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Oldland Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 29th 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

Oldland Dental Practice is located in the High Street in Oldland Common and provides mainly NHS treatment to adults and children and some private treatment. The practice consists of four treatment rooms, toilet facilities for patients and staff, a reception/waiting area, a second waiting area and a staff room. The practice offers routine examinations and treatment. There are five dentists and a hygienist.

The practice opening hours are:

9.00 to 18.00 on Monday

9.00 to 18.00 on Tuesday

9.00 to 17.00 on Wednesday

9.00 to 19.30 on Thursday

9.00 to 16.00 on Friday

There is an on-call dentist rota for emergencies outside these times.

We carried out an announced, comprehensive inspection on 29th March 2016. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a dental specialist advisor.

Before the inspection we looked at the NHS Choices website. There were five reviews in the past 12 months

Summary of findings

and all gave five stars. There was also information about the friends and family test. There were 33 responses and all said that they would recommend the practice to friends and family.

For this inspection 23 patients provided feedback to us about the service through CQC comment cards. We also spoke with three patients. All these patients were positive about the care they received from the practice. They were complimentary about the service offered which they said was good and very good. They told us that staff were professional, caring, helpful and friendly. Patients told us that the practice was clean and hygienic. We received no negative comments.

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

Our key findings were:

• Safe systems and processes were in place, including a lead professional for safeguarding and infection control.

• Staff recruitment policies were appropriate and most of the relevant checks were completed. Staff received relevant training.

• Risk assessments were in place and they were regularly reviewed.

• The clinical equipment in the practice was appropriately maintained. The practice appeared visibly clean throughout.

•The process for decontamination of instruments followed relevant guidance.

• The practice maintained appropriate dental care records and these were updated.

• Patients were provided with health promotion advice to promote good oral care.

• Written consent was obtained for dental treatment.

• The dentists were not all aware of the process to follow when a person lacked capacity to give consent to treatment.

• Feedback that we received from patients was positive. Patients said that they received a caring and effective service.

• There were governance systems at the practice such as systems for auditing patient records, infection control and radiographs.

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

- Review the process for following up incidents when a patient is harmed as a result of their care and develop guidance for staff about the duty of candour.
- Review the process of recruitment of staff to make sure written references are obtained in line with current guidance about recruitment.
- Review the system for recording the training and continuing professional development (CPD) of all staff in the practice so that it is clear that all the staff have up to date relevant training and it is possible to see when updates are due.
- Review the guidance for staff about the Mental Capacity Act 2005 and how to treat a person if they lack capacity to consent for themselves.

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.

There were appropriate systems for reporting incidents and for learning from incidents. Staff had received training about safeguarding adults and children. There were policies about safeguarding and whistleblowing and staff knew how to report any concerns.

There were also arrangements for dealing with foreseeable emergencies, for fire safety and for managing risks to patients and staff. There was a business continuity plan. Hazardous substances were managed safely.

The appropriate checks were being made to make sure staff were suitable to work with vulnerable people. The necessary emergency medicines were in place. Equipment was regularly serviced. X-rays were dealt with safely.

The surgeries were fresh and clean. We found that guidance about decontamination of instruments was being followed to prevent the risk of the spread of infection.

Are services effective?

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

The dentists took X-rays at appropriate intervals. The practice was checking the condition of the gums for every patient and they were checking for oral cancers. Patients completed medical history questionnaires and these were updated at each visit. The practice kept up to date with current guidelines and research. They promoted the maintenance of good oral health through information about effective tooth brushing. The dentists discussed health promotion with individual patients according to their needs.

The practice had sufficient staff to support the dentists. Staff received appropriate professional development and the expected training.

The practice had suitable arrangements for working with other health professionals and making appropriate referrals to ensure quality of care for their patients. Patients were asked for written consent to treatment. Most of the dentists showed understanding about the Mental Capacity Act 2005 (MCA) and what they would do if an adult lacked the capacity to make particular decisions for themselves.

Are services caring?

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

Staff in the practice were polite and respectful when speaking to patients. Patients' privacy was respected and treatment room doors were closed during consultations. The practice used an electronic record system and the computer screens in reception were shielded so that they could not be seen by patients.

