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Ashdown Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 08 December 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Ashdown dental practice is a dental practice located in Crowbrough, East Sussex. The premises are situated on the first floor of a building accessed by a flight of stairs. There are two treatment rooms, a dedicated decontamination room, a reception area, waiting room and staff room / kitchen.

The practice provides NHS and private services to adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers, crowns and bridges and implants.

The staff structure of the practice comprises a principal dentist (who is also the owner), two dental hygienists, two dental nurses, both of whom are student nurses, a receptionist and the practice manager.

The practice opening hours are Monday, Tuesday and Thursday 9am to 5.30pm, Wednesday 8.30am to 6.30pm and Friday 9am to 3pm. Saturday appointments could be arranged for private treatments and emergencies.

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.

The inspection took place over one day and was carried out by a CQC inspector and a specialist advisor.

Summary of findings

Eight people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the staff.

Our key findings were:

- There were effective systems to reduce and minimise the risk and spread of infection.
- The practice had effective safeguarding processes and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Equipment, such as the air compressor, X-ray units and autoclave (steriliser), had been checked for effectiveness and had been regularly serviced.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring team.
- Staff understood the importance of obtaining informed consent prior to treatment. Staff could demonstrate awareness of the needs of higher-risk groups, including young people and those with impaired decision-making capacity.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- Staff were well supported and were committed to providing a quality service to their patients.
- Staff had received training appropriate to their role and were supported in their continued professional development.

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

- Arrange current DBS checks for staff to ensure they are safe to work with vulnerable adults and children.
- Collate and maintain a working radiation protection folder.
- Ensure all staff have completed medical emergency training

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had policies and protocols related to the safe running of the service. Staff were aware of these and were following them. There were effective systems in place to reduce and minimise the risk of infection. The practice had systems for the management of medical emergencies and equipment and medicines were checked and were in line with current guidance. However, Student nurses were not aware of what to do if a medical emergency arose. The practice had maintained all of the equipment such as the autoclave and X-ray units in line with current guidance.

Are services effective?

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

The practice monitored patients' oral health and gave appropriate health promotion advice. The practice worked well with other providers and followed up on the outcomes of referrals made to other health professionals. Staff had engaged in continuous professional development (CPD) and were meeting all of the training requirements of their registration with the General Dental Council (GDC).

Are services caring?

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

We received positive feedback from patients through comments cards, by speaking to patients nd by checking the results of the practice's collection of patient feedback forms submitted for their patient survey. Patients felt that the staff were kind and caring; they told us that they were treated with dignity and respect at all times. We found that dental care records were stored securely and patient confidentiality was well maintained.

Are services responsive to people's needs?

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

Patients had good access to appointments, including emergency appointments, which were available on the same day. The needs of people with disabilities had been considered and there was an arrangement with a practice close by which was located on the ground floor. Staff told us that when enquiries were made to join the practice, prospective patients were informed that the practice was on the first floor. Patients could then decide if they wished to join.

There was a complaints policy in place and we saw that complaints received had been acted on in line with this policy. The principal dentist carried out relevant investigations and recorded the outcome of these. The practice disseminated the outcomes of these investigations at staff meetings with a view to preventing a recurrence of any problems.

Are services well-led?

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

The practice was well led by the principal dentist and practice manager with systems to maintain clinical governance. There was an audit plan to monitor and assess the quality of the service the practice provided. Audited aspects of the service had led to learning and improvements for staff and patients.

Summary of findings

Staff felt supported to make suggestions for the improvement of the practice. There was a culture of openness and transparency. Staff at the practice were supported to complete training for the benefit of the practice, their patients and for their continuous professional development. Although some staff had not had training in medical emergencies. Following our inspection the practice informed us that training in medical emergencies had been booked.

Ashdown Dental 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 practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an announced, comprehensive inspection on 08 December 2015. The inspection took place over one day and was carried out by a CQC inspector and a specialist advisor.

We reviewed information received from the provider prior to the inspection. During our inspection we reviewed policy documents and spoke with the principal dentist, a dental nurse, a receptionist and the practice manager. We conducted a tour of the practice and looked at the arrangements for emergency medicines and equipment. The dental nurse demonstrated how they carried out decontamination procedures of dental instruments.

