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Ashbury Dental Care

Inspection Report

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Date of inspection visit: 23 July 2015
Date of publication: 12/11/2015

Overall summary

We carried out an announced comprehensive inspection of Ashbury Dental Care on 23 July 2015 to ask the practice the following five 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

The practice is an independent private practice which provides general and specialist dental treatment for approximately 3,000 patients.

The staff structure of the practice consists of four dentists (all of which are male), one clinical dental technician, two dental nurses, two hygienists one of whom was also a dental therapist, and three receptionists. The practice is open from 8am to 8pm two days a week and 8am to 5.30pm three days a week. The practice is also open on a Saturday morning. Outside of these hours the practice provides emergency cover and has a mutual arrangement with another nearby practice to provide support.

We spoke with four patients who used the service on the day of our inspection and reviewed 21 Care Quality Commission (CQC) comment cards that had been completed by patients prior to the inspection. The patients we spoke with were complimentary about the service. They told us they found the staff to be friendly and informative. They felt they were treated with respect. The comments on the CQC comment cards were also very complimentary about the staff and the service provided. During the inspection we spoke with five members of staff, including the principal dentist.

The principal dentist is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'.

Summary of findings

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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

There were systems in place to help ensure the safety of staff and patients. These included policies for safeguarding children and adults from abuse, maintaining the required standards of infection prevention control and maintenance of equipment used at the practice and the maintenance of the premises itself. The practice assessed risks to patients and managed these well. We found training and equipment to respond to medical emergencies. In the event of an incident or accident occurring, the practice documented, investigated and learnt from it. The practice followed procedures for the safe recruitment of staff, this included carrying out Disclosure Barring Service (DBS) checks, and obtaining references.

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

The practice followed guidance issued by National Institute for Health and Care Excellence (NICE) for example, in regards to prescribing antibiotics and dental recall intervals. Patients were given appropriate information to support them to make decisions and obtain informed consent for the treatment they received. The practice kept detailed dental care records of treatments carried out and monitored any changes in the patient's medical and oral health.

Staff were supported by the practice in continuing their professional development (CPD) and were meeting the requirements of their professional registration. Records showed patients were given health promotion advice appropriate to their individual oral health needs such as smoking cessation and dietary advice.

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

The patients we spoke with told us they were treated with dignity and respect. They told us that staff were kind, informative and attentive to their needs. Comment cards were very positive about the service provided by the practice. We observed that staff treated patients with kindness and respect and were aware of the importance of confidentiality.

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 at the practice and emergency appointments were available on the same day. There was sufficient well maintained equipment, to meet the dental needs of the practice patient population. There was a complaints policy clearly publicised in the reception area. We saw that the practice responded to complaints in line with the complaints policy and had a proactive approach to seeking and responding to feedback and complaints.

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

Summary of findings

The principal dentist had a clear vision for the practice that was shared by the staff. Staff felt supported by the principal dentist and there were regular meetings where staff were given the opportunity to give their views of the service. There were good governance arrangements and an effective management structure. Appropriate policies and procedures were in place, and there was effective monitoring of various aspects of care delivery. Staff guidance was provided via policies

and procedures distributed on the company's intranet service. There was provision for induction and training for staff.

Ashbury Dental Care

Detailed findings

Background to this inspection

We carried out an announced inspection on 23 July 2015. This inspection was led by a CQC Inspector and a dental specialist advisor.

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.

We informed the NHS England area team that we were inspecting the practice; however we did not receive any information of concern from them. The practice sent us their statement of purpose and a summary of complaints they had received in the last 12 months. We also reviewed further information on the day of the inspection.

We spoke with four patients who used the service on the day of our inspection. We reviewed 21 Care Quality Commission comment cards that had been completed by patients prior to the inspection. We also spoke with five members of staff, including the principal dentist. We reviewed the policies, toured the premises and examined the cleaning and sterilisation of dental equipment.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Staff understood their responsibilities to raise concerns, to record safety incidents and near misses, and reported them internally and externally where appropriate.