Patients were positive about the care they received from the practice. They reported that staff were, professional, caring, helpful and friendly. People were given treatment plans by the dentists, which they had signed to show their consent and agreement to them.Are

Are services responsive to people's needs?

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

Summary of findings

The practice had a system to schedule enough time to assess and meet patients' needs. Most patients who commented said that they could get an appointment easily. Emergencies were usually fitted in on the day the patient contacted the practice. The practice actively sought feedback from patients on the care being delivered. There was a procedure about how to make a complaint and the process for investigation. We saw evidence that the practice responded to feedback made direct to the practice and made changes when necessary. This included extending the receptionist hours so that a receptionist was available from 8.45am.

There was an equality and diversity policy and staff had received training about equality and diversity. There were systems for people to help them to access the service. These included a translation for people whose first language was not English. There was level access for wheelchair users to two of the surgeries. There was a hearing loop system for patients who had a hearing impairment and there was access to a sign language service for deaf people.

Are services well-led?

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

The practice had systems for clinical governance such as audits of infection control, radiographs and record keeping. There were checks of equipment. The autoclave and compressor were serviced and there were daily checks of the autoclave.

The practice had a range of policies which were made available to staff.

The principal dentist was the lead professional for the practice. There was a whistleblowing policy. There was no information for staff about the duty of candour but the practice had been open and apologised when an incident occurred where a patient suffered harm.

There were three monthly team meetings and staff discussed developments in the practice such as learning from incidents. Staff were responsible for their own continuing professional development and kept this up to date.

The practice sought feedback from patients through patient satisfaction feedback forms and these were analysed by the principal dentist annually. There were also Friends and Family Test comment cards which were considered monthly. The principal dentist had made changes in the practice in response to patient feedback.

Oldland Dental Practice

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 29th March 2016. The inspection took place over one day.

The inspection was led by a CQC inspector. They were accompanied by a dental specialist advisor.

We reviewed information received from the provider prior to the inspection. We also informed the local Healthwatch and NHS England. We did not receive any information from Healthwatch, however, NHS England raised some concerns about preventive treatments for children.

During our inspection visit, we reviewed policy documents and dental care records. We spoke with two dental nurses, three dentists and three patients. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We observed a nurse carrying out decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area.

Twenty three patients provided feedback about the service by completing comment cards. Patients were positive about the care they received from the practice. They were complimentary about the friendly, professional, helpful and caring attitude of the dental staff. We spoke with three patients who said that the staff were caring and friendly and listened to what they had to say. They said it was easy to get an appointment including emergency appointments. Patients told us that the surgery was clean and hygienic.

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 for reporting and learning from incidents. Incidents were reported to the principal dentist, recorded and analysed. We saw an accident book. There was information in the front about when an incident needed to be reported to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There was also a policy about reporting through RIDDOR. There had been three accidents in the last 12 months and these had been appropriately recorded and followed up. We spoke with two nurses who were both aware of the policies and procedures about accidents and the process for reporting. The incident recording sheets and information about any incidents in the last 12 months had been sent to CQC before the inspection.

There was a process to follow if a member of staff had a needlestick or sharps injury. A needlestick injury is when a person is injured by a needle or other sharp object. One of the nurses said that they had followed the accident procedure when one the dentists had a needlestick injury. We saw an accident record where a dentist had had a sharps/needlestick injury. This was appropriately followed up with a blood test. The practice had a sharps risk assessment and they used single use syringes to minimise the risk of injury.

There was learning from accidents and incidents. The principal dentist said that they followed up all accidents and learned from them to prevent reoccurrence. They said that following one incident they discussed the situation in a dentists' meeting and discussed how they could minimise future risks. We saw the minutes of this meeting. One of the nurses also said that they had staff meetings every few months and they discussed learning from accidents and incidents.

The principal dentist had been open and transparent following an incident when a patient had been harmed. They sent the patient a letter with an apology and an explanation about what had happened. However, the practice did not have guidance about the duty of candour and being open with patients if they are harmed as a result of their care.

Reliable safety systems and processes (including safeguarding)

There was a procedure about what to do if a member of staff had a sharps injury. There had been an incident which had been dealt with according to the protocol. We saw evidence that clinical staff were immunised against blood borne viruses (Hepatitis B) to ensure the safety of patients and staff.