Eight people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

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 a system to manage significant events, safety concerns and complaints and staff could demonstrate a good understanding of the procedures to follow. There had not been any reported significant events within the last year. However, staff knew what to do should a significant event or incident occur.

There was also an accident reporting book. The practice manager showed us that they filed completed accident forms separately to protect the privacy of people involved. They had a system for cross referencing these so they could easily identify and locate them if needed. None of the accidents recorded were serious enough to have been reportable to either RIDDOR or CQC.

The prinicipal dentist told us they received national and local safety alerts by email. However, we did not see any evidence of this and staff when questioned were not sure what the safety alerts were. The practice provided evidence following our inspection that demonstrated how they received, stored and acted on safety alerts.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures for safeguarding children and vulnerable adults, which had been updated annually. The policies were localised and contained the direct contact details of the local authority safeguarding team and what to do out of hours. This information was displayed prominently and all staff were aware of the procedure to follow.

The principal dentist was the safeguarding lead. All staff had completed safeguarding training to the appropriate level. Staff were spoke with were confident when describing potential abuse or neglect and how they would raise concerns with the safeguarding lead.

Staff were aware of the procedure for whistleblowing if they had concerns about another member of staff's performance. Staff told us they would be confident about raising such issues with either the practice manager or principal dentist.

The British Endodontic Society uses quality guidance from the European Society of Endodontology recommending the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work. The practice showed us that they had rubber dam kits available for use when carrying out endodontic (root canal) treatment.

The practice had clear processes to make sure that they did not make avoidable mistakes such as extracting the wrong tooth. The dentists told us they always checked and re-checked the treatment plan and re-examined the patient. They said they took particular care with this where they were extracting a tooth on the recommendation of another dentist (such as when carrying out orthodontic extractions). They told us they had a final read of the letter from the orthodontist and also asked the dental nurse assisting them to check this. The dentists were aware that carrying out incorrect dental treatment of any kind would be reportable to CQC.

Medical emergencies

The practice had arrangements to deal with medical emergencies and the dentist was the lead for this. The practice employed two student dental nurses, who had not received any mediacl emergency training. We asked what they would do in the event of a medicical emergency. They told us that they had not got to that part of their course as they had started only two months previously. If a medical emergency happened theywould call for help and follow instructions from the dentist or members of staff that had received training. There was an automated external defibrillator (AED - a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). Some staff had received annual training in how to use this. However, we checked the AED as part of our inspection and found it was working but the pads had expired. We brought this to the attention of the principal dentist and the practice manager who assured us they would replace the pads immediately. We received confirmation following our inspection that new pads had been ordered. The practice had the emergency medicines set out as advised in the British National Formulary guidance. Oxygen and other related items such as face masks were available in line with the Resuscitation Council UK guidelines.

Are services safe?

The emergency medicines were all in date and stored securely with emergency oxygen in a central location known to staff. The practice monitored the expiry dates of medicines but had omitted to check the equipment so they could replace out of date items promptly. During our inspection the practice manager added the emergency equipment checks to the check list to ensure items were replaced when required.

Staff recruitment

The practice showed us evidence that they did not always obtain all of the required information for members of the team before they had contact with patients.

The practice's written procedures contained clear information about all of the required checks for new staff. These included educational certificates, a valid UK Passport or National Identity Card, General Dental Council (GDC) and professional indemnity certificates (if applicable) and Hepatitis B vaccination evidence if available.

The Disclosure and Barring Service carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The practice had obtained DBS checks for some of the staff employed there but some of these were not current and had different work places on them. DBS checks of this kind are not portable between employers and it is the providers responsibility to ensure that staff are suitable to work with vulnerable adults and children. Two members of staff had applied for a DBS check but they had not yet been completed. The two members of staff had started work before the checks had been carried out.

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety policy. The freeholder was responsible for assessing the premises for risk of fire, and fire extinguishers were placed throughout the building. The practice was in a shared building with a GP practice and a Pharmacy. Staff told us they were regularly engaged in fire drills which included all staff in the building.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. Actions were described to minimise identified risks. COSHH products were securely stored. Staff were aware of the COSHH file and of the strategies to minimise the risks associated with these products.

