Ms. Sally Fitzgibbon

Fartown Dental Practice - Huddersfield

Inspection Report

306 Bradford Road
Fartown
Huddersfield
West Yorkshire
HD1 6LQ
Tel: 01484 545045
Website: www.fartowndental.co.uk

Date of inspection visit: 31 March 2016
Date of publication: 13/06/2016

Overall summary

We carried out an announced comprehensive inspection on 31 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

Fartown Dental Practice – Huddersfield is situated in the Fartown area of Huddersfield, West Yorkshire. It offers mainly NHS treatment to patients of all ages but also offers private dental treatments. The services include preventative advice and treatment and routine restorative dental care.

The practice has four surgeries, a decontamination suite, one waiting area and a reception area. The reception area, waiting area and one surgery are on the ground floor. The other three surgeries are on the first floor. There are patient and staff toilet facilities on the first floor of the premises.

There are two dentists, three dental hygiene therapists, two qualified dental nurses, six trainee dental nurses and three receptionists. One of the qualified dental nurses also acts as the practice manager.

The opening hours are Monday to Friday from 8-00am to 6-00pm.

Summary of findings

The practice owner 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.

During the inspection we received feedback from 17 patients. The patients were generally positive about the care and treatment they received at the practice. Comments included that the staff were caring, respectful and professional. They also commented that the environment was clean, safe and hygienic and that they felt listened to.

Our key findings were:

- The practice appeared clean and hygienic.
- The practice had some systems in place to assess and manage risks to patients and staff including infection prevention, control and health and safety and the management of medical emergencies.
- The decontamination and sterilisation processes were effective.
- Staff had received training appropriate to their roles.
- Patients were involved in making decisions about their treatment and were given clear explanations about their proposed treatment including costs, benefits and risks.
- Oral health advice and treatment were provided in-line with the 'Delivering Better Oral Health' toolkit (DBOH).
- We observed that patients were treated with kindness and respect by staff. Staff ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood.
- Patients were able to make routine and emergency appointments when needed.
- The practice regularly audited clinical and non-clinical areas of the service.

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

- Review the availability of buccal midazolam in the emergency drug kit.
- Review the availability of oropharyngeal airways in the emergency resuscitation kit.
- Review the local rules for the X-ray machines to ensure they are updated and include the names of the current practitioners.
- Review its complaint recording procedures to ensure that complaints are correctly logged and all documentation is kept.
- Review the process for undertaking the Infection Prevention Society audit to ensure it is completed every six months.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

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

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

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

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

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

Are services effective?

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

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

The practice followed best practice guidelines when delivering dental care. These included Faculty of General Dental Practice (FGDP), National Institute for Health and Care Excellence (NICE) and guidance from the British Society of Periodontology (BSP). The practice focused strongly on prevention and the dentists were aware of the 'Delivering Better Oral Health' toolkit (DBOH) with regards to fluoride application and oral hygiene advice.

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

Referrals were made to secondary care services if the treatment required was not provided by the practice.

Are services caring?

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

During the inspection we received feedback from 17 patients. Patients commented that staff were caring, respectful and professional. Patients also commented that they were involved in treatment options and everything was explained thoroughly.

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

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection.

Summary of findings

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

Are services responsive to people's needs?

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

The practice had an efficient appointment system in place to respond to patients' needs. There were vacant appointments slots for urgent or emergency appointments each day.

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

There was a procedure in place for responding to patients' complaints. This involved acknowledging, investigating and responding to individual complaints or concerns. Staff were familiar with the complaints procedure. However, we noted that there was not a particularly efficient method for recording the details of complaints.

Are services well-led?

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

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

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

They conducted patient satisfaction surveys, staff satisfaction surveys and were currently undertaking the NHS Friends and Family Test (FFT).

Fartown Dental Practice - Huddersfield

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 registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

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

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

During the inspection received feedback from 17 patients. We also spoke with one dentist, one qualified dental nurse, two trainee dental nurses and a receptionist. To assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had clear guidance for staff about how to report incidents and accidents. We reviewed the incidents which had occurred in the last year and these had been documented, investigated and reflected upon by the dental practice. Staff described to us a recent incident which had occurred which had been dealt with well and also documented well within the accident book. Any accidents or incidents would be reported to the registered provider. Any incidents would be discussed at staff meetings in order to disseminate learning.