The practice had policies and procedures for child protection and safeguarding adults. This included contact details for the local authority social services. Staff had signed a sheet to say that they had read and understood the procedure for reporting allegations of abuse. The principal dentist was the safeguarding lead professional for the protection of vulnerable children and adults. We saw certificates to show that staff had completed training about safeguarding adults and children. This was updated annually. Staff would raise concerns or allegations of abuse with the principal dentist. The two nurses we spoke with knew how to raise a concern. We spoke with the principal dentist who knew how to make a referral to the safeguarding team if there was a concern. There had been no safeguarding issues reported by the practice to the local safeguarding team. There was a whistleblowing policy which staff could follow if they had concerns about another member of staff's performance.

Medical emergencies

The practice had arrangements to deal with medical emergencies. Staff had received in–house training in emergency resuscitation and basic life support and this was refreshed every year. We saw certificates for this training going back several years. The most recent training was in July 2015. The staff we spoke with were aware of the practice procedures for responding to an emergency. The practice had emergency equipment in accordance with guidance issued by the Resuscitation Council UK. This included relevant emergency medicines, oxygen and an automated 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). There were defibrillator pads for both adults and children. The oxygen cylinder and resuscitation mask were in date. The oxygen cylinder was being routinely checked for effectiveness. We reviewed the contents of the emergency medicines kit and we saw that all the emergency medicines were in date. The glucagon injections were being kept in the fridge.

Are services safe?

Recruitment

The practice staffing consisted of the principal dentist, four dentists, one hygienist, five dental nurses and four receptionists. We looked at the records of recruitment checks for seven staff and found that they had the right recruitment information. Each member of staff had submitted a curriculum vitae with their employment history and a list of their qualifications and training. They each had a disclosure and barring service (DBS) check and had a copy of their passport as proof of identity and information about their right to work in the UK.

Two dentists did not have any references. The principal dentist said that these dentists were trainees (Foundation Dentists) and they were recruited through a national programme so they did not usually receive their references. However, they had received confirmation that the appropriate checks had been carried out. One of the nurses had no written references but a verbal reference had been obtained. Another member of staff did not have any references but they had the other recruitment checks. The principal dentist said that they had employed this member of staff in another practice and they had taken up references. However, the references had remained with the previous practice when the member of staff transferred. There was a record of the immunisation status of the nurses, the hygienist and the dentists. We saw that appropriate checks of registration with the General Dental Council (GDC) had been carried out for all the qualified staff.

Monitoring Health and Safety and responding to Risk

There were arrangements to deal with foreseeable emergencies. We saw that there was a health and safety policy. The practice had a fire risk assessment and there were certificates dated 11th January 2016 showing that the fire alarm system and emergency lighting had been serviced. There were records of fire drills and weekly fire alarm checks. The principal dentist said that they aimed to carry out a fire drill every six months and the records confirmed this. There was a detailed health and safety risk assessment for the whole practice. There was a certificate to show that the electrical wiring was checked in January 2015. All staff received annual fire safety training. This training was due again in November 2015 and was overdue. We were shown evidence that it was booked to take place in April 2016.

There were arrangements to meet the Control of Substances Hazardous to Health 2002 (COSHH) Regulations. There were COSHH risk assessments and these were reviewed once a year and when a new product was introduced.

The practice followed national guidelines for patient safety. For example, the practice used a rubber dam for root canal treatments and some tooth restorations. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth.

The practice had a business continuity plan to ensure continuity of care in the event that the practice's premises could not be used for any reason.

Infection control

There were systems to reduce the risk and spread of infection. The principal dentist was the infection control lead professional for the practice. There was a comprehensive infection control policy in the decontamination room. This was updated in November 2015. Clinical staff were required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. We saw confirmation of this for the nurses and the dentists. There were good supplies of protective equipment for patients and staff members including gloves, masks, eye protection and aprons. There were hand washing facilities in the treatment rooms and the toilet. The dentists, nurses and hygienist wore uniforms in the clinical areas and they were responsible for laundering these.