Response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) as well as from other relevant bodies, such as Public Health England (PHE) were received by the provider. Staff when questioned were not sure what these were and we asked the principal dentist how staff would be made aware of any alerts that would affect dentistry. We were informed that this did not happen but a new system would be implemented to ensure all staff were aware. Followng our inspection we received details of how this system would work.

There were arrangements to refer patients to another practice in close proximity, should the premises become unfit for use. Emergency arrangements had been considered. For example, the appointments book was backed up online There was a business continuity plan with key contacts, such as for electrics or plumbing, which could be referred to in the event of service failures.

Infection control

The 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05) published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for the cleaning, sterilising and storage of dental instruments and reviewed their policies and procedures. This assured us that the practice was meeting the HTM01-05 essential requirements for decontamination in dental practices. The dentist had overall lead responsibility for infection prevention and control (IPC) as both of the dental nurses were students.

We saw that dental treatment rooms, decontamination room and the general environment were clean, tidy and clutter free. Feedback confirmed that the practice maintained a good standard regarding this at all times. The practice employed a cleaner for general cleaning at the practice and we saw that cleaning equipment was safely stored in line with guidance about colour coding equipment for use in different areas of the building.

During the inspection we observed that the dental nurses cleaned the surfaces, dental chair and equipment in treatment rooms between each patient. We saw that the

Are services safe?

practice had a supply of personal protective equipment (PPE) for staff and patients including face and eye protection, gloves and aprons. There was also a good supply of wipes, liquid soap, paper towels and hand gel available. The decontamination room and treatment rooms all had designated hand wash basins separate from those uses for cleaning instruments.

A dental nurse showed us how the practice cleaned and sterilised dental instruments between each use. The practice had a well-defined system which separated dirty instruments from clean ones in the decontamination room, in the treatment rooms and while being transported around the practice. The practice had a separate decontamination room where the dental nurses cleaned, checked and sterilised instruments. All of the nurses at the practice had been trained so that they understood this process and their role in making sure it was correctly implemented. The dental nurses took it in turns to work in the decontamination room each day and the other dental nurses delivered and collected instruments in colour coded boxes with lids. Different boxes were used for the dirty and clean instruments.

The dental nurse showed us the full process of decontamination including how staff manually scrubbed and rinsed the instruments, checked them for debris and used the ultrasonic bath and autoclaves (equipment used to sterilise dental instruments) to clean and then sterilise them. Clean instruments were packaged and date stamped according to current HTM01-05 guidelines. They confirmed that the nurses in each treatment room checked to make sure that they did not use packs which had gone past the date stamped on them. Any packs not used by the date shown were processed through the decontamination cycle again.

The dental nurse showed us how the practice checked that the decontamination system was working effectively. They showed us the paperwork they used to record and monitor these checks. These were fully completed and up to date. We saw maintenance information showing that the practice maintained the decontamination equipment to the standards set out in current guidelines.

The practice used single use dental instruments whenever possible which were never re-used and the special files used for root canal treatments were used for one treatment.

A specialist contractor had carried out a legionella risk assessment for the practice and we saw documentary evidence of this. Legionella is a bacterium which can contaminate water systems. We saw that staff carried out regular checks of water temperatures in the building as a precaution against the development of Legionella. The practice used a continuous dosing method to prevent a build-up of legionella biofilm in the dental waterlines. Regular flushing of the water lines was carried out in accordance with the manufacturer's instructions and current guidelines.

The practice carried out audits of infection control every six months using the format provided by the Infection Prevention Society. The practice also completed an annual IPC report in line with guidance from the Department of Health code of practice for infection prevention and control.

The practice had a record of staff immunisation status in respect of Hepatitis B a serious illness that is transmitted by bodily fluids including blood. There were clear instructions for staff about what they should do if they injured themselves with a needle or other sharp dental instrument including the contact details for the local occupational health department.

The practice had adopted a policy that all staff should attend occupational health to be checked following a sharps injury even where the risk of infection was assessed as low. The practice manager would contact the patient for whom the instrument had been used to ask them to consider taking a blood test. The practice manager told us that all sharps injuries were recorded as accidents and we saw evidence that this was done.

