St Catherines Dental Practice

St Catherine's Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 5 October 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

St Catherines Dental Practice is a mixed dental practice providing private and NHS dental care for both adults and children. Where private treatment is provided some is provided under a fee per item basis and some under a dental insurance plan. The practice holds a contract to provide NHS orthodontic treatment and accepts referrals from other providers. The practice is situated in a converted domestic property.

The practice has three dental treatment rooms, one on the ground floor and two on the first floor. There is a separate decontamination room on the first floor where cleaning, sterilising and packing dental instruments takes place. There is also a reception and waiting area and other rooms used by the practice for office facilities and storage. The practice is open from 8.30am to 5.15pm Monday to Thursday and on Friday from 8.30am to 4.30pm.

The practice has five dentists who are able to provide services including the provision of dental implants (a dental implant is a metal post that is placed surgically into the jaw bone to support a tooth, orthodontic treatment (where malpositioned teeth are repositioned to give a better appearance and improved function) and periodontal treatment, which is the treatment of gum disease. They are supported by five dental nurses, two of whom also carry out reception duties, a trainee dental nurse, a dental hygienist and a practice manager. Other staff include a dedicated receptionist.

Summary of findings

One of the partners 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. The registered manager was supported in their role by the practice manager.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience. We received feedback from 46 patients. These provided a very positive view of the services the practice provides. Patients commented on the high quality of care, the caring and friendly nature of all staff, the cleanliness of the practice and the professionalism of all staff.

Our key findings were:

Staff reported incidents which were investigated and learning implemented to improve safety. However there was no log of significant events in place which would have helped to identify any themes or trends. The practice manager told us that they would implement a log and ensure all events were fully recorded at the outset to ensure it was clear what actions had been taken.

- The practice was visibly clean and well maintained.
- Infection control standards were in line with national guidance.
- The practice had available medicines and equipment for use in a medical emergency which were in accordance with national guidelines.
- Staff had received training appropriate to their roles and were supported in their continued professional development (CPD).
- Patients commented that they received excellent care, that staff went out of their way to help and were professional and that appointments were flexible.
- The practice had links with a local primary school and gave talks to promote oral health in children.
- The practice had suitable facilities and was well equipped to treat patients and meet their needs, with the exception of the availability of a hearing loop.
- Governance arrangements were in place for the smooth running of the service. However the practice did not have a system in place to carry out audits of radiography at regular intervals. They planned to establish a system for this.

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

- Review the system for recording significant events to incorporate a log of significant events to help identify any themes or trends and clarify what actions had been taken.
- Review the practice's audit protocols in respect of radiography to ensure audits are carried out at regular intervals to monitor and improve the quality of service.
- Review the availability of a hearing loop for patients with hearing difficulties.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had a system in place to identify, investigate and learn from significant events.

There were sufficient numbers of suitably qualified staff working at the practice.

Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

Use of X-rays on the premises was in line with the Regulations.

Infection control procedures were in line with the requirements of the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' published by the Department of Health. Infection control procedures were audited to ensure they remained effective.

Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. The clinicians used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice.

Staff demonstrated a commitment to oral health promotion.

The staff received ongoing professional training and development appropriate to their roles and learning needs.

Clinical staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration

The practice had a process in place to make referrals to other dental professionals when appropriate to do so.

Are services caring?

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

We received feedback from 46 patients and these provided a positive view of the service the practice provided. Comments reflected that the quality of care was very good.

Patients commented on the friendly and helpful nature of the staff.

We saw that treatment options were explained to patients in order for them to make an informed decision.

We observed that patients were treated with dignity and respect.

The confidentiality of patients' private information was maintained.

Are services responsive to people's needs?

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

The ground floor treatment room was accessible for patients using wheelchairs, or with prams or pushchairs.

The practice had access to telephone interpreter services should they be required.