There was a clear understanding and reporting of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) and COSHH (Control of Substances Hazardous to Health). There had been no reportable incidents in the last 12 months. There was a nominated health and safety lead for the service.

The practice complied with relevant patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Authority (MHRA) and through the Central Alerting System (CAS). Minutes showed that a clinical governance meeting took place every month which discussed these items and provided staff with the necessary information and actions to take.

Reliable safety systems and processes (including safeguarding)

There were reliable safety processes in place. These included systems which ensured the safe use of rubber dams (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). Rubber dams used by the practice were made of a latex free material, in order to safeguard against latex allergies. The use of latex and its potential allergenic properties had been risk assessed and as a result of this all gloves used in the practice were latex free nitrile type gloves to further reduce the risk to staff and patients.

Risk assessments had been undertaken for issues affecting the health and safety of staff and patients using the service. This included for example use of radiography equipment, sharps storage and security of the premises.

The safeguarding policy had been reviewed annually and most recently in June 2015 and contained up to date contact details of the local authority and other relevant agencies. Safeguarding guidance was also displayed in both of the treatment rooms. Staff knew how to identify report and respond to suspected or actual abuse.

Staff understand the reporting system for raising concerns, such as safeguarding, whistleblowing, complaints and felt confident to do so and, fulfil their responsibility to report concerns. One of the dentists was a vulnerable adult safeguarding lead at the practice and another member of staff was the child safeguarding lead. Both of these had received level three safeguarding training which met current practice. All staff had received safeguarding training as part of their mandatory annual training.

During our visit we found that the dental care and treatment of patients was planned and delivered in a way that ensured patients' safety and welfare. Dental care records contained patient's medical history that was obtained when people first signed up at the practice and was updated every time patients visited the practice for a check-up or treatment. The dental care records we saw were well structured and contained sufficient detail enabling another dentist to know how to safely treat a patient.

Medical emergencies

There were arrangements in place to deal with on-site medical emergencies. Staff had received emergency first aid training. The practice had a medical emergency kit which included emergency medicines and equipment. We checked the medicines and we found that all the medicines were within their expiry date. The emergency equipment including an automated external defibrillator (AED – a device used to restart a patient's heart in the event of a cardiac arrest) and oxygen. Staff had been trained to use the emergency equipment. There was a system in place for checking the medical emergency kit. This included checking the expiry dates of medicines in the kit.

The practice complied with the guidance for emergency equipment recommended by the Resuscitation Council UK and with the guidance on emergency medicines from the British National Formulary (BNF).

Medical alerts and National Institute for Health and Care Excellence (NICE) updates had been shared with staff. For example, the minutes of staff meetings had discussed NICE guidance regarding drug allergy diagnosis, the management of drug allergy in adults, children and young people and different oral health approaches.

Staff recruitment

Are services safe?

The practice had a policy for the safe recruitment of staff. We looked at two staff files. We saw that appropriate background checks had been completed prior to recruitment. Employment contracts and photographic proof of identity and proof of address were on file. Disclosure Barring Service background checks (DBS) had been completed. It was the dental practice's policy to request a DBS check for all staff. The Disclosure and Barring Service (DBS) 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.

Staff files also included training, registration updates, employment history, absences, appraisals and correspondence. There were sufficient numbers of suitably qualified and competent staff.

Monitoring health & safety and responding to risks

The practice had arrangements in place to deal with foreseeable emergencies. A Health and Safety Policy was in place. The practice had a risk management process which was continually being updated and reviewed to ensure the safety of patients and staff members. For example, we saw risk assessments for fire safety, manual handling, use of visual display screens and environmental building issues. The assessments were reviewed annually and included the controls and actions to manage risks.

The practice had a comprehensive business continuity plan to deal with emergencies that could disrupt the safe and smooth running of the service. The plan covered what to do in the event of computer failure, fire or staffing issues. The plan included contact details of who to contact in event of an incident that affected the continuity of the business.

