Drs Prince and Hansson

Glen Lea Dental Suite

Inspection Report

20 York Road
Wetherby
West Yorkshire
LS22 6SL
Tel: 01937 583 502
Website: www.glenleadental.co.uk

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Overall summary

We carried out an announced comprehensive inspection on 10 May 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

Glen Lea Dental Suite is situated in Wetherby, West Yorkshire. It offers mainly NHS treatment to patients of all ages but also offers private dental treatments. The services include preventative advice and treatment, routine restorative dental care and dental implants.

The practice currently has three surgeries, a decontamination room, a waiting area and a reception area. All facilities are on the ground floor of the premises. There are accessible toilet facilities on the ground floor of the premises. The practice is currently undergoing renovation to add an extra surgery and a dental laboratory.

There are four dentists, one dental hygiene therapist, six dental nurses (including one trainee), one receptionist and a practice co-ordinator.

The opening hours are Monday to Wednesday and Friday from 8-30am to 6-00pm, Thursday from 8-30am to 7-00pm and Saturday from 8-30am to 1-00pm.

One of the practice owners is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. 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.

Summary of findings

During the inspection we received feedback from 45 patients. The patients were positive about the care and treatment they received at the practice. Comments included that the premises were clean and hygienic and that staff were friendly, reassuring and helpful. Patients also commented that the advice provided was genuine and pertinent.

Our key findings were:

- The practice had systems in place to assess and manage risks to patients and staff including infection prevention, control and health and safety and the management of medical emergencies.
- Staff were qualified and had received training appropriate to their roles.
- Dental care records were detailed and showed that treatment was planned in line with current best practice guidelines.
- Oral health advice and treatment were provided in-line with the 'Delivering Better Oral Health' toolkit (DBOH).
- We observed that patients were treated with kindness and respect by staff.
- Patients were able to make routine and emergency appointments when needed.
- The practice had a complaints system in place and there was an openness and transparency in how these were dealt with.
- There were clearly defined leadership roles within the practice and staff told us that they felt supported, appreciated and comfortable to raise concerns or make suggestions.

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

- Review the arrangement for the disposal of out of date medical emergency drugs.
- Review the process for documenting where risks and benefits have been discussed with regards to treatment options.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

Staff told us they felt confident about reporting incidents, accidents and the notifications which need to be made to the CQC.

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

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

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

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

Are services effective?

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

Patients' dental care records provided comprehensive information about their current dental needs and past treatment. The practice monitored any changes to the patient's oral health and provided treatment when appropriate.

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

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

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

Are services caring?

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

During the inspection we received feedback from 45 patients. Common themes were that patients felt they were treated with dignity and respect. Patients also commented that staff were friendly, reassuring and helpful.

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

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

Are services responsive to people's needs?

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

Summary of findings

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

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

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

The practice had made reasonable adjustments to enable patients in a wheelchair or with limited mobility to access treatment.

Are services well-led?

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

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

Effective arrangements were in place to share information with staff by means of practice meetings which were well minuted for those staff unable to attend.

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

They conducted annual patient satisfaction surveys, post-implant treatment questionnaires and were currently undertaking the NHS Friends and Family Test (FFT) for patients to make suggestions to the practice.

Glen Lea Dental Suite

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

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

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

During the inspection we received feedback from 45 patients. We also spoke with two dentists, the dental hygiene therapist, two dental nurses and the practice co-ordinator. To assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had clear guidance for staff about how to report incidents and accidents. Staff described an incident which had occurred in the last year and this had been well documented, investigated and reflected upon by the dental practice. We saw that this incident had been discussed at a staff meeting and staff had been made aware of steps to prevent it from occurring again.

The registered manager understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR) and the notifications which need to be made to the CQC. .

The practice received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) that affected the dental profession. We saw evidence that any alerts which came through were discussed with all staff to ensure learning was disseminated appropriately.

Reliable safety systems and processes (including safeguarding)

The practice had child and vulnerable adult safeguarding policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff. Staff had access to contact details for both child protection and adult safeguarding teams. The registered manager was the safeguarding lead for the practice and all staff had undertaken level two safeguarding training.