Summary of findings

Patients said they were easily able to get an appointment. Patients who were in pain or in need of urgent treatment were seen on the same day.

There was information available to support patients to raise complaints. When complaints had been made they were responded to appropriately and in a timely way.

Are services well-led?

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

There was strong and effective leadership within the practice provided by the partners and practice manager. Staff were clear about their role and responsibilities.

The practice had policies and protocols in place to assist in the smooth running of the practice.

Clinical audit was used as a tool to highlight areas where improvements could be made. However the practice did not have a system in place to carry out audits of radiography at regular intervals. They planned to establish a system for this.

There was an open culture within the practice and staff were well supported and able to raise any concerns within the practice.

Feedback was obtained from patients and we saw evidence that this was discussed and acted upon to make changes to the service provided if appropriate.

St Catherine's Dental Practice

Detailed findings

Background to this inspection

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

We carried out an announced, comprehensive inspection on 5 October 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Before the inspection we asked the for information to be sent, this included the complaints the practice had received in the last 12 months; their latest statement of purpose; the details of the staff members, their qualifications and proof of registration with their professional bodies. We spoke with seven members of staff during the inspection.

We also reviewed the information we held about the practice and found there were no areas of concern.

We reviewed policies, procedures and other documents.

We received feedback from 46 patients about the dental 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 systems in place to report, investigate and learn from significant events and near misses. Events were recorded initially by any member of staff on a simple significant event template and the information later transferred to a form which recorded the investigation, discussion and learning from the event. These were completed by a member of staff designated to deal with reported events. We saw evidence that significant events were a standing item on practice meeting agendas, that they were discussed and learning from them implemented. However at the time of our inspection there were seven completed initial templates which were not dated and had not yet been transferred to the investigation form. It was therefore not clear when these had occurred or what actions had been taken. However discussions with staff confirmed that actions had been taken and they were due to be discussed at the next practice meeting. There was no log of significant events in place which would have helped to identify any themes or trends. The practice manager told us that they would implement a log and ensure all events were fully recorded at the outset to ensure it was clear what actions had been taken.

The provider showed an awareness of the duty of candour and this was encouraged through the significant event reporting and complaint handling process. Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

The practice received alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). Relevant alerts were logged and included a record of actions taken in response to alerts.

We discussed with the practice manager their responsibility in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). The practice were aware of when a report should be made and accident forms were available which aided staff to consider when a report was necessary.

Reliable safety systems and processes (including safeguarding)

The practice had a policy in place for safeguarding children and vulnerable adults which was dated August 2016. In addition an action plan had been completed which ensured that the practice had taken all necessary steps to empower staff to raise a concern should the situation arise.

A flow chart detailing the actions a staff member may take if concerned and contact numbers for raising a concern were available in the safeguarding folder.

We saw evidence that all staff had received safeguarding training to the appropriate level for their role.

The practice had an up to date employers' liability insurance certificate which was displayed in the waiting room. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

Discussions with dentists identified the dentists were using rubber dams when providing root canal treatment to patients. This was in line with guidance from the British Endodontic Society. A rubber dam is a thin, square 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 (treatment involving the root canal of the tooth) is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured.

We spoke with staff about the procedures in place to reduce the risk of sharps injury in the practice. The practice had a risk assessment in place relating to sharps which stated that 'safer sharps' were used throughout the practice in line with the requirements of the Health and Safety (Sharp Instruments in Healthcare) 2013 regulation.

Medical emergencies

The dental practice had medicines and equipment in place to manage medical emergencies. These were stored together securely and staff we spoke with were aware how to access them. Emergency medicines were available in line with the recommendations of the British National Formulary.

Equipment for use in a medical emergency was in line with the recommendations of the Resuscitation Council UK, and included an automated external defibrillator (AED). An AED

is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.

There was a system in place to ensure that all medicines and equipment were checked on a regular basis to confirm they were in date and serviceable should they be required.

All staff had undertaken basic life support training at appropriate intervals.