Risks to safety from service developments and disruption were assessed, planned for, and managed in advance. There were systems in place to report physical hazards or defects and ensure they were followed up promptly by a maintenance contractor. For example, the cistern on the staff toilet had broken once in the past and had overflowed. Signage was displayed and the defect reported. The cistern was fixed within two days. The practice had cones and signage for the car park in the event of adverse weather conditions.

Fire alarms were tested weekly. A fire evacuation drill was undertaken annually. A fire assessment audit had taken place in April 2015. The findings of this audit had been implemented. These findings included the use of emergency torches in case of power failure in addition to the already installed emergency lighting. The practice had portable fire extinguishers available and there were auto fire extinguishers in vulnerable electrical areas such as computer server cabinets.

Infection control

The Department of Health published in November 2009 a document called Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05). It was up-dated in 2013. It set out in detail the processes and practices essential to prevent the transmission of infections and provide clean safe care.

Premises and equipment were clean, secure, properly maintained and kept in accordance with current legislation and guidance such as HTM 01-05 and National Patient safety Agency (NPSA) guidance. For example, the practice demonstrated they had followed the safe sharps directive to keep patients and staff safe.

The practice had a dedicated decontamination room in line with HTM01-05, which was used to sterilise all equipment used during patient consultations.

There was a lead dental nurse who was responsible for infection control who showed us the cleaning process for instruments. There was a flow of work which was meant to ensure that once cleaned, instruments would not be recontaminated. The room had a red, amber and green lighting system which helped to remind staff of the dirty (red) to clean (green) areas in this well lit room.

We saw that staff moved items in accordance with the correct direction of flow. Lidded boxes of dirty instruments were brought from treatment rooms and placed on a work surface to the right of the washer disinfector, then placed in the machine for its cleaning cycle. Then staff brought them out and put them on the correct side of the washer disinfector, where an illuminated magnifying lamp was fitted.

Staff checked each item under this lamp and if there was no visible debris, placed them on trays and put them in the autoclave to be sterilised. After this, they placed them on a work top in the clean area of the room and did not return them to the dirty side.

Are services safe?

Staff bagged the sterilised instruments and stamped them with the date of expiry. All the packs we saw were within their expiry date. We saw there had been a daily audit of expiry dates. The clinical waste bins had been placed in the dirty area of this system in order to protect the cleanliness of the room. Staff carried out daily checks on the machines to ensure they were working effectively. Any problems were reported to the registered manager and an engineering contractor summoned. We saw that responses from them were prompt and effective.

The practice used an Infection control audit template recommended by the infection prevention society (IPS) the last such audit had been completed in July 2015 achieved an overall score of 86%. The practice had a schedule in place to repeat the audit every six months in line with Department of Health recommendations. Actions from the audit included the removal of a laboratory storage area from one area of the decontamination room into a dedicated laboratory.

Guidance from the Department of Health currently stated that decontamination processes in dental practices should be audited every six months. The next audit was planned to take place in December 2015. This showed that recommendations set down by the Department of Health in HTM01-05 were being followed.

Cleaning contractors carried out cleaning duties at the practice. They cleaned the toilets, communal areas and floors of the entire practice. Signed off cleaning schedules showed that this took place on a daily basis when the practice was closed. Dental nurses cleaned clinical work surfaces and the decontamination room. Written cleaning schedules were also in place for this and showed they were being followed.

We observed the practice was clean and tidy. Cleaning equipment and materials were stored appropriately in line with Control of Substances Hazardous to Health (COSHH)Regulations. COSHH is the law that requires employers to control substances that are hazardous to health.

The dental water lines were maintained in accordance with current guidelines to prevent the growth and spread of Legionella bacteria. Flushing of the water lines was carried out in accordance with current guidelines and supported by an appropriate practice protocol. A weekly legionella risk assessment had been carried out and documentary evidence was provided to support this. Legionella is a germ found in the environment which can contaminate water systems in buildings.