We found that the practice was following relevant guidance about cleaning and infection control. The practice looked clean throughout. The nurses cleaned the surgeries. There was a separation of clean and dirty areas in the surgeries. Three patients we spoke with during our visit said that the practice was always clean and hygienic. Twenty three patients who completed comment cards confirmed that the environment was always clean and hygienic. Ten people who completed comment cards said that he environment was safe and hygienic.

We examined the facilities for cleaning and decontaminating dental instruments in the decontamination room. The practice had followed the guidance on decontamination and infection control issued

Are services safe?

by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)' when setting up their decontamination room. In accordance with HTM 01-05 guidance dirty instruments were carried from the surgery to the decontamination room in a designated sealed box to ensure the risk of the spread of infection was minimised.

There was a clear flow from 'dirty' to 'clean.' There were two sinks, one for washing and one for rinsing the instruments, and a washer disinfector. One of the nurses showed us the process for the decontamination of instruments. They put on personal protective equipment (PPE) including domestic style rubber gloves. They washed the instruments in the washing bowl after testing the temperature of the water and scrubbed the instruments with a long handled brush. They rinsed them then inspected them for debris under an illuminated magnifying glass. They put the instruments into the washer disinfector. After the washing cycle was complete they placed them on trays and put them into the autoclave to sterilise. An autoclave is a device for sterilising dental and medical instruments. An ultrasonic bath was also available but this was only used if the washer disinfector was not working.

After the sterilisation cycle was complete they took the instruments out of the steriliser to the clean area of the room, put them into date stamped bags and put them into a clean container to take back to the surgery. The nurses also showed us how they cleaned down the surgeries and sanitised the surfaces between patients.

The autoclave was checked daily for its performance, for example, in terms of temperature and pressure. The washer disinfector was also checked. Logs were kept of the results demonstrating that the equipment was working well. The principal dentist said that the autoclave and washer disinfector were serviced annually and we saw certificates to confirm this.

Procedures to control the risk of infection were monitored as part of the daily checks and the practice had carried out cross infection audits. The practice had an on-going contract with a clinical waste contractor. Waste was being appropriately stored and segregated. This included clinical waste and safe disposal of sharps. There was a Legionella risk assessment (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). The nurse showed us how they flushed the dental unit water lines in accordance with current guidance in order to prevent the growth of Legionella.

Equipment and medicines

We found that the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor, fire equipment and X-ray equipment had all been inspected and serviced. We saw a portable appliance testing (PAT) certificate for all electrical items dated 15th December 2015.

Medicines were stored securely in a cupboard and a designated fridge. One of the nurses was responsible for checking that the medicines were in date and for ordering new stock. Prescription pads were locked in a cupboard in reception. There was no system for tracking the use of prescriptions to make sure none could go missing. The principal dentist planned to introduce a tracking system. The defibrillator was stored securely. There was an oxygen cylinder with an up to date certificate.

There were sufficient instruments for use in all the surgeries. These were checked regularly to make sure there were enough and they did not need to be re-sterilised.

Radiography (X-rays)

There was an X–ray unit in each of the surgeries. There were suitable arrangements in place to ensure the safety of the equipment. There were logs to show that they were maintained. The name of an external radiation protection adviser (RPA) was made available and the principal dentist was the radiation protection supervisor (RPS). We saw critical exam packs and records of user acceptance testing for all machines. A digital system was used and X-rays were graded as they were taken. We saw records of an audit- of the radiographs dated March 2016.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We reviewed more than ten adult dental care records and two children's records. The dentists took X-rays at appropriate intervals, as informed by guidance issued by the Faculty of General Dental Practice (FGDP). They also recorded the justification, findings and quality assurance of X-ray images taken. The dental care records showed that an assessment of periodontal tissues was undertaken using the basic periodontal examination (BPE) screening tool. (The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to a patient's gums.)

We found evidence that the practice conducted audits of infection control, radiographs and record keeping. Medical histories were recorded and updated at each visit. This information was kept up to date so that the dentists were informed of any changes in patients' physical health which might affect the type of care they received.

We saw evidence that the practice kept up to date with some current guidelines and research in order continually 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 referring patients for removal of wisdom teeth and prescribing antibiotics. They also conducted risk assessments for patients to help them to decide appropriate intervals for recalling patients. We saw evidence that the practice had protocols and procedures in place for promoting the maintenance of good oral health giving due regard to guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention.'

