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High Ash Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 9 September 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

High Ash Dental Practice is situated approximately five miles north of Leeds, West Yorkshire. It offers mainly NHS dental treatment to patients of all ages but also offers private treatment options. The services include preventative advice and treatment, routine restorative dental care and private orthodontic treatments.

The practice has three surgeries, an orthodontic consultation room, a decontamination room, two waiting areas and a reception area. The reception area, one waiting area and one surgery are on the ground floor. The other two surgeries, the orthodontic consultation room, a waiting area and the decontamination room are on the first floor. There were accessible toilet facilities available on the ground floor of the premises. There was step free access to the premises at the front of the building. Parking is available on the road or behind the premises in a car park.

There are three dentists, three dental nurses, one receptionist and a practice manager (who is also a qualified dental nurse).

The opening hours are Monday, Tuesday and Thursday from 9-00am to 5-30pm, Wednesday from 9-00am to 1-00pm and Friday from 8-30am to 4-00pm.

Summary of findings

The practice owner is registered with the Care Quality Commission (CQC) as an individual. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

During the inspection we received feedback from 30 patients. The patients were positive about the care and treatment they received at the practice. Comments included that staff were helpful, the dentists listened to any concerns and that they were seen quickly for an emergency appointment. They also commented that treatments were well explained and options were discussed.

Our key findings were:

- The practice was visibly clean and uncluttered.
- The practice had systems in place to assess and manage risks to patients and staff including health and safety and the management of medical emergencies.
- Staff were qualified and had received training appropriate to their roles.
- Patients were involved in making decisions about their treatment and were given clear explanations about their proposed treatment including costs, benefits and risks.
- Dental care records 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.
- Staff ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood.
- The practice had a complaints system in place and there was an openness and transparency in how these were dealt with.
- Patients were able to make routine and emergency appointments when needed.
- The governance systems were effective.
- 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 was no handwashing sink in the orthodontic consultation room.
- There were some inconsistencies when the Infection Prevention Society (IPS) audit was carried out.
- There were some gaps in the recruitment process.

There were areas where the provider could make improvements and should[FA1]:

- Review the availability of handwashing facilities in the orthodontic consultation room.
- Review the practice's protocols for the completion of the IPS audit giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health.
- Review the practice's recruitment policy and procedures to ensure proof of identification and immunisation to Hepatitis B are requested and recorded suitably in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.

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 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

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

Staff were trained to respond to with medical emergencies. All emergency equipment and medicines were in date and in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines.

Staff were suitably qualified for their roles. We noted some gaps in the practice's recruitment process including not obtaining photo identification and checking staff immunity to Hepatitis B.

We found the equipment used in the practice, including the compressor and radiography equipment was well maintained and tested at regular intervals.

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. There were some inconsistencies in how frequently the IPS audit was carried out.

We noted there were no hand washing facilities in the orthodontic consultation room. This was highlighted to the registered provider on the day of inspection. We were later sent evidence that a handwashing sink was due to be installed in this room.

No action



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 provided preventative advice and treatment in line with the 'Delivering Better Oral Health' toolkit (DBOH). This included fluoride application, oral hygiene advice and smoking cessation advice.

Staff had completed training relevant to their roles and this was monitored by the practice 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. A log was kept of all referrals which were sent.

No action



Summary of findings

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 30 patients. Comments included that staff are very caring, friendly and professional. They also commented that treatments were well explained and options were discussed.

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.

No action



Are services responsive to people's needs?

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

The practice had an efficient appointment system in place to respond to patients' needs. There were vacant appointments slots for urgent or emergency appointments each day. 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. These included step free access to the premises and an accessible ground floor toilet.

No action



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 staff felt supported and appreciated in their own particular roles. The registered provider was responsible for the day to day running of the practice and was supported by a practice manager.

There was a range of policies, procedures and protocols to guide staff in undertaking tasks. We saw these were regularly reviewed.

Effective arrangements were in place to share information with staff by means of monthly practice meetings which were minuted for those staff unable to attend. This gave everybody an opportunity to openly share information and discuss any concerns or issues.