The practice had systems in place to help ensure the safety of staff and patients. These included the use of a re-sheathing device, a protocol whereby only the dentists or the dental hygiene therapist handle sharps and guidelines about responding to a sharps injury (needles and sharp instruments).

Rubber dam (this is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth) was used in root canal treatment in line with guidance from the British Endodontic Society.

Medical emergencies

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

We noted that the emergency drugs were stored in a three drawer unit. We noted that out of date emergency medicines were also stored in one of the drawers. We were told that these medicines were being kept for training purposes to allow staff to practice opening vials of medicines. In the event of an emergency these could potentially be used inadvertently. This was brought to the attention of the practice owners and we were told that these would be disposed of.

The emergency resuscitation kits, oxygen and emergency medicines were stored in one of the surgeries. Staff knew where the emergency kits were kept. The practice had an Automated External Defibrillator (AED) to support staff in a medical emergency and this was stored in the decontamination room. (An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm).

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

Staff recruitment

The practice had a policy and a set of procedures for the safe recruitment of staff which included seeking references, proof of identity, checking relevant qualifications and professional registration. We reviewed a sample of recruitment files and found the recruitment procedure had been followed. The registered manager told us they carried out Disclosure and Barring Service (DBS) checks for all newly employed staff. These checks identify whether a person has a criminal record or is on an official list of

Are services safe?

people barred from working in roles where they may have contact with children or adults who may be vulnerable. We reviewed records of staff recruitment and these showed that all checks were in place.

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

Monitoring health & safety and responding to risks

A health and safety policy and risk assessment was in place at the practice. This identified the risks to patients and staff who attended the practice. The risks had been identified and control measures put in place to reduce them. We saw that the practice manager carried out an annual health and safety audit of the premises to ensure that any risks were identified and managed. This included checks on the general upkeep of the building, electrical safety and checks on workstations.

There were policies and procedures in place to manage risks at the practice. These included infection prevention and control, fire evacuation procedures and risks associated with Hepatitis B. We saw that the practice conducted and monthly fire checks to ensure that any risks were appropriately managed. They conducted fire drills on an annual basis and fire equipment was serviced on an annual basis. We saw the practice had undertaken a risk assessment whilst they were having renovation work done to the practice. This involved ensuring that patients did not enter any areas where building work was being undertaken. We felt that this was a proactive and insightful approach to risk management.

The practice maintained a file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including substances such as disinfectants, and dental materials in use in the practice. The COSHH folder was also available on any of the computers within the practice. The practice identified how they managed hazardous substances in its health and safety and infection control policies and in specific guidelines for staff, for example in its blood spillage and waste disposal procedures. Any new materials or substances would be added to the COSHH folder and staff would be made aware of any particular precautions associated with it.

Infection control

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

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

We observed the treatment rooms and the decontamination room to be clean and hygienic. Work surfaces were free from clutter. Staff told us they cleaned the treatment areas and surfaces between each patient and at the end of the morning and afternoon sessions to help maintain infection control standards. There was a cleaning schedule which identified and monitored areas to be cleaned and staff signed a log book to confirm this had been done. We saw evidence of daily, weekly and monthly cleaning schedules for each surgery.

There were hand washing facilities in the treatment room and staff had access to supplies of personal protective equipment (PPE) for patients and staff members. Posters promoting good hand hygiene and the decontamination procedures were clearly displayed to support staff in following practice procedures. Sharps bins were appropriately located, signed and dated and not overfilled. We observed waste was separated into safe containers for disposal by a registered waste carrier and appropriate documentation retained.

Decontamination procedures were carried out in a dedicated decontamination room in accordance with HTM 01-05 guidance. An instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which minimised the risk of the spread of infection. Colour coded boxes were used to ensure clean and dirty instruments were not mixed up.