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

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

Reliable safety systems and processes (including safeguarding)

The practice had child and vulnerable adult safeguarding policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff. Staff had access to contact details for both child protection and adult safeguarding teams. The registered provider was the safeguarding lead for the practice and had completed level three safeguarding training and all other staff had undertaken level two safeguarding training. Staff told us they were confident about raising any concerns with the safeguarding lead or the local safeguarding team.

The practice had systems in place to help ensure the safety of staff and patients. These included the use of a safe sharps system or re-sheathing devices, a policy whereby on the dentists deal with sharps and guidelines about responding to a sharps injury (needles and sharp instruments).

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

We saw that patients' clinical records were computerised, and password protected to keep people safe and protect them from abuse. Any paper documentation relating to dental care records were stored in lockable drawers when the practice was closed.

Medical emergencies

The practice had procedures in place which provided staff with clear guidance about how to deal with medical emergencies. Staff were knowledgeable about what to do in a medical emergency and had completed training in emergency resuscitation and basic life support within the last 12 months.

The emergency resuscitation kits, oxygen and emergency medicines were stored in a cupboard adjacent to the reception area. Staff knew where the emergency kits were kept. We looked at the emergency resuscitation kit and the emergency kits and found the contents to be generally in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). However, we noted that the practice did not have any oropharyngeal airways or buccal midazolam. This was brought to the attention of the registered provider on the day of inspection and we were told that these would be ordered immediately.

The practice had an Automated External Defibrillator (AED) to support staff in a medical emergency. (An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm).

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

Staff recruitment

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

Are services safe?

and found the recruitment procedure had been followed. The registered provider told us they carried out Disclosure and Barring Service (DBS) checks for all newly employed staff. These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. We reviewed records of staff recruitment and these showed that all checks were in place.

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

Monitoring health & safety and responding to risks

A health and safety policy and risk assessment was in place at the practice. This identified the risks to patients and staff who attended the practice. The risks had been identified and control measures put in place to reduce them.

We saw that a fire risk assessment had been completed on the practice in June 2015. As a result of the fire risk assessment the practice conducted weekly fire alarm tests and monthly emergency lighting tests. We also saw that fire extinguishers were serviced on an annual basis.

There were policies and procedures in place to manage risks at the practice. These included infection prevention and control, fire evacuation procedures and risks associated with staff who do not respond to the Hepatitis B vaccination.

The practice maintained a file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including substances such as disinfectants, and dental materials in use in the practice. The practice identified how they managed hazardous substances in its health and safety and infection control policies and in specific guidelines for staff, for example in its blood spillage and waste disposal procedures.

Infection control

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

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

We observed the treatment rooms and the decontamination room to be clean and hygienic. Work surfaces were free from clutter. Staff told us they cleaned the treatment areas and surfaces between each patient and at the end of the morning and afternoon sessions to help maintain infection control standards. There was a cleaning schedule which identified and monitored areas to be cleaned and staff signed a log book to confirm this had been done. There were hand washing facilities in the treatment rooms and staff had access to supplies of personal protective equipment (PPE) for patients and staff members. Posters promoting good hand hygiene and the decontamination procedures were clearly displayed to support staff in following practice procedures. Sharps bins were appropriately located, signed and dated and not overfilled. We observed waste was separated into safe containers for disposal by a registered waste carrier and appropriate documentation retained.

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

One of the dental nurses showed us the procedures involved in disinfecting, inspecting and sterilising dirty instruments; packaging and storing clean instruments. The practice routinely used a washer disinfector to clean the used instruments (and also had an ultrasonic bath as back up), examined them visually with an illuminated magnifying glass, and then sterilised them in a validated autoclave. As there were separate decontamination and sterilisation rooms this greatly reduces the risk of cross contamination. Staff wore appropriate PPE during the process and these included disposable gloves, aprons and protective eye wear.

Are services safe?