Staff recruitment

We reviewed four staff recruitment files and found that appropriate recruitment checks had been undertaken prior to employment. For example, references, qualifications, photographic proof of identification, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. (DBS 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).

Monitoring health & safety and responding to risks

The practice had systems in place to identify and mitigate risks to staff, patients and visitors to the practice.

The practice had a health and safety policy which was updated in March 2016 and was accessible for all staff to reference in a folder. A health and safety risk assessment had been carried out and last reviewed in January 2016 and included risk assessments for blood and saliva, sharps, clinical waste disposal, the autoclave and radiation.

A fire risk assessment had been carried out in April 2013 but had not been reviewed since then. Staff had received fire safety training and there were appointed fire marshals. We saw that a fire drill had last been undertaken in March 2016. Some checks of equipment such as emergency lighting had not been carried out on a regular basis. However following our inspection the practice carried out a review of the fire risk assessment.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a comprehensive file of information pertaining to the hazardous substances used in the practice with a risk assessment and safety data sheet for each product which detailed actions required to minimise risk to patients, staff and visitors.

There was a comprehensive business continuity plan in place for major incidents such as computer loss, power failure or flood. The plan included emergency contact numbers for staff.

Infection control

The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for cleaning, sterilising and storing dental instruments and reviewed their policies and procedures.

The practice had an infection control policy in place which was dated May 2016. This gave guidance on areas which included the decontamination of instruments and equipment, hand hygiene and waste disposal and environmental cleaning of the premises.

The decontamination process was performed in a dedicated decontamination room on the first floor and we observed the process being carried out by a dental nurse.

Instruments were cleaned manually in a dedicated sink before being further cleaned in an ultrasonic bath (this is designed to clean dental instruments by passing ultrasonic waves through a liquid). Instruments were then inspected under an illuminated magnifier before being sterilised in an autoclave. After this the instruments were placed in pouches and dated with a use by date.

We saw that the required personal protective equipment was not worn throughout the process as the dental nurse was not wearing an apron. We raised this with the provider who told us that currently aprons were only worn for manual cleaning but they would amend their protocol to ensure that they were worn for all aspects of decontamination.

We found that appropriate tests were completed on the process to ensure it remained effective.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and general waste were used and stored in accordance with current guidelines, with the exception that sharps containers were not fixed to the walls. The practice told us they would contact the waste contractor to source brackets to correctly mount the sharps containers. The

practice used an appropriate contractor to remove clinical waste from the practice. This was stored securely in the cellar of the premises prior to collection by the waste contractor. We saw the appropriate waste consignment notices.

Practice staff told us how the dental water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings) they described the method they used which was in line with current HTM 01 05 guidelines. We saw that a Legionella risk assessment had been carried out at the practice by an external company in August 2015. The recommended procedures contained in the report were carried out and logged appropriately. Control measures such as monthly water monitoring checks were carried out as well as annual checks by an external contractor.

All clinical staff had been vaccinated against Hepatitis B (a virus that is carried in the blood and may be passed from person to person by blood on blood contact). Evidence of this was retained in the staff recruitment files.

We saw that the three dental treatment rooms, waiting area, reception and toilets were clean, tidy and clutter free. Hand washing facilities were available including liquid soap and paper towel dispensers in each of the treatment rooms, the decontamination room and toilet. Hand washing protocols were also displayed appropriately in various areas of the practice.

Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

The practice contracted a cleaning company to carry out daily cleaning tasks in line with their

cleaning schedule. The practice used their own colour coding system for cleaning equipment; however this did not conform to national guidance in respect of colour coding. The practice manager told us they would ensure the appropriate colour coding was implemented.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclave had been serviced and calibrated in accordance with the Pressure Vessel Regulations 2000. The practices' X-ray machines had been serviced and calibrated as specified under current national regulations. Portable appliance testing (PAT) had been carried out in July 2016.