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

They conducted patient satisfaction surveys and the NHS Friends and Family Test (FFT). We were told that patient feedback had led to improvements in the practice.

No action



High Ash Dental Practice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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. We did not receive any information of concern from them.

During the inspection we received feedback from 30 patients. We also spoke with two dentists, two dental

nurses and the practice manager. 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 guidance for staff about how to report incidents and accidents. Staff were familiar with the importance of reporting significant events. There had not been any significant events in the last 12 months. We saw historically accidents had been recorded and the appropriate action had been taken. Any accidents or incidents would be reported to the practice manager and would also be discussed at staff meetings in order to disseminate learning.

The practice received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) that affected the dental profession. These were actioned if necessary and were stored for future reference.

Reliable safety systems and processes (including safeguarding)

The practice had child and adult safeguarding policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. Staff had access to contact details for both child protection and adult safeguarding teams. The practice manager was the safeguarding lead for the practice and had undertaken level two safeguarding training. All staff had undertaken safeguarding training appropriate to their role. Staff were familiar with the signs and symptoms of abuse especially with regards to dental neglect in children.

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

The dentists told us they routinely used a rubber dam when providing root canal treatment to patients in line with guidance from the British Endodontic Society. 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 and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons is recorded in the patient's dental care records giving details as to how the patient's safety was assured.

We saw patients' clinical records were computerised, password protected and regularly backed up to secure storage to keep personal details safe. The practice still kept paper dental record cards as they had only recently moved to electronic records. The paper records were stored in a locked room but not in fire proof containers. This was brought to the attention of the provider and we were told this was due to be done as part of the computerisation process.

Medical emergencies

The practice had procedures in place which provided staff with clear guidance about how to deal with medical emergencies. Staff were knowledgeable about what to do in a medical emergency and had completed training in emergency resuscitation and basic life support within the last 12 months.

The practice kept an emergency resuscitation kit, medical emergency oxygen and emergency medicines. Staff knew where the emergency kits was kept. We checked the emergency equipment and medicines and found them to be in date and in line with the Resuscitation Council UK guidelines and the BNF.

The practice had an Advisory External Defibrillator (AED) to support staff in a medical emergency. (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.).

Records showed weekly checks were carried out on the AED and monthly checks on the emergency medicines and the oxygen cylinder. These checks ensured that the oxygen cylinder was full, the AED battery was charged and the emergency medicines were in date. Guidance from the Resuscitation Council UK states that the oxygen cylinder should be checked on a weekly basis. This was highlighted to the provider and we were told this would be implemented. We saw 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. We reviewed staff files and found some gaps in the recruitment procedure. For example, we noted that photographic identification was not always sought and evidence of immunisation to Hepatitis B was not available for one member of staff.

Are services safe?

The practice 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 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). There were copies of current registration certificates and 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 assessments were in place at the practice. This identified the risks to patients and staff who attended the practice. There were details of the practice's waste control procedure within the policy.

There were risk assessments in place to manage risks at the practice. These included the use of the autoclave, manual handling, fire and sharp instruments.

We saw that visual health and safety checks were carried out on the premises. This included checking for slips and trips and any material wear to the practice. They also carried out quarterly fire drills and smoke alarm checks.

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 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. We saw there was a quick reference sheet at the front of the COSHH folder for frequently used substances.

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)'. Staff had received training in infection prevention and control.

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 colour coded equipment was used.

There were hand washing facilities in the surgeries and decontamination room. 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. We noted there was no handwashing facilities in the orthodontic consultation room. We were later sent evidence that a sink was due to be installed in this room.

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.

We observed that clinical waste awaiting collection was stored in an external bin. This bin was locked but was not attached to the wall. This could be an issue if the bin was ever removed from the premises and was broken open. This was highlighted to the provider and we were told this would be addressed.

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.