One of the dental nurses showed us the procedures involved in disinfecting, inspecting and sterilising dirty instruments; packaging and storing clean instruments. The practice manually scrubbed the used instruments,

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examined them visually with an illuminated magnifying glass, and then sterilised them in a validated autoclave (a device for sterilising dental and medical instruments). The decontamination room had clearly defined dirty and clean zones in operation to reduce the risk of cross contamination. Staff wore appropriate PPE during the process and these included disposable gloves, aprons and protective eye wear.

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

The practice had carried out the self- assessment audit in March 2016 relating to the Department of Health's guidance on decontamination in dental services (HTM01-05).This is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. The audit showed the practice was meeting the required standards. This had been completed every six months in accordance with HTM 01-05 guidance.

Records showed a risk assessment process for Legionella had been carried out and was reviewed on an annual basis by an external company (Legionella is a term for particular bacteria which can contaminate water systems in buildings). The practice undertook processes to reduce the likelihood of legionella developing which included running the water lines in the treatment rooms at the beginning and end of each session, monitoring cold and hot water temperatures each month, the use of a water conditioning agent in the water lines and quarterly tests on the on the water quality to ensure that Legionella was not developing. The registered manager was fully aware that a new Legionella risk assessment would be needed once the refurbishment work had been completed.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as X-ray sets, the autoclaves and the compressor. The practice maintained a comprehensive list of all equipment including dates when maintenance contracts which required renewal. We saw evidence of validation of the autoclaves. A new compressor had recently been installed and we saw evidence that it had a written scheme of examination in accordance with the • Pressure Systems Safety Regulations 2000.

Portable appliance testing (PAT) had been completed in February 2016 (PAT confirms that portable electrical appliances are routinely checked for safety).

Prescriptions were stamped only at the point of issue and were kept locked away when not needed to ensure their safe use. The practice kept a log of all prescriptions given to patients which enabled the practice to audit the provision of prescriptions. The practice also dispensed antibiotics for private patients. These were kept locked away and a log was kept of when each type of antibiotic was prescribed. This meant that there was an effective stock control system.

Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. Records we viewed demonstrated that the X-ray equipment was regularly tested and serviced. A Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure that the equipment was operated safely and by qualified staff only. We found there were suitable arrangements in place to ensure the safety of the equipment. Local rules were available in all surgeries and within the radiation protection folder for staff to reference if needed. The local rules identified which staff were allowed to undertake roles with regards to radiography. These included referrer, operator and practitioner. We saw that a justification, grade and a report was documented in the dental care records for all X-rays which had been taken.

X-ray audits were carried out every year. This included assessing the quality of the X-rays which had been taken. The results of the most recent audit undertaken confirmed they were compliant with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

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

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

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

The practice used current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, following clinical assessment, the dentists followed the guidance from the FGDP before taking X-rays to ensure they were required and necessary. Justification for the taking of an X-ray, quality assurance of each x-ray and a detailed report was recorded in the patient's care record.

Health promotion & prevention

It was clearly evident that the practice had a strong focus on preventative care and supporting patients to ensure better oral health in line with the 'Delivering Better Oral Health' toolkit (DBOH). DBOH is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. For example, the dentist applied fluoride varnish to children who attended for an examination. Fissure sealants were also applied to children at high risk of dental decay. High fluoride toothpastes were prescribed for patients at high risk of dental decay. There was a great deal of information with regards to prevention displayed in the waiting room for the parents of children to reference.

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

The medical history form patients completed included questions about smoking and alcohol consumption. We were told by the dentist and saw in dental care records that smoking cessation advice and alcohol awareness advice was given to patients where appropriate. Patients were made aware of the effects of smoking with regards to oral cancer and gum disease.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. The induction process included getting the new member of staff aware of the location of emergency medicines, arrangements for fire evacuation procedures, cross infection control and PPE requirements. We saw evidence of completed induction checklists in the recruitment files.

Staff told us they had good access to on-going training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). The practice organised in house training for medical emergencies to help staff keep up to date with current guidance on treatment of medical emergencies in the dental environment. They also subscribed to an on-line CPD system which staff could use. Records showed professional registration with the GDC was up to date for all staff and we saw evidence of on-going CPD.