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Records we reviewed confirmed that batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. However we found that local anaesthetic cartridges were not being kept in blister packs but rather in a plastic container. This was not in line with national guidance. We spoke with the practice manager who advised us that going forward they would order the cartridges in blister packs.

The practice had maintenance contracts in place to ensure equipment was maintained, serviced and tested at the appropriate intervals.

Radiography (X-rays)

The practice demonstrated compliance with the Ionising Radiation Regulations (IRR) 1999, and the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.

The practice had an intra-oral X-ray machine in each of the three treatment rooms; these can take an image of one or a few teeth at a time. There was also a pan oral X-ray machine which is used to capture the entire mouth in a single image, including the teeth, upper and lower jaws, surrounding structures and tissues. The practice displayed the 'local rules' of the X-ray machine in the room where each X ray machine was located.

The practice used exclusively digital X-rays, which were available to view almost instantaneously, as well as delivering a lower effective dose of radiation to the patient.

The practice kept a radiation protection file which contained the names of the Radiation

Protection Advisor and the Radiation Protection Supervisor and demonstrated that the X-ray machines had undergone testing and servicing in line with current regulation.

Clinical staff were up to date with radiation training as specified by the General Dental Council. The justification for taking an X-ray as well as the quality grade, and a report on the findings of that X-ray were documented in the dental care record.

We saw that the last radiological audit had been carried out in December 2014 and had been discussed at a

Are services safe?

practice meeting in February 2015. The minutes of the meeting stated that the next audit was due in June 2015 but we found that this had not been undertaken.Data was being gathered on an ongoing basis via the practice computer system but had not yet been analysed in order to monitor and improve quality.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists we spoke with carried out consultations, assessments and treatment in line with recognised general professional guidelines. The dentists described to us and we observed how they carried out their assessment of patients for routine care. The assessment began with the patient completing a medical history questionnaire and we observed that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer.

Through discussion the patient was then made aware of the condition of their oral health and whether there were any changes since they last attended. Following the clinical assessment the diagnosis was then discussed with the patient and different treatment options explained.

Dental care records that were shown demonstrated that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums).

We found that the dentists we spoke with used current National Institute for Health and Care Excellence (NICE) guidelines to assess each patient's risks and needs and to determine how frequently to recall them. They also used NICE guidance to aid their practice regarding antibiotic prophylaxis for patients at risk of infective endocarditis (a serious complication that may arise after invasive dental treatments in patients who are susceptible to it).

The decision to take X-rays was guided by clinical need, and in line with the Faculty of General Dental Practitioners directive. A justification, grade of quality and report of the X-ray taken was documented in the dental care record. The practice software system required justification and grading to be recorded appropriately in the record before allowing the clinician to proceed further.

Health promotion & prevention

The practice was committed to and focussed on the prevention of dental disease and the maintenance of good oral health and actively promoted this in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health: an evidence based toolkit for prevention.' This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Appointments were available with a hygienist in the practice one day a week to support the dentists in delivering preventative dental care. We saw evidence of dentists providing fluoride varnish applications for children (Fluoride varnish is a material that is painted on teeth to prevent cavities or help stop cavities that have already started).

Smoking and alcohol use were recorded on medical history forms and oral hygiene assessments were made during examinations. Clinicians used this information to discuss oral health and referrals to smoking cessation services were offered.

A wide range of health promotion leaflets and information was available in both waiting rooms and on the ground floor there was an effective display focusing on children's oral health which had been created by one of the dental nurses.

The practice had links with local schools and one of the dental nurses had delivered oral health talks relating to daily tooth brushing to the new intake of primary school children for the previous two years.

We reviewed a sample of dental care records which demonstrated dentists had given appropriate oral health advice to patients. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the waiting room.