One of the dental nurses showed us the procedures involved in disinfecting, inspecting and sterilising dirty instruments; packaging and storing clean instruments. The practice routinely used a washer disinfectant to clean the used instruments, examined them visually with an illuminated magnifying glass, and then sterilised them in a validated autoclave (a device for sterilising dental and

Are services safe?

medical instruments). Instruments were appropriately bagged and stamped with a use by date one year from the day of sterilisation. 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 and sterilisation 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 an Infection Prevention Society (IPS) self- assessment audit in January 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. There was no action plan from this audit and it had only been completed on an annual basis. We highlighted this deficiency to the practice manager and discussed that it should be every six months and if it is done electronically then an action plan is automatically formulated.

Records showed a risk assessment process for Legionella had been carried out in April 2015 (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 and between patients, monitoring cold and hot water temperatures each month and the use of reverse osmosis water with a disinfectant.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as X-ray sets, the autoclaves and the compressor. The practice manager maintained a comprehensive list of all equipment including dates when equipment required servicing. We saw evidence of validation of the autoclaves and the compressor. Portable appliance testing (PAT) had been completed in January 2016 (PAT confirms that portable electrical appliances are routinely checked for safety).

We saw that the practice was storing NHS prescription pads securely in accordance with current guidance and operated a system for checking deliveries of blank NHS prescription pads. Prescriptions were stamped only at the point of issue.

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 within the radiation protection folder for staff to reference if needed. 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 six months. 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).

We saw evidence of recent radiology training for relevant staff in accordance with IR(ME)R requirements.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept up to date detailed electronic dental care records. They contained information about the patient's current dental needs and past treatment. The 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 dentists used NICE guidance to determine a suitable recall interval for the patients. This takes into account the likelihood of the patient experiencing dental disease. The dentists were also aware of other NICE guidelines relating to dentistry.

During the course of our inspection we discussed patient care with the dentists and checked dental care records to confirm the findings. Dental care records were comprehensive and included details of the condition of the teeth, soft tissue lining the mouth, gums and any signs of mouth cancer. Records showed patients were made aware of the condition of their oral health and whether it had changed since the last appointment. If the patient had more advanced gum disease then a more detailed inspection of the gums was undertaken.

Medical history checks were updated 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 dentist followed the guidance from the FGDP before taking X-rays to ensure they were required and necessary. Justification for the taking of an X-ray, quality assurance of each x-ray and a detailed report was recorded in the patient's care record.

Health promotion & prevention

The practice had a strong focus on preventative care and supporting patients to ensure better oral health in line with the 'Delivering Better Oral Health' toolkit (DBOH). DBOH is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. For example, the dentists 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 recommended for patients at high risk of dental decay. Oral hygiene advice was provided and patients confirmed this was done.

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 ill effects of smoking on their gum health and the synergistic effects of smoking and alcohol with regards to oral cancer. Patients were also signposted to their own GP for further cessation advice and treatment if appropriate. There were health promotion leaflets available in the waiting room to support patients.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. We saw evidence of completed induction checklists in the personnel 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. Records showed professional registration with the GDC was up to date for all staff and we saw evidence of on-going CPD.

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

The practice manager was also a qualified dental nurse as was available to cover unforeseen events at the practice such as illness or holidays.

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

Are services effective?

(for example, treatment is effective)

patient and in line with current guidance. For example, referrals were made to hospitals and specialist dental services for further investigations or specialist treatment including orthodontics, oral surgery and sedation. Patients would be given a choice of where they could be referred and the option of being referred privately for treatment.

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 scanned into the patient's dental care records. Letters received back relating to the referral were first seen by the dentist to see if any action was required and then scanned in the patient's dental care records.

The practice had a procedure for the referral of a suspected malignancy. This involved sending an urgent fax the same day and a telephone call to the hospital. If possible an appointment was arranged for the patient while they were still at the practice. The patient was also called to ensure they had attended the appointment.

The practice maintained a log of all referrals which had been sent. This allowed them to actively monitor their referrals.

Consent to care and treatment

Patients were given 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. The dentists described to us how valid consent was obtained for all care and treatment and the role family members and carers might have in supporting the patient to understand and make decisions.

Staff had completed training and had an understanding of the principles of the Mental Capacity Act (MCA) 2005 and how it was relevant to ensuring patients had the capacity to consent to their dental treatment. The dentists had not needed to make a best interest decision yet but were aware of the process which would be involved.