There were hand washing facilities in each treatment room and staff had access to good supplies of personal protective equipment (PPE), such as gloves and masks for patients and staff members. Staff and patients we spoke with confirmed that staff wore protective aprons, gloves and masks during assessment and treatment in accordance with infection control procedures.

Equipment and medicines

The practice met the requirement of relevant legislation to ensure that the premises and equipment had been properly purchased, used and maintained such as Sharps regulations 2013, HTM 07-01 (healthcare waste). There was a waste contractor in place, which included a contract for clinical waste.

We found that all of the equipment used in the practice was maintained in accordance with the manufacturer's instructions. This included the equipment used to clean and sterilise the instruments and X-ray equipment. Portable appliance testing (PAT) was completed in accordance with good practice guidance. There were no other medicines stored on the premises apart from the ones in the emergency kit.

There were sufficient quantities of instruments/equipment to cater for each clinical session which took into account the decontamination process.

Radiography (X-rays)

The practice maintained suitable records in the radiation protection file demonstrating the maintenance of the x-ray equipment. The practice had a radiation protection supervisor (RPS). They were named on x-ray guidance information in each of the three surgery rooms. X-ray audits were undertaken on a weekly basis.

The audits looked at issues such as the maintenance of X-ray equipment, quality of images and the radiography training staff had undertaken. This was done to ensure X-rays that were taken were of the required standard. We saw there were continuous professional development (CPD) records related to radiography for all staff that undertook radiography tasks.

Are services safe?

The practice met the requirement of relevant legislation to ensure that premises and equipment were properly purchased, used and maintained such as, Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

Routine checks on radiography equipment were carried out. Daily routine tests had been performed to ensure images were being read correctly by the X-ray scanner. Equipment had been serviced and maintained.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept detailed electronic and paper records of the care given to patients. We reviewed the information recorded in patients' dental care records about the oral health assessments, treatment and advice given to patients. We found these were comprehensive and included details of the condition of the teeth, soft tissues lining the mouth and gums. These were repeated at each examination in order to monitor any changes in the patient's oral health. Patients were asked about any changes to their medical history each time they visited the practice for a check-up or treatment. This was captured electronically on the patient's record.

Records showed assessment of the periodontal tissues was undertaken and recorded using the basic periodontal examination (BPE) screening tool. (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). BPE scores were noted in the records and the dentist planned treatment around the score that was achieved.

The practice kept up to date with current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, the dentists used current National Institute for Health and Care Excellence (NICE) guidelines to assess each patient's risks, needs and to determine how frequently to recall them for checks.

Staff told us that discrimination on the grounds of age, disability, gender reassignment, pregnancy and maternity status, race, religion or belief were avoided when making care and treatment decisions.

Health promotion & prevention

Patients medical histories were updated regularly which included questions about smoking and alcohol intake. Appropriate advice was provided by staff to patients based on their response to the questionnaire. We saw the practice provided preventive care advice on tooth brushing and oral health instructions as well as smoking cessation, fluoride application, alcohol use, and dietary advice.

The practice had participated in an oral health outreach programme to local schools. Dentists from the practice visited the local school three times a year to provide presentations on oral hygiene, healthy teeth and healthy mouths. The practice offered free examinations up to the age of six and half price up to the age of eighteen. The principal dentist worked closely with the youth liaison officer who worked for the local church and provided oral health presentations when requested.

The practice worked closely with local care providers. The practice provided free training to local care staff on oral health. The practice supported the older persons information day which is an event for older people. Dentists from the practice attended this event annually and provided a presentation on oral health and a question and answer session.

Staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. Staff attended the Exeter Continuing Professional Development Group on a quarterly basis. Dentists had attended the British Dental Association conferences over the last few years. This covered oral cancer updates, safeguarding, and periodontal monitoring. In June 2014 many of the staff had attended a national dentistry event; the practice had provided the time and resources for its staff to attend.