The practice employed a dental hygiene therapist. Dental hygiene therapists are trained dental care professionals who are qualified to undertake certain treatments, for example, fillings, periodontal treatments and the extraction

Are services effective?

(for example, treatment is effective)

of deciduous teeth. The dentists would refer patients for such treatments to the dental hygiene therapist. This allowed the dentists to focus on more advanced or complicated treatments.

One of the dental nurses had extended duties with regards to dental radiography. We were told that they would help out by taking X-rays when needed.

A Clinical Dental Technician (CDT) also worked at the practice occasionally. CDTs are trained dental care professionals who are qualified to construct, repair and fit removable dental appliances (dentures). The dentists would often consult with the CDT to help them with more complicated denture cases.

Staff told us they had annual appraisals and training requirements and job satisfaction were discussed at these. We saw evidence of completed appraisal documents.

Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. There was a referral policy in place which outlined the reasons why a patient should be referred for specialist treatments. For example, referrals were made to hospitals and specialist dental services for further investigations or specialist treatment including orthodontics, oral surgery and sedation.

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

The practice had a procedure for the referral of a suspected malignancy. This involved faxing a copy of the letter to the local hospital and also a telephone call to confirm the fax had arrived.

Consent to care and treatment

Patients were given appropriate information to support them to make decisions about the treatment they received. Staff were knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent. Staff described to us how valid consent was obtained for all care and treatment and the role family members and carers might have in supporting the patient to understand and make decisions. The dentists understood the concept of Gillick competency with regarding to gaining consent from children under the age of 16.

Staff had received training and had a good understanding of the principles of the Mental Capacity Act (MCA) 2005 and how it was relevant to ensuring patients had the capacity to consent to their dental treatment. For example, one of the dentists told us that if a patient can understand and process the information provided to them then they could be deemed as having capacity.

We were told that individual treatment options, risks, benefits and costs were discussed with each patient. We noted for simple treatments that the risks and benefits of the different treatment options were not always clearly documented in the dental care records. This was discussed with the practice owners and we were told that this would be done.

The dentists ensured patients gave their consent before treatment began. For simple treatments a treatment plan was signed by the patient which outlined the proposed treatment and the associated costs. For more complicated treatments including dental implants a detailed treatment plan was given to the patient which clearly articulated the risks and benefits and other treatment options. It was clear that the patients' wishes were upheld with regards to treatments and that patients were given time to consider different treatment options.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

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

We observed privacy and confidentiality were maintained for patients who used the service on the day of inspection. The layout of the reception and waiting area was conducive for maintaining confidentiality. We observed staff to be helpful, discreet and respectful to patients. Staff were aware that no personal details should be discussed at the reception desk to ensure the dignity of patients. They also told us that if a patient wished to speak in private, an empty room would be found to speak with them.

We saw that patients' clinical records were computerised and password protected to keep patients' personal information safe. If computers were ever left unattended then they were locked to ensure no personal details could be obtained. Any paper documentation relating to the dental care records were locked away in secure cabinets when the practice was closed.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients commented they felt involved in their treatment and it was fully explained to them. Staff described to us how they involved patients' relatives or carers when required and ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood. The practice had intraoral cameras in the surgeries. We saw that these were used to assist patients in understanding what dental problems they had and what treatments were available. The dentists would also use models and pictures to assist patients in making decisions about care and treatment.

When treating children one dentist told us that they would use the "tell-show-do" technique in order to help children overcome any anxieties. They would also spend more time with children, use pictures and models and communicate in simple words.

Patients were informed of the range of treatments available in the practice information leaflet, on notices in the waiting area and on the practice website.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We found the practice had an efficient appointment system in place to respond to patients' needs. Staff told us that patients who requested an urgent appointment would be seen the same day. We saw evidence in the appointment book that there were dedicated emergency slots available each day for each dentist. If the emergency slots had already been taken for the day then the patient was offered to sit and wait for an appointment if they wished. We also saw during the inspection that one of the dental nurses who was working on the reception desk offered patients advice over the telephone for conditions which could be managed at home and did not necessitate an appointment, the patient was also advised to contact the surgery again if the problem did not resolve.