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

The practice had carried out an Infection Prevention Society (IPS) self- assessment audit in August 2015 relating to the Department of Health's guidance on decontamination in dental services (HTM01-05).This is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. The results of the audit showed that the practice was performing well. HTM 01-05 states that this audit should be completed every six months therefore this audit was overdue to be completed again. This was brought to the attention of the registered provider and we were told that this would be completed as soon as possible.

One of the qualified dental nurses carried out an inspection of instrument audit. This involved checking sterilised instruments to check if they were free from debris. If there was any debris remaining on an instrument then the individual responsible for sterilising the instrument would be made aware of this. As a result of this audit dental nurses working in surgery were told to remove any materials as soon as possible to prevent the material from hardening hence making them easier to clean.

Records showed a risk assessment process for Legionella had been carried out in 2014 (Legionella is a term for particular bacteria which can contaminate water systems in buildings). The practice undertook processes to reduce the likelihood of legionella developing which included running the water lines in the treatment rooms at the beginning and end of each session and between patients, monitoring cold and hot water temperatures each month and the use of a water conditioning system in the water lines. We also saw that the practice manager had completed training about Legionella awareness.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as X-ray sets, the autoclave, the washer disinfector and the compressor. Portable appliance testing (PAT) had been completed in July 2015 (PAT confirms that portable electrical appliances are routinely checked for safety).

Prescriptions were stamped only at the point of issue to maintain their safe use. The practice kept a log of all prescriptions given to patients to keep a track of their safe use. Prescription pads were kept locked away when not needed to ensure they were secure.

Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. Records we viewed demonstrated that the X-ray equipment was regularly tested, serviced and repairs undertaken when necessary. We found there were suitable arrangements in place to ensure the safety of the equipment. Local rules were available in all surgeries and within the radiation protection folder for staff to reference if needed. We noted that the local rules did not contain the details of the new members of staff who were permitted to take X-rays in the practice.

We saw that a justification, grade and a report was documented in the dental care records for all X-rays which had been taken.

X-ray audits were carried out every year. This included assessing the quality of the X-rays which had been taken. The results of the most recent audit undertaken confirmed they were compliant with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). However, we noted that there were no action plans associated with the audit results.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

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

During the course of our inspection we discussed patient care with the dentists and checked dental care records to confirm the findings. Clinical records were very detailed and included information about the condition of the teeth, soft tissue lining the mouth, gums and any signs of mouth cancer. If the patient had more advanced gum disease then a more detailed inspection of the gums was undertaken.

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

The practice used current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, following clinical assessment, the dentists 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, quality assurance of each X-ray and a detailed report was recorded in the patient's care record.

Health promotion & prevention

The practice had a strong focus on preventative care and supporting patients to ensure better oral health in line with the 'Delivering Better Oral Health' toolkit (DBOH). DBOH is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. For example, the dentist applied fluoride varnish to children who attended for an examination. Fissure sealants were also applied to children at high risk of dental decay. High fluoride toothpastes were prescribed for patients at high risk of dental decay. We saw that diet advice was always provided to patients regarding their intake of sugar.

The practice had a dedicated social media page where advice regarding brushing, fluoride and diet were covered.

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

The medical history form patients completed included questions about smoking and alcohol consumption. We were told by the dentist and saw in dental care records that smoking cessation advice and alcohol awareness advice was given to patients where appropriate. Patients were made aware of the synergistic effects of smoking and alcohol with regards to oral cancer. There were health promotion leaflets and posters available in the waiting room to support patients. The practice website also had a great deal of information about preventative dentistry, the implications of gum disease and the importance of looking after children's' teeth.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. We saw that the practice used specific induction sheets for individual job roles, for example, dental nurse, receptionist or dentist. The induction process included making the new member of staff aware of the location of emergency medicines, arrangements for fire evacuation procedures, waste disposal and the infection control procedures. We were told and saw evidence that as part of the induction programme that staff had a three month assessment to assess any training needs. We saw evidence of completed induction checklists in the recruitment files.

The practice mainly employed unqualified dental nurses and trained them in-house. We were told that all trainee dental nurses were enrolled on a dental nurse training programme in order to ensure all training was appropriate for GDC registration.

Staff told us they had good access to on-going training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council

Are services effective?