Health promotion & prevention

The dentists said that they discussed health promotion with individual patients according to their needs. This included discussions around oral hygiene, use of fluoride, smoking cessation, sensible alcohol use and dietary advice. We saw records of examinations of soft tissue to check for the early signs of oral cancer.

The practice promoted the maintenance of good oral health through information about effective tooth brushing. We observed that there was some information about tooth brushing and some dental conditions displayed in the waiting area. This could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition.

Staffing

The practice had a principal dentist, four dentists, five nurses, a dental hygienist and four receptionists. The principal dentist told us that all staff received professional development and training. We saw training certificates for staff for safeguarding, cardio pulmonary resuscitation, medical emergencies, infection control, health and safety, fire awareness, risk assessment, equality and diversity and the Mental Capacity Act 2005 (MCA.) The dentists, hygienist and the nurses were responsible for their own continuing professional development (CPD.) They logged all their training hours online with the General Dental Council (GDC.) The practice kept copies of certificates but we noted that there was no central record in the practice of the training and CPD hours the dentists, nurses and hygienists had completed to ensure they were up to date with their training.

Annual appraisals were completed by the principal dentist for the dentists and nurses and records were seen of these. The principal dentist had a 360 degree appraisal by all the staff. We saw that each member of staff had a personal development plan which identified ways they could develop and improve their performance.

Working with other services

The practice had suitable arrangements for working with other health professionals to ensure quality of care for their patients. The dentists used a system of onward referral to other providers, for example, sedation, oral surgery, implants, orthodontics or endodontics. Where there was a concern about oral cancer a referral was made to the local hospital. Records showed that referral information was sent to the specialist service about each patient, including their medical history and X-rays.

Consent to care and treatment

The practice ensured that valid consent was obtained for all care and treatment. Records showed that the dentists discussed treatment options, including risks and benefits, as well as costs, with each patient. They provided

Are services effective?

(for example, treatment is effective)

treatment plans for private treatment and the patient signed these to show consent. NHS patients signed the NHS treatment plans. When treatment was needed for children the dentist obtained consent from their parents.

When we spoke with the trainee dentists we found that they had understanding about the Mental Capacity Act 2005 (MCA.) 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. One dentist gave examples of how they would treat a person if they lacked capacity. They demonstrated an understanding about someone with power of attorney making decisions on a person's behalf if they lacked capacity. They also demonstrated an understanding about providing treatment in the person's best interests. The principal dentist gave an example of how they would treat a person who lacked capacity which was not in line with the MCA code of practice. We saw the minutes of a team meeting where consent had been discussed. The minutes stated "Any patients with dementia need to be accompanied with a care/next of kin to obtain valid consent." This is not in line with MCA code of practice. We found evidence of training about the MCA for the dentists and nurses.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We observed that patient confidentiality was respected. The practice had paper based records and used an electronic record system. We noted that the paper records were stored in a filing cabinet behind reception and away from patients. Electronic records were password protected and the computer screens in reception were angled so that they could not be seen by patients. Patients were afforded appropriate privacy as the treatment room doors were closed during consultations. The waiting room was away from the consulting rooms so that conversations could not be heard from the other side of the door. Patients were offered the staff room or the small waiting room in case they wished to discuss appointments or payments in private. We observed that staff in the practice were polite and respectful when speaking with patients. Patients told us that they were treated with respect.

Patients, who completed comment cards, were positive about the care they received from the practice. Patients reported that staff were helpful, professional, caring, and friendly. They said that they provided a very good service. Three patients we spoke with said that the dentist and nurse were friendly, helpful and caring.

Involvement in decisions about care and treatment

The practice provided treatment plans for private patients which gave options for treatment and indicative costs. There were also clear NHS treatment plans. Written consent was obtained for the dentists' treatment plans showing that patients were involved in decisions about their care. Three patients we spoke with said that the dentist discussed options for treatment and explained treatment to them very clearly so that they could make decisions. They said that they had signed their treatment plans and consented to treatment. The patient records showed that any issues or options for treatment were discussed with the patient.

