Care Quality Commission

Xeon Smiles UK Limited

Smiles Dental Wolverhampton

Inspection Report

62a Victoria Street
Wolverhampton
West Midlands
WV1 3NX
Tel: 01902425397
Website: www.oasisdentalcare.co.uk

Date of inspection visit: 2 February 2016
Date of publication: 10/05/2016

Overall summary

We carried out an announced comprehensive inspection on 2 February 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

Smiles Dental Wolverhampton is a mixed dental practice providing NHS and private dental treatment for both adults and children. The service is provided by seven dentists and three dental hygienists. They are supported by a practice manager, a practice co-ordinator, two receptionists and seven dental nurses (one of whom is a trainee). Another dentist visits the practice on an ad hoc basis to provide implants (approximately on a monthly basis). One of the dentists also provides orthodontic treatment on a private basis.

The practice is located in the heart of Wolverhampton city centre. There is wheelchair access to the premises via a portable ramp. There is a waiting area and two treatment rooms on the ground floor to accommodate patients who cannot use the stairs. The premises consist of a reception area, waiting room, two treatment rooms and accessible toilet facilities on the ground floor. There are a further three treatment rooms, a second waiting room, a decontamination room and an office on the first floor. There is also a basement area comprising a staff room and storage area for dental materials and clinical waste.

Summary of findings

Opening hours are from 8am to 7.30pm on Mondays, 8am to 8pm on Tuesdays, Wednesdays, and Thursdays and from 8am to 5.30pm on Fridays. The practice is also open on Saturdays from 9am to 2pm.

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

Twenty-seven patients provided feedback about the practice. We looked at comment cards patients had completed prior to the inspection and we also spoke with three patients on the day of the inspection. Overall the information from patients was complimentary. Patients were positive about their experience and they commented that they were treated with respect. They said that staff were polite and friendly.

Our key findings were:

- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- The practice had systems to assess and manage risks to patients, including infection prevention and control, health and safety, safeguarding and the management of medical emergencies.
- Patients' care and treatment was planned and delivered in line with evidence based guidelines, best practice and current legislation.
- The practice had a structured plan in place to audit quality and safety.
- Staff received training appropriate to their roles.
- Patients told us they found the staff helpful and respectful. Patients commented they felt involved in their treatment and that it was fully explained to them.
- Patients were able to make routine and emergency appointments when needed. However, some patients commented they had to wait beyond their allocated time for appointments.
- The practice had an effective complaints system in place and there was an openness and transparency in how these were dealt with.

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

- Review the practice's recruitment policy and procedures to ensure character references for new staff are requested, checked and recorded suitably.
- Monitor any defects in the dental chairs so that areas of rust and/or tears are repaired promptly to facilitate effective cleaning.

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 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Accidents and incidents in the previous 12 months to our inspection had been documented.

The practice had systems to assess and manage risks to patients, whistleblowing, complaints, safeguarding, health and safety and the management of medical emergencies. It had a robust recruitment policy to help ensure the safe recruitment of staff; however, not all of the staff files contained two references as stated in their own policy.

Patients' medical histories were obtained before any treatment took place. The dentist was aware of any health or medicines issues which could affect the planning of treatment. Staff were trained to deal 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. They had access to an automated external defibrillator (AED). 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.

Are services effective?

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

The practice monitored any changes to the patients' oral health and made referrals for specialist treatment or investigations where indicated. Explanations were given to patients in a way they understood and risks, benefits and options were explained. Record keeping was in line with guidance issued by the FGDP (Faculty of General Dental Practice).

The dentists followed national guidelines when delivering dental care. These included FGDP and National Institute for Health and Care Excellence (NICE). We found that preventative advice was given to patients in line with the guidance issued in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Are services caring?

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

On the day of the inspection we observed privacy and confidentiality were maintained for patients using the service. Patient feedback was generally positive about the care they received from the practice. They commented they were treated with kindness and respect while they received treatment. Patients commented they felt involved in their treatment and it was fully explained to them.

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. They were usually able to see patients requiring urgent treatment within 24 hours. There were clear instructions for patients requiring urgent care when the practice was closed. Some patients commented they had to wait lengthy periods beyond their allocated appointment time.

Summary of findings

There was an effective procedure in place for acknowledging, recording, investigating and responding to complaints made by patients. This system was used to improve the quality of care.

The practice offered access for patients with disabilities; it had accessible toilet facilities and two treatment rooms on the ground floor.

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 we spoke with felt supported in their own particular roles.

There were several systems in place to monitor the quality of the service including various audits. The practice used various methods to successfully gain feedback from patients. Practice meetings had not taken place on a regular basis in the 12 months prior to our visit. The practice recognised this and had planned to introduce meetings on a six weekly basis in 2016.