Staff were supported to deliver effective care through opportunities to undertake training, learning and development and through meaningful and timely supervision. Staff had received annual appraisals from their line managers. The principal dentist carried out nurses and dentist's appraisals.

The learning needs of staff had been identified. One dental nurse told us that they had been provided with the time and resources to complete a conscious sedation course in London.

The practice maintained a programme of professional development to ensure that staff were up to date with the latest practices. This was to ensure that patients received high quality care as a result. The practice used a variety of ways to ensure development and learning was undertaken including both face to face and e-learning. Examples of staff training included core issues such as health and safety, safeguarding, radiography, medical emergencies and infection control. We reviewed the system in place for

Are services effective?

(for example, treatment is effective)

recording training that had been attended by staff working within the practice. We also reviewed information about continuing professional development (CPD) and found that staff had undertaken the required number of CPD hours.

Working with other services

Effective arrangements were in place for working with other health professionals to ensure quality of care for the patient. The service worked closely with the local school, church and local care providers to offer guidance and presentations on oral health.

There were clear guidelines for referring patients to specialist colleagues based on current guidelines. The practice had referred patients to special care general anaesthetic services. This included patients protected under the Mental Capacity Act 2005 (MCA) The MCA is a legal framework which protects patients who need support to make important decisions.

When people had been referred to another dental service, such as referral to the local hospital for general anaesthesia, all information that was needed to deliver their on-going care was appropriately shared in a timely way.

Consent to care and treatment

Patients' who used the service were given appropriate information and support regarding their dental care and treatment. We spoke with four patients who used the service and reviewed 21 comments cards. Patients told us they had been given clear treatment options which were discussed in an easy to understand language by practice staff. Patients told us they understood and consented to treatment. This was confirmed when we reviewed patient records and found signed consent forms for treatments.

Practice dentists had received training on the MCA and had talked with staff about implications it had for staff and patients. Staff were aware of how they would support a patient who lacked the capacity to consent to dental treatment. They explained how they would involve the patient and carers to ensure that the best interests of the patient were met. This meant where patients did not have the capacity to consent, the dentist acted in accordance with legal requirements and that vulnerable patients were treated with dignity and respect.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patients were treated with kindness, dignity, respect and compassion while they received care and treatment.

We spoke with families during our inspection who told us the dentists were experienced in dealing with children and were very patient and considerate. The dentists told us they deployed various strategies such as providing children with stickers, offering flavourless toothpaste, using background music, and providing more time for patients according to individual need.

Both of the two treatment rooms had a visual display unit available. These units enabled the dentist to show patients photographs of the inside of their mouths, X ray photographs and allowed images to be enlarged to assist explanations of care and treatment.

The practice had access to a language line telephone translation service to assist communication with any patients who found it difficult to communicate in English. The practice had links with a local school for the deaf and had developed an oral hygiene promotion scheme targeted at deaf patients.

The reception desk was separate to the waiting room. Staff told us that if patient's wished to speak in private there were rooms available. The practice was very aware of patient confidentiality. Patients we spoke with confirmed this. During our visit we saw that the waiting room often contained no more than one patient waiting for their appointment. We saw that treatment room doors were always closed when a patient was receiving treatment.

Staff took time to interact with patients and those close to them in a respectful, appropriate and considerate manner.

Staff recognised and respected people's diversity, values and human rights. Staff had received equality and diversity training on an annual basis.

Patients told us that staff were sympathetic and caring towards them to ensure that patients who used services, and those close to them, received the support they needed to cope emotionally with their care and treatment. During our inspection we noticed that patients knew staff well and there was much friendly interaction between patients and staff. Patients reported that staff responded to pain, distress and discomfort in a timely and appropriate way.

Involvement in decisions about care and treatment

The practice displayed information in the reception area that gave full details of dental charges. We also saw that the practice had a website that included information about dental care and treatments, costs and opening times. The website also contained information regarding how patients could access emergency dental care if required; this information was also available in the patient information leaflet located in the reception area.

