Mr Stuart Osborne

1st Practice

Inspection Report

2-4 Boothferry Road
Hessle
Humberside
HU13 9AY
Tel: 01482 643864
Website: 1stpractice.co.uk

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Overall summary

We carried out an announced comprehensive inspection on 7 July 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

1st Practice is located in the town of Hessle near Hull, Humberside. It is a NHS and private dental practice which offers private dental payment plans. The practice has three surgeries, a decontamination room, a waiting area, a reception area and patient toilets. All facilities are located on the ground floor of the premises. There are staff facilities on the first floor of the premises.

There is one dentist (the principal dentist), one dental hygiene therapist, one dental hygienist, five dental nurses one of which is training to become the practice manager.

The opening hours are:

Monday, Tuesday and Thursday 09:00 –17:00

Wednesday (reception only) 09:00 – 12:30

Alternate Fridays 09:00 – 17:00

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.

During the inspection we received feedback from 24 patients. The patients who provided feedback were very positive about the care and attention to treatment they received at the practice. They told us they were involved in all aspects of their care and found the staff to be very good with children and nervous patients, helpful,

Summary of findings

respectful, friendly and communicated well. Patients commented they could access emergency care easily and they were treated with dignity and respect in a clean and tidy environment.

Our key findings were:

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

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

- Undertake a Legionella risk assessment, giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance' the HSE Legionnaires' disease. Approved Code of Practice and guidance on regulations L8.

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?

No action

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

The practice had effective systems and processes in place to ensure that all care and treatment was carried out safely. For example, there were systems in place for infection prevention and control, clinical waste control, dental radiography and management of medical emergencies. All emergency equipment and medicines were in date and in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines.

Staff had received training in safeguarding patients and knew how to recognise the signs of abuse and who to report them to including external agencies such as the local authority safeguarding team.

Staff were appropriately recruited and suitably trained and skilled to meet patients' needs and there were sufficient numbers of staff available at all times. Staff induction processes were in place and had been completed by all staff. We reviewed the newest member of staff's induction file and evidence was available to support the policy and process.

The practice had not undertaken a Legionella risk assessment; no water testing was in place although evidence showed they managed the dental unit water lines effectively with reverse osmosis water and disinfection tablets.

Are services effective?

No action

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

Consultations were carried out in line with best practice guidance from the National Institute for Health and Care Excellence (NICE). For example, patients were recalled after an agreed interval for an oral health review, during which their medical histories and examinations were updated and recorded. Any changes in risk factors were also discussed and recorded.

The practice followed best practice guidelines when delivering dental care. These included guidance from the Faculty of General Dental Practice (FGDP) and NICE. The practice focused strongly on prevention. The staff were aware of the 'Delivering Better Oral Health' toolkit (DBOH) with regards to diet and oral hygiene advice.

Patients dental care records provided information about their current dental needs and past treatment. The dental care records we looked at included discussions about treatment options and relevant X-rays. The records we checked included a grade and a justification for taking an X-ray. The practice monitored any changes to the patients oral health and made referrals for specialist treatment or investigations where indicated in a timely manner.

Staff were registered with the General Dental Council (GDC) and maintained their registration by completing the required number of hours of continuing professional development (CPD). Staff were supported to meet the requirements of their professional registration.

Summary of findings

Are services caring?

No action

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

Staff explained that enough time was allocated in order to ensure the treatment and care was fully explained to patients in a way which they understood. Time was given to patients with complex treatment needs to decide what treatment options they preferred.

During the inspection we received feedback from 24 patients reporting they were involved in all aspects of their care and found the staff to be very good with children and nervous patients, helpful, respectful, and friendly and communicated well. Patients commented they could access emergency care easily.

We observed patients being treated with respect and dignity during interactions at the reception desk and over the telephone. Privacy and confidentiality were maintained for patients using the service on the day of the inspection. We also observed the staff to be welcoming and caring towards the patients.

Are services responsive to people's needs?

No action

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

The practice had an efficient appointment system in place to respond to patients' needs. Any patients requesting an emergency appointment would be seen the same day as the principal dentist would provide care as required on the days the practice did not hold a surgery.

