IDH Limited

Mydentist - Town Street - Shepton Mallet

Inspection Report

Town Street,
Shepton Mallet,
BA4 5BE.
Tel: 01749 342560
Website: www.mydentist.co.uk/dentists/practices/england/south-west-england/shepton-mallet/13-town-street

Date of inspection visit: 4th October 2016
Date of publication: 25/11/2016

Overall summary

We carried out an announced comprehensive inspection on 4th October 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

Mydentist Shepton Mallet is located in the centre of Shepton Mallet, in Somerset, and provides NHS and private treatment to patients of all ages. The practice consists of four treatment rooms, toilet facilities for patients and staff, a reception, two waiting areas, an office and a staff room.

The practice treats both adults and children. The practice offers routine examinations and treatment. There are two dentists and a hygienist and more dentists are being recruited.

The practice's opening hours are

8.30 to 19.00 on Monday

8.30 to 17.00 on Tuesday

8.30 to 17.00 on Wednesday

8.00 to 17.00 on Thursday

8.30 to 17.00 on Friday

The practice was opening some Saturday mornings.

Summary of findings

Out of hours the practice provided contact information for an emergency helpline and the patient will be seen in 48 hours in the Somerset area.

We carried out an announced, comprehensive inspection 4th October 2016. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a dental specialist advisor.

Before the inspection we looked at the NHS Choices website. In the previous year there had been 16 comments about the practice. The practice received an average of 4.5 stars. The organisation responded to all the comments and offered to follow up any outstanding issues with patients who responded.

For this inspection 7 people provided feedback to us about the service. Patients were positive about the care they received from the practice. They were complimentary about the service offered which most patients said was good and two said was excellent. They told us that staff were helpful and friendly. Patients told us that the practice was clean and hygienic. We received two negative comments that there was a long wait for available appointments.

Our key findings were:

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

• Staff recruitment policies were appropriate and most of the relevant checks were completed. Staff received relevant training. The practice was recruiting more dentists.

• The practice had ensured that risk assessments were in place and that they were regularly reviewed.

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

•The process for decontamination of instruments followed relevant guidance.

• The practice maintained all appropriate dental care records and patients' clinical details were updated suitably.

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

• Written consent was obtained for dental treatment.

• One of the dentists was aware of what process to follow when a person lacked capacity to give consent to treatment.

• All feedback that we received from patients was positive; they reported that it was a caring and effective service.

• There were sufficient governance systems in place at the practice such as systems for auditing patient records and radiographs.

The two requirements from the previous inspection had been addressed.

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

- Review the recruitment process to ensure that two written references are obtained when recruiting new staff.
- Review the arrangements for the storage of oxygen so that there is a suitable sign to show where a hazardous substance is being stored.

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.

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

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

Appropriate checks were being made to make sure staff were suitable to work with vulnerable people. However, two references were not always obtained. There were not always sufficient permanent dentists and the practice was managing this by employing locums and recruiting more dentists.

The necessary medicines were in place. Equipment was regularly serviced. X-rays were dealt with safely.

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

Are services effective?

No action

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

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

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

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

Summary of findings

Are services caring?

No action

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

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

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 a system to schedule enough time to assess and meet patients' needs. People also said that they could get an appointment easily. Emergencies were usually fitted in on the day the patient contacted the practice. The practice actively sought feedback from patients on the care being delivered. There was a procedure about how to make a complaint and the process for investigation. We saw evidence that the practice responded to feedback made direct to the practice and made changes when necessary.

There was an equality and diversity policy and staff had received training about equality and diversity. There was information about translation services for people whose first language was not English. There was level access for wheelchair users to one of the surgeries and there was an accessible toilet. There was a hearing loop system for patients who had a hearing impairment.

Are services well-led?

No action

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

The practice had systems for clinical governance such as audits of record keeping, infection control and radiographs. The records were being kept up to date. There were checks of equipment. The autoclave and compressor were serviced and there were daily checks of the autoclaves and washer disinfector.

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

The practice manager was the lead for the practice supported by more senior managers in the organisation. There was a whistleblowing policy and information for staff about the duty of candour and the need to be open if an incident occurred where a patient suffered harm. So far there had been no such incidents.