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

Tackling inequity and promoting equality

The practice had equality and diversity, and disability policies to support staff in understanding and meeting the needs of patients. Reasonable adjustments had been made to the premises to accommodate patients with disabilities. These included a ramp at the front of the building, a ground floor accessible toilet and a magnifying glass on the reception desk. All of the surgeries were large enough to accommodate a wheelchair or a pram. We also witnessed staff to be helpful and providing assistance to older patients.

Access to the service

The practice displayed its opening hours in the premises, in the practice information leaflet and on the practice website. The opening hours are Monday to Wednesday and Friday from 8-30am to 6-00pm, Thursday from 8-30am to 7-00pm and Saturday from 8-30am to 1-00pm.

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

Concerns & complaints

The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. There were details of how patients could make a complaint displayed in the waiting room and in the practice's information leaflet. The registered manager was responsible for dealing with complaints when they arose. Staff told us they raised any formal or informal comments or concerns with them to ensure responses were made in a timely manner. Staff told us that they aimed to resolve complaints in-house initially. We reviewed the complaints which had been received in the past 12 months and found that they had been dealt with in line with the practices policy and to the patient's satisfaction. We also saw evidence that as a result of a complaint that learning was derived disseminated and implemented in order to prevent it from occurring again.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients. The practice maintained a detailed log where correspondence relating to the complaint was recorded. This enabled the registered manager to ensure a timely response to any complaints. The practice acknowledged the complaint within three working days and providing a formal response within two months. If the practice was unable to provide a response within two months then the patient would be made aware of this.

Are services well-led?

Our findings

Governance arrangements

The practice was a member of the British Dental Association 'Good Practice' accreditation scheme. This is a quality assurance scheme that demonstrates a visible commitment to providing quality dental care to nationally recognised standards.

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

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

There was an effective management structure in place to ensure that responsibilities of staff were clear. Each staff member had their own duties outlined in their personal files. Staff told us that they felt supported and were clear about their roles and responsibilities.

Leadership, openness and transparency

The culture of the practice encouraged candour, openness and honesty to promote the delivery of high quality care and to challenge poor practice. This was evident when we looked at the complaints they had received in the last 12 months.

Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. These were discussed openly at staff meetings where relevant and it was evident that the practice worked as a team and dealt with any issue in a professional manner.

The practice held regular staff meetings. These meetings were minuted for those who were unable to attend. During these staff meetings topics such as training, significant events, patient satisfaction, infection control and the appointment booking procedure. We were also told that the dentists and dental hygiene therapist would also have clinician meeting where more clinical topics were discussed.

All staff were aware of whom to raise any issue with and told us that the practice owners were approachable, would listen to their concerns and act appropriately. We were told that there was a no blame culture at the practice and that the delivery of high quality care was part of the practice's ethos.

Learning and improvement

Quality assurance processes were used at the practice to encourage continuous improvement. The practice audited areas of their practice as part of a system of continuous improvement and learning. This included clinical audits such as dental care records, X-rays, health and safety, staff training and infection control. We looked at the audits and saw that the practice was performing well. However, where improvements could be made these were discussed with the relevant staff member and an action plan was formulated. This would be followed up with repeat audit.

Staff told us they had access to training to ensure essential training was completed each year; this included medical emergencies, basic life support, infection control and safeguarding. Staff working at the practice were supported to maintain their continuous professional development as required by the General Dental Council. The practice owners had registered with an online CPD where all staff would sign in to complete the mandatory CPD. They also arranged for in-house training for medical emergencies and basic life support.

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

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

The practice had systems in place to involve, seek and act upon feedback from people using the service including carrying out annual patient satisfaction surveys and post-treatment questionnaires. The satisfaction survey

Are services well-led?

included questions about the opening times, cleanliness, waiting time and the suitability of the facilities. The most recent patient survey showed a high level of satisfaction with the quality of the service provided.

The post-implant treatment questionnaire included questions such as whether the dentist listened, if the patient understood the treatment options available and whether they were happy with end result. Again, the results of this questionnaire were very positive.

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