The dentists understood the concept of Gillick competency with regarding to gaining consent from children under the age of 16. The Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

The dentists ensured patients gave their consent before treatment began. We were told that individual treatment options, risks, benefits and costs were discussed with each patient. Patients were given a written treatment plan which outlined the treatments which had been proposed, the associated costs and any further treatment which may be required. Patients would be given time to consider and make informed decisions about which option they preferred. The dentists were aware that a patient could withdraw consent at any time.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Feedback from patients was positive and they commented that they were treated with care, respect and dignity. They also commented that staff were friendly as well as professional.

We observed privacy and confidentiality were maintained for patients who used the service on the day of inspection. This included ensuring dental care records were not visible to patients and keeping surgery doors shut when patients were inside.

We observed staff to be helpful, discreet and respectful to patients. Staff told us that if a patient wished to speak in private an empty room would be found to speak with them.

Staff understood the importance of emotional support when delivering care to patients who were nervous of dental treatment. Several patients commented they were good at putting children at ease.

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. The dentists 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. One of the dentists showed us models, books and leaflets which they used to describe treatment to patients. They would also speak to patients in a way they would understand in line with their age and capacity. Patients commented that they were listened to and confirmed that treatment options, risks and benefits were discussed with them.

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. 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 saw the dentists tailored appointment duration to patients' individual needs and patients could choose from morning and afternoon appointments. Patients commented they had sufficient time during their appointment and they were not rushed. We observed the clinics ran smoothly on the day of the inspection and patients were not kept waiting.

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 mobility difficulties. These included step free to access the premises and a ground floor accessible toilet. The ground floor surgery was large enough to accommodate a wheelchair or a pram. The practice offered interpretation services to patients whose first language was not English.

Access to the service

The practice displayed its opening hours on the premises, in the practice information leaflet and on the practice website. The opening hours are Monday, Tuesday and Thursday from 9-00am to 5-30pm, Wednesday from 9-00am to 1-00pm and Friday from 8-30am to 4-00pm.

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 available on the telephone answering service, displayed in the waiting area and 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. The practice manager was responsible for dealing with complaints when they arose. Staff told us they raised any formal or informal comments or concerns with the practice manager 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 they had been responded to in line with the practice's policy. The practice kept a log of any complaints which had been raised. This included details of any correspondence with the patient and telephone calls. Complaints would be analysed to see if any learning could be gained from them. They would be discussed at staff meetings if appropriate.

Are services well-led?

Our findings

Governance arrangements

The practice was a member of an accreditation scheme. This is a quality assurance scheme that demonstrates a visible commitment to providing quality dental care to nationally recognised standards.

The registered provider was responsible for the day to day running of the service and was supported by a practice manager. There was a range of policies and procedures in use at the practice. We saw they had systems in place to monitor the quality of the service and to make improvements.

The practice had an 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 the use of the autoclave, manual handling, fire and sharp instruments.

There was an effective management structure in place to ensure that responsibilities of staff were clear. 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. Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues or offer ideas at any time. These would be 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. Staff gave us examples of when their ideas were implemented into the practice.

The practice held monthly staff meetings. These meetings were minuted for those who were unable to attend. During these staff meetings topics such as any changes to practice policies, upcoming training and practice specific issues.

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 audits such as dental care records, X-rays and hand hygiene. We looked at the audits and saw the practice was performing well. Where any improvements had been identified these had been discussed with the individual practitioner.

Staff told us they had access to training and this was monitored to ensure essential training was completed each year; this included medical emergencies and basic life support. Staff working at the practice were supported to maintain their continuous professional development as required by the General Dental Council. The practice paid for the dental nurses to be registered with the British Association of Dental Nurses (BADN) and also their GDC registration.

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. The practice had recently acquired tablets where patients could complete feedback. We were told that as a result of feedback from patients that grab rails had been installed at the bottom and top of the stairs to assist patients with limited mobility.

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 97% of patients asked said that they would recommend the practice to friends and family.