The practice manager held team meetings where staff discussed developments in the practice. Staff were responsible for their own continuing professional development and kept this up to date.

The practice sought feedback from patients through patient text surveys and these were analysed by the organisation. The practice manager had made changes in the practice in response to this feedback.

Mydentist - Town Street - Shepton Mallet

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 4th October 2016. The inspection took place over one day.

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

We reviewed information received from the provider prior to the inspection. We also informed the local Healthwatch and NHS England but we received no information about the practice.

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

Seven people provided feedback about the service. Patients, who completed comment cards, were positive about the care they received from the practice. They were complimentary about the friendly, professional 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

There was an effective system for reporting and learning from incidents. There was an incident reporting procedure with information about never events. Never events are serious incidents that should never happen, for example taking out the wrong tooth. The procedure described how incidents should be recorded and reported. The reporting procedure was on the notice board in the staff room so that staff were aware of how to report accidents and incidents. Staff reported any accidents or incidents to the health and safety team in the organisation who decided whether the incident needed to be reported to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been one accident and no incidents in the practice in the past 12 months. A patient had tripped on the stairs to the car park. Patients rarely used these stairs. The practice had put edging on the stair treads and introduced a procedure for escorting patients if they used the stairs to the car park.

The health and safety team for the organisation received information about all accidents and incidents and analysed and tracked them. The organisation sent quarterly newsletters to all practices with information and learning from incidents in other practices. The practice manager told us that they gave these to staff to read and discussed them in team meetings. We saw minutes of team meetings where health and safety was a regular agenda item. There was a record to show that staff had discussed the accident when a patient fell on the stairs and also ways to prevent further falls in the practice. We saw information from one of the quarterly health and safety meetings with updates to each practice. There was information on the staff room notice board about the duty of candour and what staff needed to do if a patient suffered harm as a result of their treatment. Information about the duty of candour would also be covered in any reporting of a significant event.

Reliable safety systems and processes (including safeguarding)

There was a procedure on the wall in each surgery about what to do if a member of staff had a sharps injury. There had been no such incidents in the practice. The clinical staff we spoke with were aware of the policy. A safe system for syringes was used to minimise the risk of incidents. We saw evidence that staff were immunised against blood borne viruses (Hepatitis B) to ensure the safety of patients and staff.

The practice had policies and procedures for child protection and safeguarding adults. Contact details for the local authority social services were posted on the notice boards in the manager's office. The practice manager was the safeguarding lead for the protection of vulnerable children and adults. We saw records to show that staff completed training about safeguarding adults and children. Staff would raise concerns with the safeguarding lead. There had been no safeguarding issues reported by the practice to the local safeguarding team.

There was a whistleblowing policy which staff could follow if they had concerns about another member of staff's performance. Staff would report concerns to the practice manager or a manager in another practice. There was also a company whistle blowing helpline so that staff could raise a concern in confidence.

There was a process for responding to patient safety alerts. The manager received safety alerts by email from the central operations team that received alerts from the Medicines and Healthcare Regulatory Agency (MHRA) and NHS England. The manager told us that they printed off the alerts and shared them with the team. Staff read them then signed a form to say that they had read and understood them. We noted that there was a regular health and safety agenda item for staff meetings which would include discussion of safety alerts. The manager would make any changes needed as a result of an alert.

Medical emergencies

The practice had arrangements to deal with medical emergencies. Staff had received training in emergency resuscitation and basic life support and this was refreshed every year. We saw certificates for this training. Staff also practiced the procedure for responding to medical emergencies every three months. The staff we spoke with were aware of the practice procedures for responding to an emergency. The practice had emergency equipment in accordance with guidance issued by the Resuscitation Council UK. This included relevant emergency medicines and oxygen and an automated external defibrillator (AED). (An AED is a portable electronic device that analyses life

threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm). There were defibrillator pads for both adults and children. The oxygen cylinder and resuscitation mask were in date. The oxygen cylinder was being routinely checked for effectiveness and we saw records for these daily tests. We noted that there was no sign on the surgery door where it was kept to show that oxygen was stored in that room. We reviewed the contents of the emergency medicines kit. We saw records of weekly and monthly audits of the medicines and equipment and all the emergency medicines were in date. The glucagon injections were not being kept in the fridge, however, the expiry date had been adjusted accordingly to take account of this.