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 for both private and NHS patients.

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

The practice was fully accessible to all patients and reasonable adjustments had been made to the practice where possible. The practice had step free access at the front of the building for wheelchair users and pushchairs and an automatic door.

Are services well-led?

No action

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 registered provider and practice manager were responsible for the day to day running of the practice.

The practice held quarterly staff meetings which were minuted and gave everybody an opportunity to openly share information and discuss any concerns or issues which had not already been addressed during their daily interactions.

Summary of findings

The practice undertook various audits to monitor their performance and help improve the services offered. The audits included infection prevention and control and X-rays. The X-ray audit findings were in line with the guidelines of the National Radiological Protection Board (NRPB).

The practice conducted patient satisfaction surveys and they were currently undertaking the NHS Friends and Family Test (FFT) for the patients who used the service. All responses were collated and audited to ensure all leaning outcomes and action plan were in place to respond to feedback.

1st Practice

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 carried out on 7 July 2016 and was led by a CQC Inspector and a specialist advisor.

The methods that were used to collect information at the inspection included interviewing staff, observations and reviewing documents.

During the inspection we spoke with the principal dentist, the dental hygiene therapist, three dental nurses (including the decontamination lead) and the practice manager. We saw policies, procedures 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. Staff were familiar with the importance of reporting significant events. We were told that incidents would be reported to the practice manager. Any incidents would be discussed at staff meetings in order to disseminate learning and to prevent it from happening again. We were told by staff that if a patient was involved then they would be given an apology and an explanation.

Staff understood the Reporting of Injuries, Disease and Dangerous Occurrences Regulations 2013 (RIDDOR) and provided guidance to staff within the practice's health and safety policy. The practice manager was aware of the notifications which should be reported to the CQC.

The principal dentist received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) that affected the dental profession. Relevant alerts were discussed with staff, actioned and stored for future reference.

Reliable safety systems and processes (including safeguarding)

The practice had child and adult safeguarding policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. They included the contact details for the local authority safeguarding team, social services and other relevant agencies. The policies were readily available to staff. The principal dentist was the lead for safeguarding. This role included providing support and advice to staff and overseeing the safeguarding procedures within the practice.

We saw evidence all staff had received safeguarding training in vulnerable adults and children. Staff demonstrated their awareness of the signs and symptoms of abuse and neglect. They were also aware of the procedures they needed to follow to address safeguarding concerns.

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

The principal dentist told us they routinely used a rubber dam when providing root canal treatment to patients in line with guidance from the British Endodontic Society. 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 whistleblowing policy which staff were aware of. Staff told us they felt confident they could raise concerns about colleagues without fear of recriminations. The staff told us they felt they all had an open and transparent relationship. Staff felt they would have someone to go to if they had any concerns at all.

Medical emergencies

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

The emergency medicines, emergency resuscitation kits and medical oxygen were stored in the reception area of the practice. Staff knew where the emergency kits were kept. 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 weekly checks were carried out on the emergency medicines and daily checks were carried out on the medical oxygen cylinder and the AED. These checks ensured the oxygen cylinder was sufficiently full, the AED was fully charged and the emergency medicines were in date. We saw that the oxygen cylinder was serviced on an annual basis.

Staff recruitment

The practice had a recruitment policy in place and this process had been followed when employing new staff. This

included obtaining proof of their identity, checking their skills and qualifications, registration with relevant professional bodies and seeking references. We reviewed the newest member of staff's recruitment file which confirmed the processes had been followed. All personal information was stored securely in the practice.

We saw all staff had been checked by the Disclosure and Barring Service (DBS). The DBS 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 recorded all relevant staff had personal indemnity insurance (insurance professionals are required to have in place to cover their working practice). In addition, there was employer's liability insurance which covered employees working at the practice.

Monitoring health & safety and responding to risks

The practice had undertaken a number of risk assessments to cover the health and safety concerns that arise in providing dental services generally and those that were particular to the practice. The practice had a Health and Safety policy which included guidance on fire safety, manual handling and dealing with clinical waste. We saw this policy was reviewed annually.