Smiles Dental Wolverhampton

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 inspected Smiles Dental Wolverhampton on 2 February 2016. The inspection team consisted of one CQC inspector and a dental specialist advisor.

Prior to the inspection we reviewed information we held about the provider from various sources. We informed NHS England and Healthwatch that we were inspecting the practice and we did not receive any information of concern from them. We also requested details from the provider in advance of the inspection. This included their latest statement of purpose describing their values and objectives and a record of patient complaints received in the last 12 months.

During the inspection we toured the premises, spoke with the practice manager, three dentists, the practice co-ordinator, two receptionists and one dental nurse. One of the area managers from the organisation was also available at the practice on the day of the inspection. We spoke with patients and reviewed CQC comment cards which patients had completed. We reviewed a range of practice policies and practice 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 arrangements for staff to report incidents and accidents. We saw that incidents were documented, investigated and reviewed by the practice. All incidents were reviewed by the practice manager on a regular basis. We saw evidence that an incident took place in September 2015 and was documented appropriately. The most recent accident was recorded in November 2015. There was no evidence that incidents/accidents were discussed with staff members during practice meetings. We were told they were discussed informally with staff members at the earliest opportunity.

Staff members we spoke with all understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any RIDDOR reportable incidents in the last 12 months.

The practice responded to national patient safety and medicines alerts that affected the dental profession. We were told that the practice had registered with the MHRA (Medicines and Healthcare products Regulatory Agency). They also received alerts from NHS England. The practice manager was responsible for obtaining information from relevant emails and disseminating the information to staff members. The practice manager told us they printed relevant information and disseminated the information to all dentists and to the lead nurse. The practice had not registered with a specific organisation for reporting any adverse drug reactions. However, we were told they would do this via incident reporting to the local Health and Safety team.

Reliable safety systems and processes (including safeguarding)

The practice had child protection and vulnerable adult 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 – these were clearly displayed in the staff room. The practice manager was the safeguarding lead in the practice. Staff members we spoke with were all knowledgeable about safeguarding but not all had completed safeguarding training in the past 12 months. There had not been any safeguarding referrals to the local safeguarding team; however staff members were confident about when to do so.

The British Endodontic Society recommends the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a rectangular sheet of latex used by dentists for effective isolation of the root canal and operating field and airway. We were told that rubber dam kits were available in the treatment rooms and that all dentists used them when carrying out root canal treatment.

The practice had a policy for raising concerns. All staff members we spoke with were aware of the whistleblowing process within the practice. All dental professionals have a professional responsibility to speak up if they witness treatment or behaviour which poses a risk to patients or colleagues. Within the organisation, there was a mandatory requirement for the practice manager to report any concerns to the head of clinical concerns – this was in addition to their professional responsibility.

We reviewed the practice policy on duty of candour and all staff members had signed it to confirm they had read and understood the contents. The intention of this regulation is to ensure that staff members are open and transparent with patients in relation to care and treatment.

Medical emergencies

Within the practice, the arrangements for dealing with medical emergencies were in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). The practice had access to emergency resuscitation kits, oxygen and emergency medicines. There was an Automated External defibrillator (AED) present. 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.

Staff received annual training in the management of medical emergencies. The organisation took responsibility for ensuring that all of their staff received annual training in this area. We saw that three members of staff did not undergo the training in October 2015. The practice manager told us they were aware of this and we saw evidence to show that these individuals were booked to have the equivalent training at the organisation's sister practices locally.

Are services safe?

The practice undertook regular checks of the equipment and emergency medicines to ensure they were safe to use. The emergency medicines were all in date and stored securely. Glucagon (one type of emergency medicine) was stored in the fridge and the temperature was logged daily.

Two staff members were also qualified in administering first aid treatment. We were told that more staff were interested in undertaking this training in addition to the core training provided by the practice.

Staff recruitment

The practice had a policy for the safe recruitment of staff. We looked at the recruitment records for three members of the practice team. The records we saw contained evidence of immunisation status, dental indemnity, curricula vitae and an induction plan. The employment contracts were not available as they were held at the practice's head office. One piece of evidence relating to the identity of a staff member was not present – the practice manager told us they did request this but had misplaced it. They contacted us within 48 hours of our visit with evidence of this. Their recruitment policy stated that two references for each prospective employee must be sought; however, not all staff members had two references. We were told that the organisation paid for all staff members' dental indemnity. There were Disclosure and Barring Service (DBS) checks present for all of the staff files we viewed. The DBS carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or vulnerable adults.