Recruitment and staffing

The practice staffing consisted of one dentist and a trainee dentist, a hygienist, a qualified dental nurse, two trainee dental nurses, two receptionists and a practice manager. The manager told us that two new permanent dentists were being recruited. They said that they had sufficient nurses to support the number of dentists but they had access to other nurses from within the company or they would use agency nurses if they were short staffed.

There was a recruitment procedure recorded on the computer system. This provided information about the appropriate checks that needed to be carried out to ensure new staff were suitable and competent for their role. This included an interview, a review of employment and medical history, checking of qualifications, identification, references and a check of the right to work in the UK. At the previous inspection we made a requirement because checks were not taking place in line with the organisation's recruitment policy. For example, one member of staff had one reference and another had no references. One member of staff also had no Disclosure and Barring check before they started work.

During this visit we found that this requirement had been addressed. We looked at the records of recruitment checks for three staff. Each member of staff had completed an application form. They each had a disclosure and barring service (DBS) check and had a copy of their passport as proof of identity and information about their right to work in the UK. One member of staff had two references, one had one reference from a previous employer and one had a character reference. The manager told us that the head office recruited the dentists and their checks were kept there. However, they could request copies of the dentists' checks to keep in the practice. There was a record of the immunisation status of the nurses and dentists. We saw that appropriate checks of registration with the General Dental Council (GDC) had been carried out for all the qualified staff. There were certificates of qualifications. New staff had an induction and probationary staff had an induction an s

Monitoring Health and Safety and responding to Risk

There were arrangements to deal with foreseeable emergencies. We saw that there was a health and safety policy. The practice had a fire risk assessment and there were certificates showing that the fire alarm system and emergency lighting had been serviced. The practice manger was the fire marshal. There were records of fire drills which showed that a fire evacuation happened about one a year. There were risk assessments for the general risks in the practice. These included the action to be taken to manage risk and were reviewed annually. The practice had a business continuity plan to ensure continuity of care in the event that the practice's premises could not be used for any reason.

There were arrangements to meet the Control of Substances Hazardous to Health 2002 (COSHH) Regulations. There was information from the Health and Safety Executive about COSHH. There were COSHH risk assessments and there were also safety data sheets for hazardous substances and cleaning products.

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

Infection control

There were systems to reduce the risk and spread of infection. One of the dental nurses was infection control lead for the practice. There was a comprehensive infection control policy displayed in the decontamination room and available on the organisation's intranet. Clinical staff were required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. There were good supplies of protective equipment for patients and staff members including gloves, masks, eye protection and

aprons. There were hand washing facilities in the treatment rooms and the toilet. The dentists, nurses and hygienist wore uniforms in the clinical areas and they were responsible for laundering these.

We found that the practice was following relevant guidance about cleaning and infection control. The lead nurse was the designated lead professional for infection control. The manager told us that a cleaner was employed to clean the surgery. At the previous inspection we found that the cleaner was not following the provider's cleaning schedule. At this inspection we noted that cleaning schedules were completed and the practice looked clean throughout. The nurses cleaned the surgeries. One patient we spoke with said that the practice was always clean and hygienic. Four people who provided written feedback said that the environment was always clean and hygienic. Ten people who completed comment cards said that he environment was safe and hygienic.

We examined the facilities for cleaning and decontaminating dental instruments in the decontamination room. The practice had followed the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)' when setting up their decontamination room. In accordance with HTM 01-05 guidance dirty instruments were carried from the surgery to the decontamination room in a designated sealed box to ensure the risk of the spread of infection was minimised.