The practice had maintained a Control of Substances Hazardous to Health (COSHH) folder. COSHH was implemented to protect workers against ill health and injury caused by exposure to hazardous substances - from mild eye irritation through to chronic lung disease. COSHH requires employers to eliminate or reduce exposure to known hazardous substances in a practical way. If any new materials were implemented into the practice a new risk assessment was put in place.

A fire risk assessment had been completed. We saw as part of the checks by the team the smoke alarms were tested and the fire extinguishers were regularly serviced. There was evidence that a fire drill had been undertaken with staff and discussion about the process reviewed at practice meetings. These and other measures were taken to reduce the likelihood of risks of harm to staff and patients.

Infection control

There was an infection prevention and 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 prevention and control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 -Decontamination in primary care dental practices (HTM 01-05)'.

There were two sinks for decontamination work in the decontamination room. All clinical staff were aware of the work flow in the decontamination room from the 'dirty' to the 'clean' zones. The procedure for cleaning, disinfecting and sterilising the instruments was clearly displayed on the wall to guide staff. We observed staff wearing appropriate personal protective equipment when working in the decontamination area this included heavy duty gloves, aprons and protective eye wear.

We found that instruments were being cleaned and sterilised in line with published guidance (HTM01-05). The dental nurses were knowledgeable about the decontamination process and demonstrated they followed the correct procedures. For example, instruments were manually cleaned (where necessary), placed in an ultrasonic bath, examined under illuminated magnification and sterilised in an autoclave (a device for sterilising dental and medical instruments). Sterilised instruments were correctly packaged, sealed, stored and dated with an expiry date. For safety, instruments were transported between the surgeries and the decontamination area in lockable boxes.

We saw records which showed the equipment used for cleaning and sterilising had been maintained and serviced in line with the manufacturer's instructions. Appropriate records were kept of the decontamination cycles of the autoclaves to ensure they were functioning properly.

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 prevention and control standards.

Are services safe?

There was a cleaning schedule which identified and monitored areas to be cleaned. The practice employed a cleaner to clean the non-clinical areas of the practice and a cleaning schedule was in place.

There were hand washing facilities in the treatment rooms and decontamination room and staff had access to supplies of personal protective equipment (PPE) for patients and staff members. Patients confirmed that staff used PPE during treatment. Posters promoting good hand hygiene and the decontamination procedures were clearly displayed to support staff in following practice procedures.

The practice had carried out an Infection Prevention Society (IPS) self- assessment audit in July 2016 relating to the Department of Health's guidance on decontamination in dental services (HTM01-05).This is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. The audit showed the practice was meeting the required standards.

Records showed the practice had not completed a Legionella risk assessment. The practice undertook processes to reduce the likelihood of Legionella developing which included running the dental unit water lines in the treatment rooms at the beginning and end of each session and between patients and the use of purified water. Legionella is a term for particular bacteria which can contaminate water systems in buildings.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as X-ray sets, the autoclaves and the compressors.

Portable appliance testing (PAT) had been completed in December 2015 (PAT confirms that portable electrical appliances are routinely checked for safety).

The practice dispensed antibiotics and painkillers for patients where indicated. These were stored securely in a locked cabinet and we saw a log was kept of these medicines to ensure the medicines were not being abused, there was sufficient stock available and medicines were in date.

Radiography (X-rays)

The X-ray equipment was located in two of the surgeries. X-rays were carried out safely and in line with the rules relevant to the practice and type and model of equipment being used.

We reviewed the practice's radiation protection file. This contained a copy of the local rules which stated how each X-ray machine needed to be operated safely. The local rules were also displayed in each of the surgeries. The file also contained the name and contact details of the Radiation Protection Advisor.

We saw all the staff were up to date with their continuing professional development training in respect of dental radiography.

The practice also had a maintenance log which showed that the X-ray machines had been serviced regularly. The registered provider showed us the last annual quality audit of the X-rays in January 2016. The audit and the results were in line with the National Radiological Protection Board (NRPB) guidance.