Staff told us that treatments, risks and benefits were discussed with each patient to ensure the patients understood what treatment was available so they were able to make an informed choice. The dentist explained what they were going to do and used aids such as models of teeth and 3D demonstrations which could be displayed on visual display units in both treatment rooms to show patients visually what their teeth or oral cavity required. They were also shown this on a radiograph (x ray) where applicable. Patients were then able to make an informed choice about which treatment option they wanted. Written treatment plans had been provided.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patient's needs

Services were planned and delivered to meet the needs of patients. The facilities and premises were appropriate for the services that were planned and delivered. Dentists told us where patients asked for particular music to be played, the practice provided this via their modern surround sound system during treatment.

One dental nurse was undergoing training at the practice. They told us they felt fully supported by the practice. A dental technician was also receiving training at the practice. He was working towards a Royal College of Surgeons recognised qualification.

Appointment times were scheduled to ensure people's needs and preferences (where appropriate) are met. The service was open 8am – 8pm Tuesdays and Wednesdays. On Mondays, Thursdays and Fridays 8am – 5.30pm. On Saturdays the service was open 9am until 2pm.

The practice made reasonable adjustments for patients such as to the environment, choice of dentist or treatment options to enable people to receive care and treatment.

The practice took into account the needs of different people on the grounds of age, disability, sex, gender reassignment, race, religion or belief, sexual orientation, pregnancy and maternity. The practice had an equal opportunities policy which had been reviewed within the last 12 months.

There was evidence that the provider gathered the views of patients when planning and delivering services, for example the practice spoke to its patients about feedback methods. There was a comments box in the waiting room.

The practice carried out a Friends and Family survey on a monthly basis. Results showed that 100% of patients would recommend the service. There was also a feedback form available on the website with the facility to provide anonymous feedback should patients wish to do so.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services that included access to telephone translation services. All leaflets were available in electronic format which could be produced in larger font format or in braille format, with key dental treatments and phrases in a number of different languages that they used to communicate with patients whose first language was not English. The building was accessible to wheelchair users and the practice had a wheelchair.

Staff were able to describe to us how they had supported patients with additional needs such as a learning disability or those who were wheelchair users. For example, dental chairs had the facility to assist wheelchair users to easily transfer onto the treatment chair. There were pictures, easy to understand diagrams and models available which dentists used to explain treatment options to patients.

Access to the service

Patients could access care and treatment in a timely way. Waiting times, cancellations and delays were minimal. The practice had level access and was entirely based on the ground floor.

Waiting room chairs were robust, comfortable, of varying heights and had arms for support. There were different sized chairs in the waiting room and in a treatment room. There was a patient's toilet which had disabled access.

There was currently no hearing aid induction loop in place at reception. Reception staff informed us that they would use written means to communicate if required, in larger font sizes. A language translation line service was available.

Patients had timely access to urgent treatment. Staff told us they always saw urgent cases within 24 hours at the latest. There was time set aside to cope with emergency appointments. During the inspection, two patients attended for emergency treatment. They were seen by a dentist on the same day.

Patients reported that they were aware of how they can access emergency treatment, including out of normal hours. This information was displayed on the front door and on the website.

Concerns & complaints

The complaints procedure was displayed in the reception area with details of how to escalate a complaint should a patient wish to do so. There were policies in place which ensured patients were told when they were affected by something that goes wrong, given an apology and informed of any actions taken as a result. This showed that the provider met their duty of candour.

Are services responsive to people's needs?

(for example, to feedback?)

Patient's concerns and complaints were listened and responded to, and used to improve the quality of care. There was a complaints system in place, which was publicised, accessible, understood by staff and patients who used the service.

There was openness and transparency in how complaints were dealt with. There had been one complaint in the past 12 months. We saw an example of how a complaint had been dealt with. The patient had been satisfied with the outcome.