Staffing

The practice was staffed by five dentists (who all worked part-time); They were supported by a dental hygienist, five qualified dental nurses, a trainee dental nurse, a receptionist and a practice manager. Prior to our visit we checked the registrations of the dental care professionals and found that they all had up to date registration with the General Dental Council (GDC). On the day of our inspection we also saw evidence of current professional indemnity cover for all relevant staff.

Staff turnover was generally low and patients commented on how friendly and helpful staff were and appreciated the consistency of staffing. We found that staff had good access

Are services effective?

(for example, treatment is effective)

to ongoing 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 GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians, orthodontic therapists and dental technicians. The training needs of staff was monitored by the practice manager.

Clinical staff were up to date with their recommended CPD as detailed by the GDC including medical emergencies, infection control and safeguarding.

Working with other services

The practice manager explained how they worked with other services when required. Dentists referred patients to a range of specialists in primary and secondary services if the treatment required was not available in the practice. There were not a large number of referrals due to the skill mix of dentists within the practice and the services they were able to provide such as orthodontics, implants and periodontal treatment. Indeed, this meant the practice received incoming referrals and had an effective system in place for accepting referrals from general dental practitioners.

The practice also had a system in place to track and follow up urgent referrals to ensure patients were seen in a timely manner.

Consent to care and treatment

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Staff had undertaken training in and demonstrated an understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment.

We found that the dentists had a clear understanding of consent issues and that they explained different treatment options and gave the patient the opportunity to ask questions before gaining consent. The practice had developed their own specific consent forms for various treatments such as crowns, bridges, tooth whitening and orthodontic treatment. We spoke with one of the dentists who was able to describe clearly the process they used to obtain valid and informed consent. This included discussing the options for treatment, as well as any alternatives, and the advantages and disadvantages of any particular option. In addition leaflets were available relating to certain treatments which patients could take away and make decisions in their own time if necessary.

Are services caring?

Our findings

Respect, dignity, compassion & empathy
Before our inspection, Care Quality Commission (CQC) comment cards were left at the practice to enable patients to tell us about their experience of the practice. We received 46 completed CQC patient comment cards which provided an overwhelmingly positive view of the service the practice provided. Patients expressed satisfaction with the quality of care they had received and reflected that they were treated with dignity and respect. Staff were described as kind, caring, pleasant and respectful. During the course of our inspection we observed staff interacting with patients and noted that they were friendly and professional.

The confidentiality of patients' private information was maintained as patient care records were computerised and all the computers were password protected. Paper records were kept securely. Practice computer screens were not visible at reception which ensured patients' confidential information could not be seen.

Involvement in decisions about care and treatment
From our discussions with dentists, extracts of dental care records we were shown and feedback from patients it was apparent that patients were given clear treatment plans which contained details of treatment options and the associated cost.

A comprehensive price list for private and NHS treatment was displayed in the waiting rooms and was also available in leaflet form and on the practice website.

Patients commented that they felt listened to and plenty of time was taken to explain and discuss treatments with them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we toured the premises and found that the practice had appropriate facilities and was well equipped to treat patients and meet their needs.

We looked at the variety of information available to patients. We saw that the practice waiting area displayed a wide range of information. This included the practice patient information leaflet and leaflets about the services offered by the practice, health promotion, complaints information and the cost of treatments. The patient information leaflet advised on opening hours, emergency arrangements for both when the practice was open and when it was closed. The practice website also contained comprehensive information for patients about different types of treatments available at the practice.

We reviewed the appointment system and saw that sufficient time was given for each type of appointment to allow for adequate assessment and discussion of patients' needs.

Prior to May 2016 the practice had been able to offer online appointment booking as their website had been integrated with the practice computer system. When the practice changed their software system in May they found that this facility was no longer supported. However the practice was investigating the possibility of restoring this method of booking as they were aware that it was popular with patients.

Patients commented that they were able to get appointments easily and they did not usually have to wait to be seen beyond their appointment time.

Tackling inequity and promoting equality

Practice staff told us that they treated all patients equally while accommodating their individual needs.