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 dentist carried out an assessment in line with recognised guidance from the Faculty of General Dental Practice (FGDP).

This was repeated at each examination in order to monitor any changes in the patient's oral health. The dentist used NICE guidance to determine a suitable recall interval for the patients. This takes into account the likelihood of the patient experiencing dental disease. The practice also recorded the medical history information within the patients' dental care records for future reference. In addition, the dentist told us they discussed patients' lifestyle and behaviour such a smoking and drinking and where appropriate offered them health promotion advice, this was recorded in the patients' dental care records.

During the course of our inspection we discussed patient dental care records with the dentist and the hygiene therapist and checked dental care records to confirm the findings. We found they were in accordance with the guidance provided by the FGDP. For example, evidence of a discussion of treatment needs with the patient was routinely recorded. The practice recorded that medical histories had been updated prior to treatment. Soft tissue examinations, diagnosis and a basic periodontal examination (BPE) – a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums, had also been recorded.

The hygiene therapist described to us the procedures they used to improve the outcome of periodontal treatment. This involved preventative advice, taking plaque and gum bleeding scores and detailed charts of the patient's gum condition. Patients were made aware that successful treatment hinged upon their own compliance and were provided with patient specific prevention advice regimes. Patients with more severe gum disease were recalled at more frequent intervals to review their compliance and reinforced home care preventative advice.

All subsequent appointments patients were always asked to review and update a medical history form. This ensured the dentists and dental hygiene therapists were aware of the patients' present medical condition before offering or undertaking any treatment.

The dentist told us they always discussed the diagnosis with their patients and, where appropriate, offered them any options available for treatment and explained the costs. By reviewing the dental care records we found these discussions were recorded and signed treatment plans were scanned into the patients' dental care records.

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 dentist 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, a grade of each x-ray and a detailed report was recorded in the patient's dental care record.

Patients requiring specialist treatments that were not available at the practice such as conscious sedation or orthodontics were referred to other dental specialists. Their oral health was then monitored after the patient had been referred back to the practice. This helped ensure patients had the necessary post-procedure care and satisfactory outcomes.

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, diet and tooth brushing advice was delivered to all children who attended for an examination and high fluoride toothpastes were prescribed for patients at high risk of dental decay. Staff told us that the dentist would always provide oral hygiene advice to patients where appropriate or refer to the hygienist and hygiene therapist for a more detailed treatment plan and advice.

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

Are services effective?

(for example, treatment is effective)

were told by the dentist and saw in dental care records that smoking cessation advice was given to patients who smoked. Patients would also be made aware if their alcohol consumption was above the national recommended limit. There were health promotion leaflets available in the waiting room to support patients.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. The induction process included ensuring the new member of staff was aware of the practice's policies, the location of emergency medicines and arrangements for fire evacuation procedures. We were told the induction checklists was a verbal process and not recorded in the induction files. We brought this to the attention of the registered provider who told us this would be formally documented from now on.

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

Staff told us they had annual appraisals and training requirements were discussed at these. We saw evidence of completed appraisal documents and training plans for the year for each staff member. Staff also felt they could approach the registered provider or practice manager at any time to discuss continuing training and development as the need arose.

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 and in line with NICE guidelines where appropriate. For example, referrals were made to hospitals and specialist dental services for further investigations or specialist treatment including oral surgery.

The practice 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 had a process for urgent referrals for suspected malignancies and had very good working relationships with local hospitals.

Consent to care and treatment

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 were clear about involving children in decision making and ensuring their wishes were respected regarding treatment.

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

Staff ensured patients gave their consent before treatment began and a treatment plan was signed by the patient. We saw within the dental care records that individual treatment options, risks, benefits and costs were discussed with each patient. Patients were given time to consider and make informed decisions about which option they preferred. The practice also gave patients with complicated or detailed treatment requirements more time to consider and ask any questions about all options, risks and cost associated with their treatment.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Feedback from the patients was positive and they commented they were treated with care, respect and dignity. They said staff supported them and were quick to respond to any distress or discomfort during treatment. Staff told us 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. We observed staff were helpful, discreet and respectful to patients. Staff said that if a patient wished to speak in private, an empty room would be found to speak with them.