Information was provided about the steps people can take if they were not satisfied with the findings or outcome once the complaint has been responded to.

Are services well-led?

Our findings

Governance arrangements

The principal dentist undertook quality audits at the practice. This included audits on X rays, health and safety, infection control and dental care records. We saw that action plans had been drafted following audits and actions taken as necessary.

The practice had a clear vision and objectives which were displayed in the patient waiting area and in staff areas. This was displayed on the practice website. This was to provide 'a state of the art dental practice where the practice strived to provide the highest standards of care and service'. The vision was to create a happy and welcoming environment for both staff and patients where patients felt relaxed and staff enjoyed coming to work. The practice appreciated that all patients were individuals and should be treated as such.

The practice consisted of the principal dentist, three other dentists, two hygienists and two practice nurses, a practice manager and reception staff. The practice had completed meetings with minutes and an agenda. The practice had significant incident forms which were completed and discussed with relevant staff.

Staff were supported and managed and were clear about their lines of accountability. There was an effective approach for identifying where quality and/or safety was being compromised and steps were taken in response to issues. These include audits of radiological images, clinical notes, legionnaires' disease, infection prevention and risks, incidents and near misses and autoclave checks.

Leadership, openness and transparency

The leadership and culture reflected the practice vision and values, encouraged openness and transparency and promoted delivery of high quality care. Staff told us that the culture of the practice encouraged this positive environment. A whistle blowing policy was in place and staff we spoke with knew where to find it.

Policies and procedures about all aspects of the work of the practice were available to all staff on a paper system. This included admin quick guides, clinical governance and the results of audits.

Dentists at this small practice spoke together on a daily basis and discussed any issues arising on an informal basis. These were recorded electronically on emails but not formally with a written agenda and minutes. Any shared learning points were shared with the rest of the team via email and verbally. For example, where a security issue had arisen over leaving windows open overnight this had been addressed and guidance discussed with all staff.

The provider had systems in place to support communication about the quality and safety of services and what actions have been taken as a result of concerns, complaints and compliments.

Candour, openness, honesty and transparency and challenges to poor practice were the norm.

Management lead through learning and improvement

Quality assurance was used to encourage continuous improvement. The practice monitored its activity via a quality assurance policy which was shared with all staff.

Audit processes functioned well and had a positive impact in relation to quality governance, with clear evidence of action to resolve concerns. Audits included a radiography audit on a weekly basis. Findings had been compared with previous audits. The audit had found that some images needed improvement and appropriate action taken where necessary.

Record keeping audits had been completed on an annual basis, within the last 12 months to ensure patient details were up to date. Financial audit had been undertaken June 2015 to ensure accuracy of patient financial payments.

Each patient had a signed treatment plan with a consent form, audited every 12 months. Patients protected under the Mental Capacity Act 2005 (MCA) had received support from their guardian or Independent Mental Capacity Advocate (IMCA) in best interest meetings.

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

The practice had gathered feedback from patients and their own feedback forms. We were shown examples of where patients had made comments on the website. All of the feedback was very positive.

Patients who used the service, the public and staff were engaged and involved. There was a feedback box in the

Are services well-led?

waiting room with blank forms and pens. We looked at 21 Care Quality Commission comments cards during our visit and saw that patients had made entirely positive comments about the practice and the staff.

The provider had processes in place to actively seek the views of patients who used the service and those close to them, and was able to provide evidence of how they took these views into account in any related decisions. For example, The service provided up to date magazines, drinks and a boot scraper at the front door, all in response to patient suggestions.

Staff reported that the provider valued their involvement and that they felt engaged and said their views were reflected in the planning and delivery of the service. Staff feedback had been received positively. The practice had a book in the office marked “Bright Ideas” for staff feedback. The practice had acted upon this feedback by providing compliment slips, information sheets about conscious sedation, keeping a “diabetic box” at reception containing biscuits, orange juice and glucose tablets to support diabetic patients in an emergency.