The practice stored their clinical and dental waste in line with current guidelines from the Department of Health. Their management of sharps waste was in accordance with the EU Directive on the use of safer sharps and we saw that sharps containers were well maintained and correctly labelled. The practice had an appropriate policy and used a safe system for handling syringes and needles to reduce the risk of sharps injuries.

The practice used an appropriate contractor to remove dental waste from the practice and we saw the necessary required waste consignment notices.

Are services safe?

Equipment and medicines

We looked at the practice's maintenance information. This showed that they ensured that each item of equipment was maintained in accordance with the manufacturer's instructions. This included the equipment used to sterilise instruments, X-ray equipment and equipment for dealing with medical emergencies. All electrical equipment had been PAT tested by an appropriate person. PAT is the abbreviation for 'portable appliance testing'. The practice manager had a list of dates when all of the equipment was next due to be checked as a quick reference tool.

Prescription pads held by the practice were securely stored. We saw that the practice had written records of prescription pads to ensure that the use of these was monitored and controlled.

The batch numbers and expiry dates for local anaesthetics were always recorded in the clinical notes.

Temperature sensitive medicines were stored in a fridge and the staff kept a record of the fridge temperatures.

Radiography (X-rays)

There was a radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor. There was also a copy of a maintenance log showing that the next service was due in 2017. A copy of the local rules was displayed in the treatment room. However, not all of the necessary documentation pertaining to the X-ray equipment was held in the file. For example, the notification to the Health and Safety Executive (HSE), as well as the critical examination and acceptance test report were not available. There was also no record of an initial risk assessment or schematic for the X-ray unit. We were informed by the practice on the day after the inspection that the HSE had been notified.

The practice carried out monitoring of the quality of each X-ray taken to demonstrate that the dental X-rays were graded and quality assured every time. We looked at the radiological quality audit. This assessment systematically analysed the quality of X-rays to identify areas for improvement. Dental care records that we checked, contained a record of X-ray quality and written justification for why X-rays were being taken.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The principal dentist described to us how they carried out dental assessments. The assessment began with the patient completing a medical history questionnaire covering any health conditions, medicines being taken and any allergies suffered. This was followed by an examination of the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were made aware of the condition of their oral health and whether it had changed since the last appointment. The medical history was updated at every visit, especially before any treatment was commenced and signed by the patient.

The patient's dental care record was updated with the proposed treatment after discussing options with them. The patient was given a treatment plan that detailed the consultation and proposed treatment options, as well as the costs involved. Patients were monitored through check up appointments and these were scheduled in line with their individual requirements.

We checked a sample of dental care records with the principal dentist to confirm the findings. The records were both handwritten and recorded on the computer. We found that the findings of the assessment and details of the treatment carried out were recorded appropriately. The condition of the gums were checked using the basic periodontal examination (BPE) scores. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). However, we found one dental care record where pocketing had been recorded at grade 3 but no pocket charting had taken place. We brought this to the attention of the principal dentist.

Examinations were recorded, and there was consistent use of the BPE scores to prompt further investigation or onward referral, for example, to one of the hygienists. Overall we found that the guidelines in clinical examination and record keeping produced by the Faculty of General Dental Practice (FGDP; 2009) had been followed. The recording of consent or social history, such as current smoking or alcohol consumption was not always recorded. The principal dentist assured us that these processes did form part of the assessment, although the recording did not reflect this full process and would address this immediately.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. The principal dentist told us they discussed oral health with their patients, for example, effective tooth brushing or dietary advice, and we saw these discussions recorded in the dental care records that we checked. These topics were re-affirmed when patients were referred to the hygienists. The principal dentist was aware of the need to discuss a general preventive agenda with their patients. This included discussions around smoking cessation, sensible alcohol use and healthy diet. The dentist also carried out examinations to check for the early signs of oral cancer.

Staffing

Staff told us they received appropriate professional development and training. We checked all of the staff files and saw that this was the case. The training covered all of the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, safeguarding, infection control and X-ray training.