(for example, treatment is effective)

(GDC). The practice organised in house training for medical emergencies to help staff keep up to date with current guidance on treatment of medical emergencies in the dental environment. Records showed professional registration with the GDC was up to date for all staff and we saw evidence of on-going CPD.

The practice had a policy to have annual appraisals for all staff. However, as none of the current staff had been in position for a year yet, they were unable to show us any evidence of these. We were told that if staff asked for further training then this was accommodated. For example, one of the reception staff told us they had asked to be trained in the decontamination process in order to provide resilience when short staffed and this had been agreed.

The practice used the skills of dental hygiene therapists. Dental hygiene therapists are trained dental care professionals who are qualified to undertake certain treatments, for example, fillings and the extraction of deciduous teeth. The dentists would refer patients for such treatments to the dental hygiene therapists. This allowed the dentists to focus on more advanced or complicated treatments.

Working with other services

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 including orthodontics, oral surgery and sedation. The practice had a procedure for the urgent referral of patients with a suspected malignancy.

The dentists completed detailed proformas or referral letters to ensure the specialist service had all the relevant information required. A copy of the referral letter was kept in the patient's dental care records. Letters received back relating to the referral were first seen by the referring dentist to see if any action was required and then stored in the patient's dental care records.

The practice kept a log of all referrals which had been sent. Patients were told an approximate time when to expect an appointment at the hospital and to report back to the practice if they had not heard anything.

Consent to care and treatment

The practice had a consent policy for staff to reference for information regarding the issues surrounding consent. Patients were given appropriate information to support them to make decisions about the treatment they received. Staff were knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent. Staff described to us how valid consent was obtained for all care and treatment and the role family members and carers might have in supporting the patient to understand and make decisions. Staff described to us that for patients with a complicated treatment plan they took extra time to discuss the treatment to ensure the patient fully understood the risks, benefits and potential complications of the associated treatment.

Staff had received training and had a good understanding of the principles of the Mental Capacity Act (MCA) 2005 and how it was relevant to ensuring patients had the capacity to consent to their dental treatment. For example, staff told us that patients were deemed to have capacity unless it was determeined otherwise.

Staff ensured patients gave their consent before treatment began and a form was signed by the patient. We were told that individual treatment options, risks, benefits and costs were discussed with each patient. These discussions were very well documented in the dental care records and patients were provided with a list of the risks, benefits and potential complications associated with each treatment as part of their individualised treatment plan.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

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

We observed privacy and confidentiality were maintained for patients who used the service on the day of inspection. Dental care records were not visible to the public on the reception desk. We observed the receptionists to be helpful, discreet and respectful to patients. They were aware that no personal details should be discussed at the reception desk to ensure the dignity of patients. They also told us that if a patient wished to speak in private, an empty room would be found to speak with them. Staff were very aware of the need to maintain patient confidentiality and told us that would not disclose patient details over the phone or during discussion at the reception desk.

Patients' electronic care records were password protected and regularly backed up to secure storage. Any paper documentation relating to dental care records were securely stored in locked cabinets.

Involvement in decisions about care and treatment

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

Patients were also informed of the range of treatments available on the practice website, their Facebook page and on notices in the waiting area.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We found the practice had an efficient appointment system in place to respond to patients' needs. Staff told us that patients who requested an urgent appointment would be seen within 24 hours if not the same day. We saw evidence in the appointment book that there were dedicated emergency slots available each day for each dentist. If the emergency slots had already been taken for the day then the patient was invited to sit and wait for an appointment if they wished.

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

The practice had a dedicated social media page where patients could send a private message to ask questions about the service. The registered provider told us that they would respond to messages out of hours if it related to a dental emergency and provide support or advice.

Staff also told us that most of them were multilingual. These languages included Urdu, Arabic, Gujarati, Punjabi, French, Polish, Greek, Dutch and Bosnian. We were told that on numerous occasions these languages have been useful with interacting with patients whose first language was not English.