There was a clear flow from 'dirty' to 'clean.' There were two sinks, one for washing and one for rinsing, and a washer disinfector. The nurse showed us the process for decontamination of instruments. They put on personal protective equipment (PPE) including domestic style rubber gloves. They washed the instruments in the washing bowl after testing the temperature of the water then placed them in the washer disinfector. We noted that there were pools of water near the sinks and washer disinfector. These could possibly be a source of cross-contamination. We brought this to the attention of the practice manager and they took immediate action to put this right. The nurse inspected the instruments for debris under an illuminated magnifying glass, placed them on trays and put them into one of the autoclaves to sterilise. After the sterilisation cycle was complete they took the instruments out of the steriliser to the clean area of the room, put them into date stamped bags and put them into a clean container to take back to the surgery. The nurse also showed us how they cleaned down the surgery between patients and sanitised the surfaces.

The autoclaves were checked daily for their performance, for example, in terms of temperature and pressure. The washer disinfector was also checked and cleaned daily. Logs were kept of the results demonstrating that the equipment was working well. We saw certificates to show that equipment was serviced annually.

Procedures to control the risk of infection were monitored as part of the daily checks and the practice had carried out cross infection audits. At the previous inspection we noted that these were not taking place at the recommended six monthly intervals and the nurse carrying out the audits was not trained in infection control. We noted during this visit that all staff were trained in infection control. An infection control audit took place in April 2016 and this was reviewed after six months to make sure it was still current and the manager monitored infection control every month.

The practice had an on-going contract with a clinical waste contractor. Waste was being appropriately stored and segregated. This included clinical waste and safe disposal of sharps. There was a Legionella risk assessment (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). We saw a log book of monthly checks of the temperatures at the cold and hot water outlets. The nurse showed us how they flushed the dental water lines in accordance with current guidance in order to prevent the growth of Legionella.

Equipment and medicines

We found that the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the sterilising equipment, air compressor, fire equipment and X-ray equipment had all been inspected and serviced. We saw an up-to-date portable appliance testing (PAT) certificate for all electrical items.

Medicines were stored securely in a cupboard and a designated fridge. The temperature of the fridge was monitored and recorded. Prescription pads were locked in the safe and there was a log of all prescriptions. The defibrillator was kept in reception. There was an oxygen cylinder and back up cylinder with up to date certificates.

Are services safe?

Radiography (X-rays)

There was an X–ray unit in each of the surgeries and an orthopantomogram (OPG) which was located in a specific X-ray room and was used for taking a full view of

the patients' teeth and supporting structures. There were suitable arrangements in place to ensure the safety of the equipment. We saw a radiation protection file which contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisors and the necessary records relating to the X-ray equipment. These were the critical examination packs for each X-ray set along with the maintenance logs, Health and Safety Executive (HSE) notification and a copy of the local rules. The local rules describe the operating procedures for the area where x-rays are taken and the amount of radiation required to achieve a good image. Each practice must compile their own local rules for each x-ray set on the premises. The local rules set out the dimensions of the controlled area around the dental chair/patient and state the lowest x-ray dose possible to use. Applying the local rules to each x-ray taken means that x-rays are carried out safely. We saw records of audits of the radiographs.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

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

We found evidence that the practice conducted audits of infection control, radiographs and record keeping. We saw that information about medical history was entered in patient's records and this information was reviewed and updated at every visit. This meant that the dentist is informed of any changes in people's physical health which might affect the type of care they receive. We spoke with one patient who confirmed that their medical history had been recorded and this was updated at every visit.

We saw evidence that the practice kept up to date with the current guidelines and research in order continually to develop and improve their system of clinical risk management. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to referring patients for removal of wisdom teeth and prescribing antibiotics. They also conducted risk assessments for patients to help them to decide appropriate intervals for recalling patients. The dentist and hygienist were aware of the Delivering Better Oral Health Toolkit when considering care and advice for patients.

Health promotion & prevention

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

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

Staffing

There was a practice manager, two dentists, one qualified nurse, two trainee nurses, a dental hygienist, two receptionists and a cleaner. There had been some staffing issues but the practice manager was managing these and was recruiting new dentists. They would also use locums to make sure that they could always deliver their NHS contract. We noted that the hygienist was supported by a dental nurse.

At the previous inspection a requirement was made that staff must receive appropriate appraisal to enable them to carry out the duties they are employed to perform and staff should be monitored to ensure that they receive regular mandatory training at appropriate intervals. This had been addressed.