There was a induction programme for new staff to follow to ensure that they understood the protocols and systems at the practice. However, when questioned some staff did not have a good understanding of what to do in a medical emergency as they had not received any training for this. Staff had not been engaged in an appraisal process which reviewed their performance and identified their training and development needs. Following our inspection we were informed of a training course that had been booked for medical emergencies and that all staff had undergone an appraisal.

Working with other services

The practice had suitable arrangements for working with other health professionals to ensure quality of care for their patients. Referrals were made to other dental specialists when required.

Staff explained how they worked with other services. Dentists were able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. For example, orthodontics. They also referred to the hygienists at the practice and had systems in place for referring patients

Are services effective?

(for example, treatment is effective)

with complex surgical needs to hospital, as well as accessing emergency care for cases of suspected oral cancer. Copies of referral letters were kept with the patient's dental care records.

Consent to care and treatment

We spoke with staff about their understanding of consent issues. They explained that individual treatment options, risks, benefits and costs were discussed with each patient. If they assessed that the patient needed a complex treatment plan then a follow up letter was written to the patient so that they could consider their decision prior to commencing treatment. We saw that these letters contained a detailed explanation of the proposed treatment, risk and benefits and costs. Therefore, implied consent was obtained when the patient made an appointment to attend for the treatment.

Patients were asked to sign their proposed treatment plan to indicate they had understood their options and any costs that may be involved. Formal, written consent forms were completed for specific treatments, such as implants. We also noted that consent was recorded in the dental care records and there was details of options discussed in the dental care records.

Staff were aware of the Mental Capacity Act 2005, but had not received any formal training in relation to their responsibilities under this act. However, when questioned they could explain the meaning of the term mental capacity and described to us their responsibilities to act in patients' best interests, if patients lacked some decision-making abilities. Staff were aware of the Gillick competency and the requirement to treat young people below the age of 16 years, without parental permission, following an assessment of their capacity to provide informed consent. The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The patients we spoke with were complimentary about the care and treatment they received at the practice. Some highlighted that they had been patients for many years. Patients commented on the kindness and gentleness of their dentist as well as the positive attitudes approach of the whole team. All the staff we met spoke about patients in a respectful and caring way and were aware of the importance of protecting patients' privacy and dignity. This view was reflected in information patients had written in compliments made directly to the service.

We observed that the staff provided a personable service as they knew their patients well. They were welcoming and helpful when patients arrived for their appointments and when speaking with patients on the telephone.

Patients indicated that they were treated with dignity and respect at all times. Doors were always closed when patients were in the treatment rooms. Patients we spoke with told us that they had no concerns with regard to confidentiality; we noted that there had been no complaints or incidents related to confidentiality and that dental care records were stored securely.

Involvement in decisions about care and treatment

We looked at dental care records and saw that the dentists recorded information about the explanations they had provided to patients about the care and treatment they needed. This included details of alternative options which had been described. The dentist explained and showed us how they described root canal treatments to patients using pictures and diagrams about the subject. We saw another example where a patient had been to the practice for an emergency appointment. The dental care records showed that the dentist gave them information about the risks and benefits of the possible treatment options. They provided temporary treatment so that a full treatment plan could be discussed in a longer appointment and the patient had time to come to a decision.

Patients told us that they felt involved in their care and had been given adequate information about their treatment, options and fees. Staff told us and we saw they took time to explain the treatment options available.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided NHS dental treatment and private dental treatment. The practice leaflet and website provided information about the types of treatments that the practice offered.

The practice had a system to schedule enough time to assess and meet patient's needs. The dentist had devised their own time frames for different treatments and procedures. Staff told us that although they were busy they had enough time to carry out treatments without rushing. The practice were able to book longer appointments for those who requested or needed them, such as those with a learning disability.

We found that the practice was flexible and able to adapt to the needs of the patients, and to accommodate emergency appointments. Patients we spoke with confirmed this and told us that they could usually get an appointment when they needed one and that they had been able to access emergency appointments on the same day. Staff told us and ptaients confirmed that if patients needed to be seen, staff would willingly work through their lunch or stay later if required.

Tackling inequity and promoting equality

The practice had recognised the needs of its patient population. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions.

