comments on the NHS Choices website. The practice had not responded to the positive or negative entries on the website.

Are services well-led?

Our findings

Governance arrangements

The provider was in charge of the day to day running of the service. We saw they had systems in place to monitor the quality of the service. These were used to make improvements to the service. The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately. One example was their risk assessment of injuries from sharp instruments – this was reviewed and changed in June 2015 to further minimise risk to staff members. We were told that the dentists always re-sheathed and dismantled needles so that fewer members of the dental team were handling used sharp instruments. This reduced the risk of injury to other staff members posed by used sharp instruments.

Leadership, openness and transparency

Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. All staff we spoke with were aware of whom to raise any issue with and told us the senior staff were approachable, would listen to their concerns and act appropriately. There were designated staff members who acted as dedicated leads for different areas, such as an infection control lead.

Learning and improvement

The provider monitored staff training to ensure essential staff training was completed each year. This was free for all staff members and included emergency resuscitation and basic life support. The practice manager also kept a log of staff members' CPD records to ensure they were meeting GDC requirements.

Staff audited areas of their practice regularly as part of a system of continuous improvement and learning. These included audits of radiography (X-rays), dental care record keeping and infection control. Several other audits also took place and we were told about changes made to practice processes as a direct result of these audits.

Staff meetings took place on a monthly basis. Additional meetings would also be held on an ad hoc basis if there were any issues that needed to be raised. The minutes of the meetings were made available for all staff. This meant that any staff members who were not present also had the information and all staff could update themselves at a later date.

No staff appraisals had been carried out in the last few years. Regular appraisals present an opportunity where learning needs, concerns and aspirations can be discussed. The practice manager told us that a new process will be implemented in April and this will include regular appraisals of all staff.

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

Patients and staff we spoke with told us that they felt engaged and involved at the practice.

The practice had systems in place to involve, seek and act upon feedback from people using the service. One example included plans to lower the height of the reception desk to accommodate patients in wheelchairs. The practice undertook the NHS Family and Friends Test (FFT). The FFT captures feedback from patients undergoing NHS dental care. The results were collated monthly and actions discussed at staff meetings. The results and actions were displayed in the reception area so that patients were kept informed.

Staff we spoke with told us their views were sought and listened to but there were no dedicated staff satisfaction questionnaires. Staff felt supported by the provider and told us there was an open door policy.