The practice manager told us that all staff received professional development and training. The company had online training for each job role. We saw the computer records which showed that all the staff had completed training. Courses for all staff included safeguarding, cardio pulmonary resuscitation, medical emergencies, infection control, health and safety, equality and diversity and the Mental Capacity Act 2005 (MCA.) The dentists, hygienist and the nurses were responsible for their own continuing professional development (CPD.) They logged all their training hours online with the General Dental Council (GDC.) A log of CPD was kept in the practice.

The practice manager had recently completed appraisals for the nurses and receptionists. They each had a personal development plan to make sure they had the right skills and training for their job. The permanent dentists had regular peer reviews within the company supported by the Clinical Support Manager.

Working with other services

The practice had suitable arrangements for working with other health professionals to ensure quality of care for their patients. The dentists used a system of onward referral to other providers, for example, for oral surgery, orthodontics or endodontics. Where there was a concern about oral

Are services effective?

(for example, treatment is effective)

cancer a referral was made to the local hospital. We saw referral letters which showed that referral information was sent to the specialist service about each patient, including their medical history and x-rays.

Consent to care and treatment

The practice ensured that valid consent was obtained for all care and treatment. The records showed that the dentists discussed treatment options, including risks and benefits, as well as costs, with each patient. Verbal consent was obtained for private treatment and NHS patients signed the NHS treatment plans. When treatment was needed for younger children the dentist obtained consent from their parents and some older children were able to consent to their own treatment. We spoke with one patient who said that the dentist discussed options for treatment, they were always asked for their consent and they signed the NHS treatment plan.

When we spoke with one of the dentists we found that they had understanding about the Mental Capacity Act 2005 (MCA.) The MCA provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The dentist gave examples of how they would treat a person if they lacked capacity. We found evidence of training about the MCA for the dentists. The dentist was also aware that some older children are competent to make their own decisions about treatment and encouraged children to be involved in decisions about their care. They gave examples of how they involved children in decision making through simple discussion and using visual aids.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patient confidentiality was respected. The practice used an electronic record system. We noted that computer screens in reception were angled so that they could not be seen by patients. There was a confidentiality policy and staff had training about information governance and Data Protection. Patients were afforded appropriate privacy as the treatment room doors were closed during consultations. Discussions about clinical issues took place in the privacy of the surgery. If patients needed to have private discussions about fees and payments they would be offered the use of the manager's office or the staff room. We observed that staff in the practice were polite and respectful when speaking to patients. Patients told us that they were treated with respect.

Patients who completed comment cards, were positive about the care they received from the practice. Patients reported that staff were helpful, and friendly. They said that they provided a very good service. One patient we spoke with said that the dentist and nurse were polite and respectful and 'lovely.' Two other patients said that the dentist and nurse were friendly and 'not scary.'

Involvement in decisions about care and treatment

There were clear NHS treatment plans. Written consent was obtained for the NHS treatment plans showing that people were involved in decisions about their care. One patient we spoke with said that the dentist obtained their consent to treatment and explained treatment to them very clearly so that they could make decisions. The patient records showed that any issues or options for treatment were discussed. As discussed previously, the dentist we spoke with was aware of the MCA and making decisions in people's best interests when obtaining consent to treatment. There was information for staff about the MCA and assessing capacity and staff had received training about the MCA.

Support to patients

The practice manager told us that the dentists would allow extra time if they had an anxious patient. Staff were able to put a marker on the computer system to identify when there was a nervous patient. The receptionists would chat and offer a drink and sometimes they would act as chaperones to offer reassurance. Some anxious patients were referred for treatment under sedation.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system to schedule enough time to assess and meet patients' needs. The practice reserved one appointment slot each day for each dentist to see emergencies. Patients commented that the staff provided a good service. Two patients who provided written feedback said that there was a long wait for available appointments but other patients did not raise this as a concern. One patient told us that it was easy to make an appointment when they wanted one and they were offered a choice of times. They said that appointments ran on time.