The practice was not accessible to wheelchairs and patients with pushchairs as the practice was located on the first floor of a shared building. Staff told us of the arrangement they had with a practice in close proximity where they would refer patients who had reduced mobility and needed level access. When prospective new patients telephoned the practice, staff informed them of the flight of stairs to access the practice and gave them the option of the other practice.

Access to the service

Appointment times and availability met the needs of the patients. The practice surgery hours were 9am – 5.30pm Monday, Tuesday, and Thursday. 9am - 6.30pm on Wednesday and 9am - 3pm on Friday. Saturday appointments could be requested for private treatments and emergencies. Information about opening times was displayed at the entrance to the practice in the waiting room, on the practice website and in the patient information leaflet.

Patients needing an appointment could book by phone, in person or request one through the practice website. Patients with emergencies were seen on the same day even if there were no appointments available, staff would work later or through their lunch break to accommodate them.

If patients required emergency treatment when the practice was closed, the answer phone message would direct them to the local NHS dental out of hours service. This was also displayed in the waiting room, on the entrance door and on both the website and patient information leaflet.

Concerns & complaints

The practice had a complaints process which was available on the practice website as well as in print at the practice. We looked at information available about comments, compliments and complaints dating back two years. The information showed that there was a commitment to listening to concerns raised and discussing these with the practice team so the learning about these could be shared. We noted that there were far more compliments recorded than concerns and that the practice recorded informal concerns as well as more significant ones. The practice had only received two complaints in the last year and we saw they both had been handled in accordance with the practice complaints policy and resolved to the patient's satisfaction.

We also looked at the practices summary of more formal complaints and the records of these. These showed that the practice had listened to patients views and concerns, looked into these and offered explanations and where necessary an apology. The complaint summary identified the learning for the practice such as improving communication with patients.

Are services well-led?

Our findings

Governance arrangements

There was a range of operational policies, procedures and protocols to govern activity. All of these policies, procedures and protocols were subject to annual review and staff had signed to indicate that they had read and understood each document. Staff we spoke with were aware of the policies, procedures and protocols, their content and how to access them when required.

The practice undertook a series of practice wide audits to monitor and assess the quality of the services they provided. These audits had been repeated to evidence that improvements had been made where gaps had been identified. Records we looked at related to audits for infection control, the quality of X-rays taken and record keeping. There was clear evidence that these were taking place regularly. The findings of the audits documented an analysis of results, areas identified for improvement, and actions taken. Results and findings were discussed at practice meetings and it was clear that these audits were driving improvement and maintaining standards.

Leadership, openness and transparency

The practice had a practice manager who was being given effective support by the principal dentist. The prinicipal dentist was responsible for the oversight of all matters relating to governance. There was a clear understanding of the requirements of the regulations under the Health and Social Care Act 2008 and how these applied to dental practices.

We saw that relationships between members of the practice team were professional, respectful and supportive. Staff in all roles described the practice as a happy place to work where they were supported by the prinicipal dentist and other team members.

Learning and improvement

The practice took learning and development seriously and encouraged staff to take part in activities to develop their knowledge and skills. We found that the clinical dental team all undertook the necessary learning to maintain their continued professional development which is a requirement of their registration with the General Dental Council (GDC). .

The practice had regular team meetings which were used to share information and to discuss significant events and complaints. These provided opportunities for shared learning within the team.

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

The practice gathered feedback from patients via the monthly NHS friends and family test. Results from the most recent months were very positive scoring between 98 and 100% of patients happy to recommend the practice to others. Other feedback was collected through an ongoing patient survey which asked patients to comment about their experiences such as, were they seen at the time of their scheduled appointment. Did they wait to been seen, and if so for how long. Patients were asked if the dentist had listened to them and had they had all of their questions answered as well as being asked about what they think would improve the service. We looked at the results of the last two surveys conducted. The overall concensus was that patients were happy with the services they had received. Some patients had suggestedthat a stair lift be installed. The practice had looked exstensively into providing a stair lift but due to constraints of the building were not able to proceed.

Staff told us that the practice manager and dentist were approachable and more like a family so they could discuss anything they needed to, whenever they needed to.