The practice had made reasonable adjustments to enable patients such as those with limited mobility or other issues to access their services. There was level access to the ground floor surgery which provided easier access for patients with a range of disabilities or frailty as well as those with prams or pushchairs.

The practice had access to an interpreting service to support patients whose first language was not English, but had not yet had to use this facility. The practice did not have a hearing loop to assist hearing aid users.

Access to the service

The practice is open from 8.30am to 5.15pm Monday to Thursday and on Fridays from 8.30am to 4.30pm. The practice used the NHS 111 service to give advice in case of a dental emergency when the practice was closed. This information was publicised in the practice information leaflet and through the telephone answering service when the practice was closed.

The practice told us they would arrange to see a patient on the same day if they were in pain or it was considered urgent. Many comments from patients described how flexible and accommodating the practice was in these circumstances.

Concerns & complaints

The practice had an effective system in place for handling complaints and concerns.

The complaints policy and procedures were in line with recognised guidance and contractual obligations for dentists in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system including advocacy support. This was displayed on the walls in the waiting areas of the practice and also within the practice leaflet. There was an area on the practice website relating to complaints but this was in the process of being updated.

We looked at the complaints which had been received in the last 12 months and found these were satisfactorily handled in a timely way. Lessons were learnt from individual concerns and complaints and action was taken as a result to improve the quality of care where appropriate. We saw evidence that complaints were discussed at practice meetings in order to share any learning with staff.

Are services well-led?

Our findings

Governance arrangements
There was a governance framework in place which provided a staffing structure whereby staff were clear about their own roles and responsibilities.

Practice specific policies which had been regularly updated were available to all staff. We reviewed policies which included those which covered infection control, health and safety, complaints and safeguarding children and vulnerable adults.

There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership, openness and transparency
The leadership team within the practice consisted of the partners and the practice manager. Staff felt able to raise concerns and were listened to and supported if they did so. The staff created a cohesive team whose pride in the service they provided was apparent.

The practice was aware of the duty of candour and this was demonstrated in the records we reviewed relating to incidents and complaints.

We saw evidence of regular staff meetings which staff were encouraged to participate in fully. The meetings had a set agenda, were minuted and were available for staff unable to attend.

Learning and improvement
There was a programme of clinical audits in place in order to monitor quality and to make improvements. We reviewed the most recent infection control audit which had been carried out on 26 September 2016. There was an action plan in place to address the minor points which had been identified. There was also an audit of clinical record keeping and an audit of X-ray quality was in progress.

Staff were supported in achieving the General Dental Council's requirements in continuing professional development (CPD). We saw evidence that clinical staff were up to date with the recommended CPD requirements of the GDC.

The practice had a trainee dental nurse who was undertaking the dental nurse training course. She was supported in her learning by the other dental nurses as well as the dentists.

The practice ensured that all staff underwent regular training in cardio pulmonary resuscitation (CPR), infection control, safeguarding of children and vulnerable adults and dental radiography (X-rays). Staff development was by means of internal training, staff meetings and attendance on external courses.

The staff files we reviewed contained evidence of appraisals and personal development plans where appropriate, which were used to identify staff learning needs.

Practice seeks and acts on feedback from its patients, the public and staff
Until May 2016 the practice had received feedback from patients the requests for which had been generated by the computer system. Since installing a new system this facility was not available and the practice was investigating new methods of gathering feedback. We saw evidence in the minutes of practice meetings which reflected that patient feedback was regularly discussed as a team and where possible changes had been implemented. For example, some patients had suggested having a television in the waiting room and this was being looked into by the practice. Other patients had fedback that they weren't informed when their appointment was running late and receptionists were reminded to advise patients on their arrival of any delays.

It was apparent from the minutes of practice meetings that staff were able to raise any issues for discussion which were acted upon. Staff were also confident to discuss suggestions informally.