The practice actively sought feedback from patients on the care being delivered. We saw evidence that the practice responded to feedback that they received on the NHS Choices website. For example, one patient had said that it was difficult to get through to the practice by phone. The practice had made changes to the telephone system so that the calls were answered more promptly. The practice sent each patient a text message survey after each appointment. Views were collated at head office and they shared the results with each practice in the organisation so they could all learn from feedback. There were feedback cards in reception and staff discussed the feedback in team meetings. The practice had received feedback about availability of appointments and had started to open until 7pm on Mondays and on some Saturday mornings to increase the choice of times for patients.

Tackling inequity and promoting equality

There was an equality and diversity policy and staff training about equality and diversity was included in the safeguarding training. There were some reasonable adjustments in place. There was information in reception about translation services and British sign language. There was a loop system for deaf people. There was level access to the ground floor reception and one of the surgeries and there was a downstairs toilet with facilities for disabled patients.

Access to the service

The opening hours were displayed in reception and on the practice website. Out of hours the practice provided contact information for an emergency helpline and the patient would be seen within 48 hours in the Somerset area. Five out of seven patients who provided feedback told us that they had no difficulty getting appointments. Emergencies were usually fitted in on the day the patient contacted the practice.

Concerns & complaints

There was a procedure about how to make a complaint, including timescales for responding to complaints and the process for investigation. We saw that information about how to make a complaint was displayed in the waiting area. One patient was not aware of the complaints procedure but knew how to make a complaint to the practice manager. They had not needed to complain. Information about concerns and complaints was logged on the computer. We saw records of an ongoing complaint. This showed that the complaints procedure was followed. There was a patient support team who monitored progress with investigation of complaints. The practice manager said that learning from complaints was discussed in practice meetings and we saw minutes to confirm this. These showed that learning points were discussed such as improving how the patient's journey through the practice was managed and staff always being positive and courteous.

Are services well-led?

Our findings

Governance arrangements

The practice had systems for clinical governance. There were audits of infection control, record keeping, radiographs, prescriptions, treatment episodes and referrals to other professionals. Improvements were made when needed and learning was discussed in team meetings.

There were checks of equipment. We saw evidence that the autoclave and compressor were serviced. The nurse told us that they conducted daily checks of the washer disinfector and autoclave and we saw records of these tests in a log book.

We saw that there was a range of policies which were made available to staff on the organisation's computer system.

A requirement was made at the previous inspection that improvements must be made to the systems to assess, monitor and improve the quality of service. Improvements had been made including better communication with staff so that policies and procedures such as cleaning schedules were implemented and auditing of infection control had become more frequent in line with current guidance. Recruitment checks were more thorough to make sure staff were suitable to work with people and training was being monitored to make sure all staff had the required training at the right intervals. Each member of staff had had an appraisal and had a personal development plan to make sure they had the right skills for their job.

Leadership, openness and transparency

The practice manager was the lead professional for the practice and the clinical support manager was the lead for safeguarding. The lead dental nurse was the lead professional for infection control and decontamination. The dentist involved would be the lead professional for medical emergencies. One of the receptionists was the lead for first aid. We saw information for staff about the duty of candour and the need to be open if an incident occurred where a patient suffered harm. So far there had been no such incidents. We saw a whistleblowing policy which was made available to staff. There was a whistleblowing helpline so that staff could discuss a concern in confidence.

Management lead through learning and improvement

The practice manager told us that there were regular team meetings. We saw the minutes of meetings, which showed that staff discussed developments in the practice such as learning from incidents, audits and complaints and patient feedback. The nurse told us that they were responsible for their own continuing professional development and kept this up to date. They said that they also had training within the practice and we saw records to show that relevant training was taking place, for example for safeguarding and health and safety.

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

We saw that patients had posted feedback on the NHS Choices website and the organisation had responded to every comment. The practice used the NHS friends and family test to obtain feedback. There were feedback forms in reception. The practice also sent out text surveys following appointments. Computer generated text messages were sent to patients following their appointments and the computer recorded the responses. This enabled the practice manager to monitor patient satisfaction and make any necessary improvements. For example, following feedback the practice made changes to the availability of appointment times and changed the telephone system so that calls were answered more promptly. Patient feedback was always included on the practice meeting agenda so that staff could learn from feedback.