Support to cope with care and treatment

The principal dentist told us that the dentists spread treatment over several appointments and provided reassurance when they identified that a patient was nervous. They said that they allowed extra time for people with disabilities or with extra needs. If necessary they would refer a patient to another practice so that they could have treatment under sedation. Each dentist kept four emergency appointments each day. Three patients we spoke with said that they could always get an appointment and if they had an emergency they were seen promptly.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system to schedule enough time to assess and meet patients' needs. The practice reserved two appointments morning and afternoon for each dentist to see emergencies. Overall patients commented that the staff provided a good service. Three patients told us that they could always get an appointment and if they had an emergency they were seen promptly. The practice actively sought feedback from patients about the care being delivered. There were feedback forms in reception and the principal dentist analysed the responses once a year. There was information in reception called "You said, we did," about what the practice had done in response to comments. Changes included publicising the local bus times and removing a picture in reception. There were also forms for the NHS Friends and Family Test and the principal dentist analysed these monthly and published the results in reception.

Tackling inequity and promoting equality

There was an equality and diversity policy which was dated and staff had received training about equality and diversity. There were some reasonable adjustments in place. There was information about translation services for patients whose first language was not English. There was a loop system for patients with a hearing impairment. There was access to sing language interpreters for deaf patients. Two surgeries on the ground floor were accessible to patients who used wheelchairs. There was a toilet that was accessible to people with disabilities.

Access to the service

The opening hours were displayed by the front door and on the practice website. There was also information about out of hours' services. Patients who commented told us that they had no difficulty getting appointments. Emergencies were usually fitted in on the day the patient contacted the practice.

Concerns & complaints

There was a procedure about how to make a complaint, including timescales for responding to complaints and the process for investigation. Information about how to make a complaint was displayed in the reception area. Three patients we spoke with had not seen this information but they said that they would ask a member of staff if they had a complaint. Information about concerns and complaints was logged on the computer. Before the inspection the principal dentist sent us information about formal complaints in the past year. This showed information about four complaints, an analysis of the situation, the response to each patient who complained and the learning and development points for the practice. The principal dentist said that they discussed the learning points with the other dentists. Changes were also made in response to complaints. For example, one complaint was about a nurse giving oral health advice after the treatment room door was opened. The practice had responded by emphasising the need for patient confidentiality, displaying the nurse's qualification in oral health and making sure that patients gave consent before oral health advice was given.

Are services well-led?

Our findings

Governance arrangements

The practice had systems for clinical governance. There were audits of emergency medicines, infection control, records, information governance, hand hygiene, waste and radiographs. All the audits included an action plan which was followed up. We saw that there was a range of policies which were made available to staff. These included safeguarding, whistleblowing, infection control, health and safety, complaint handling, fire safety, risk assessment, and information governance.

The practice carried out regular checks of equipment. We saw evidence that the autoclave and compressor were serviced. One of the nurses told us that they conducted daily checks of the autoclave and we saw records of these tests. There were checks of the portable electrical appliances.

Leadership, openness and transparency

The principle dentist was the lead professional for the practice and they were also the lead professional for safeguarding, infection control and medical emergencies. We saw that there was no information for staff about the duty of candour. However, the practice had acted in an open and transparent way and given an apology when an incident occurred where a patient suffered harm. We saw a whistleblowing policy which was made available to staff. Three patients told us that the practice was well organised and well led.

Management lead through learning and improvement

The principal dentist and two nurses told us that there were team meetings about every three months. They also said that during these meetings staff discussed changes in the practice, improvements, learning form accidents, incidents and complaints and patient feedback. We saw the minutes of meetings where improvements to practice and learning from incidents was discussed. Patient feedback was also discussed. For example, in response to feedback they changed the reception hours so that a receptionist was available from 8.45am. The nurses and dentists told us that they were responsible for their own continuing professional development and kept this up to date. We found evidence that they had a range of training, for example for safeguarding, cardio pulmonary resuscitation, medical emergencies and infection control.

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

The practice had effective systems to seek feedback from patients. There were patient satisfaction feedback forms and these were analysed about once a year. There were also NHS Friends and Family Test feedback cards. These were analysed once a month. We saw information for patients about the practice's response to recent comments. Examples of changes and improvements included introducing a receptionist from 8.45am, publicising information about local buses and removing a painting in reception.