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

A selection of magazines, children's books and a television was available in the waiting room to help relax patients before their appointments. Music was played throughout the practice.

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.

Staff told us how the dentist would provide treatment options including benefits and possible risks of each option.

Patients were also informed of the range of treatments available in information leaflets in the waiting room. The practice's website provided patients with information about the range of treatments which were available at the practice.

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 patients who requested an urgent appointment would be seen the same day. We saw evidence in the appointment book there were dedicated emergency slots available each day. 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. If the practice was closed the practice answer machine directed patients to the NHS out of hours 111 services or the private local rota out of hours service. During working hours patient could contact the principal dentist who would provide emergency care if required.

The patients commented on the CQC comment cards 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. They felt the principal dentist, the hygiene therapist and the hygienist took their time to discuss their treatment needs in depth and explained the treatment options in a way they understood.

Tackling inequity and promoting equality

Reasonable adjustments had been made to the premises to accommodate all patients. Wheelchair users had access through the front door where step free access was available to the practice and an automatic door was in operation. All of the surgeries were located on the ground floor and were large enough to accommodate a wheelchair or pushchair.

The practice had an equality and diversity policy and all staff had undertaken training to have an understanding of how to meet the needs of patients. The practice also had access to online translation services for those whose first language was not English, information leaflets could be translated or enlarged if required.

Access to the service

The practice displayed its opening hours in the premises and on the NHS choices website.

The opening hours were:

Monday, Tuesday and Thursday 09:00 –17:00

Wednesday (reception only) 09:00 – 12:30

Alternate Fridays 09:00 – 17:00

The patients told us they were rarely kept waiting for their appointment. Where treatment was urgent staff told us patients would be seen the same day so no patient was turned away. The patients told us when they had required an emergency appointment this had been organised the same day.

The practice had a system in place for patients requiring urgent dental care when the practice was closed. NHS patients were signposted to the NHS 111 service on the telephone answering machine and private patients to a local rota on call number.

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 rooms and in the practice information leaflet.

The practice manager was responsible for dealing with complaints when they arose. Staff told us they would raise any formal or informal comments or concerns with the practice manager to ensure responses were made in a timely manner. Staff told us they aimed to resolve complaints in-house initially.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients. We found there was an effective system in place which helped ensure a timely response. This included acknowledging the complaint within two working days and providing a formal response within 10 working days. If the practice was unable to provide a response within 10 working days then the patient would be made aware of this. The practice had received no complaints in the last 12 months.

Are services well-led?

Our findings

Governance arrangements

The practice was a member of a certification programme for dentists to demonstrate excellence in quality assurance, patient care and communication.

The practice manager was 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 an 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 the use of equipment and waste management.

The practice had governance arrangements in place such as various policies and procedures for monitoring and improving the services provided for patients. For example there was a health and safety policy and an infection prevention and control policy. Staff were aware of their roles and responsibilities within the practice.

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

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. These were discussed openly at staff meetings and it was evident the practice worked as a team and dealt with any issue in a professional manner.

The practice held quarterly staff meetings involving all staff members. If there was more urgent information to discuss with staff then an informal staff meeting would be organised to discuss the matter.

All staff were aware of whom to raise any issue with and told us the practice manager was approachable, would listen to their concerns and act appropriately. We were told there was a no blame culture at the practice.

Learning and improvement

Quality assurance processes were used at the practice to encourage continuous improvement. The practice audited areas of their practice as part of a system of continuous improvement and learning. This included clinical audits such as dental care records, X-rays and infection prevention and control.

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

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

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

The practice had systems in place to involve, seek and act upon feedback from people using the service including carrying out continuous patient satisfaction. The satisfaction survey included questions about the patients' overall satisfaction, the cleanliness of the premises, accessibility and length of time waiting. The most recent patient survey showed a high level of satisfaction with the quality of the service provided.

The practice was participating in the continuous NHS Friends and Family Test (FFT). The FFT is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. The latest results showed that 100% of patients asked said that they would recommend the practice to friends and family.