Tackling inequity and promoting equality

The practice had equality and diversity, and disability policies to support staff in understanding and meeting the needs of patients. There was step free access to the building and the doorways were wide enough to allow access for a wheelchair. The ground floor surgery was large enough to accommodate a wheelchair or a pram. We were told that the ground floor surgery was used for those patients who could not manage the stairs. The toilet facilities were located on the first floor of the building. Patients were made aware of this prior to booking their first appointment and it was also documented in the patient information leaflet. We were told by the registered provider that they had drawn up plans to extend the practice. This included installing an accessible toilet which would accommodate a wheelchair. We saw evidence of these plans.

Access to the service

The practice displayed its opening hours in the premises, in the practice information leaflet, on their social media page and on the practice website. The opening hours are Monday to Friday from 8-00am to 6-00pm.

Patients told us that they were rarely kept waiting for their appointment. Patients could access care and treatment in a timely way and the appointment system met their needs. Where treatment was urgent patients would be seen the same day. The practice had a system in place for patients requiring urgent dental care when the practice was closed. Patients were signposted to the 111 service on the telephone answering machine. Information about the out of hours emergency dental service was also displayed in the waiting area and in the practice's information leaflet.

Concerns & complaints

The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. There were details of how patients could make a complaint displayed in the waiting room, on the practice website and in the practice's information leaflet. The registered provider and the practice manager were responsible for dealing with complaints when they arose. Staff told us they raised any formal or informal comments or concerns with the practice manager to ensure responses were made in a timely manner. Staff told us that they aimed to resolve complaints in-house initially. We reviewed the complaints which had been received in the past 12 months and found that they had been dealt with in line with the practices policy and to the patient's satisfaction. However, we felt there was not a particularly well organised system for logging complaints. The complaints were printed out on sheets of paper and it was not particularly easy to see what letters or emails had been sent or received. We brought this to the attention of the registered provider and we were told that they would start a complaints folder in order to keep effective log of complaints

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients. We found there was an effective system in place which helped ensure a timely response. This included acknowledging the

Are services responsive to people's needs?

(for example, to feedback?)

complaint within four working days and providing a formal response within six months. If the practice was unable to provide a response within six months then the patient would be made aware of this.

Are services well-led?

Our findings

Governance arrangements

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

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

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

Leadership, openness and transparency

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

The practice held monthly staff meetings. These meetings were minuted for those who were unable to attend. During these staff meetings topics such as infection control, training requirements and significant events. A sheet of paper was displayed in the staff room with a framework for the upcoming staff meeting so staff were aware of topics which would be discussed. Staff were also encouraged to add to this list with topics which they felt were current and relevant.

We also saw that there were clinician meetings every month. This would involve one of the dentists or dental hygiene therapists presenting a case or discussing a recent course they had attended.

All staff were aware of whom to raise any issue with and there was a whistleblowing policy in place for staff to reference if necessary. We were told that there was a no blame culture at the practice and that the delivery of high quality care was part of the practice's ethos.

Learning and improvement

Quality assurance processes were used at the practice to encourage continuous improvement. The practice manager was responsible for carrying out the audits. The practice audited areas of their practice as part of a system of continuous improvement and learning. This included clinical audits such as dental care records, X-rays, infection control and instrument cleanliness. We looked at the audits and saw that the practice was performing well. However, where improvements could be made these were identified and followed up by a repeat audit.

Staff told us they had access to training and this included medical emergencies, basic life support and infection control. We were told that the practice would organise for a "lunch and learn" session where training would be undertaken. Staff working at the practice were supported to maintain their continuous professional development as required by the General Dental Council or their dental nurse training course.

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

The practice had systems in place to involve, seek and act upon feedback from patients and staff. This included feedback from the Facebook account and annual staff surveys. The registered provider told us that they regularly received feedback from the Facebook page and passed this on to staff and the monthly staff meetings. The staff satisfaction survey included questions such as whether the registered provider is approachable, listens to staff and is open to new ideas. We saw that as a result of a staff satisfaction survey that the registered provider had started to actively encourage staff to participate in staff meetings.

The practice also undertook the NHS Friends and Family Test (FFT). The FFT is a feedback tool that supports the fundamental principle that people who use NHS services

Are services well-led?

should have the opportunity to provide feedback on their experience. The latest results showed that 96% of patients asked said that they would recommend the practice to friends and family.