The practice had a robust system in place to monitor professional registration of its clinical staff members. We reviewed a selection of staff files and found that certificates were present and had been updated to reflect the current year's membership.

Monitoring health & safety and responding to risks

We saw evidence of a business continuity plan which described situations which might interfere with the day to day running of the practice. This included extreme situations such as loss of the premises due to fire. We reviewed the plan and found that it had all relevant contact details in the event of an emergency.

The practice had arrangements in place to monitor health and safety. We reviewed several risk management policies.

We saw that there was clear guidance on fire safety in the practice and we reviewed the fire evacuation procedure. We saw records that fire extinguisher and emergency lighting inspections took place monthly. Fire alarms were tested and documented weekly (by the landlord). The most recent fire drill took place in June 2015. A fire inspection certificate was present and fire extinguishers had been serviced in March 2015. The practice manager sent us evidence 48 hours after the inspection that a fire risk assessment had been carried out the day after our visit. The risk assessment was carried out by the practice manager.

Information on COSHH (Control of Substances Hazardous to Health 2002) was available for all staff to access. The practice identified how they managed hazardous substances in their health and safety and infection control policies. The COSHH folder was reviewed annually. All substances relevant to this practice were included but not saliva (this poses a potential hazard so should be included in COSHH).

Infection control

There was an infection control policy and procedures to keep patients and staff safe. 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)' but there were some areas where they could improve. All staff members (apart from one dentist) had signed this policy to state they had read and understood the contents. The practice had a nominated infection control lead that was responsible for ensuring infection prevention and control measures were followed.

We reviewed a selection of staff files and saw evidence that clinical staff were immunised against Hepatitis B to ensure the safety of patients and staff.

We observed the treatment rooms and the decontamination room to be visually clean and hygienic. Several patients commented that the practice was clean and tidy. Work surfaces and drawers were clean and free from clutter. The floors were adequately sealed in all clinical areas. In one treatment room, there were two small tears in the headrest of the dental chair which would make effective cleaning difficult. We also noted there was rust present on the base of the dental chairs in two treatment

rooms. Again, this would compromise the effectiveness of cleaning. The practice manager contacted us after the inspection and told us they had replaced the headrest with a new one. They also had replaced the foot pedals in both treatment rooms.

There were handwashing facilities in the treatment rooms and staff had access to supplies of personal protective equipment (PPE) for themselves and for patients. The treatment rooms had designated clean and dirty zones. The practice used computers and keyboards in the treatment rooms and those had water-proof covers.

Decontamination procedures were carried out in a dedicated decontamination room. In accordance with HTM 01-05 guidance an instrument transportation system was in place to ensure the safe movement of instruments between the treatment rooms and the decontamination room.

Sharps bins were appropriately located and out of the reach of children; however, they were not wall-mounted. We observed waste was separated into safe and lockable containers for weekly disposal by a registered waste carrier and appropriate documentation retained. Clinical waste storage was in an area where members of the public could not access it. The correct containers and bags were used for specific types of waste as recommended in HTM 01-05.

We spoke with clinical staff about the procedures involved in cleaning, rinsing, inspecting and decontaminating dirty instruments. Clean instruments were packaged, date stamped and stored in accordance with current HTM 01-05 guidelines.

Staff used an ultrasonic cleaning bath to clean the used instruments; they were subsequently examined visually with an illuminated magnifying glass and then sterilised in an autoclave. The practice had an illuminated magnifying glass to improve the value of the inspection process. The decontamination room had clearly defined clean and dirty zones to reduce the risk of cross contamination. Staff wore appropriate personal protective equipment during the process and these included disposable gloves, aprons and protective eye wear.

The practice had systems in place for quality testing the decontamination equipment daily and weekly.We saw records which confirmed these had taken place. There appeared to be sufficient instruments available to ensure the services provided to patients were uninterrupted. Staff also confirmed this with us. However, staff told us they sometimes experienced delays in providing treatment if certain items of equipment were not available at the practice, for example, when they needed to be repaired.

The practice had a protocol which provided assistance for staff in the event they injured themselves with a contaminated sharp instrument. There were no contact details on it for the practice's designated Occupational Health department. However, contact details were present for the organisation's support team. This was discussed with staff and they told us this would be updated.

The Department of Health's guidance on decontamination (HTM 01-05) recommends self-assessment audits of infection control procedures every six months. It is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. We saw evidence that the practice carried these out every six months in line with current guidance. Results of the most recent audit (August 2015) showed that the practice was 98% compliant in meeting the standards set by HTM 01-05. Action plans were documented subsequent to the analysis of the results. By following the action plan, the practice could subsequently assure themselves that they had made improvements as a direct result of the audit findings.

Staff members were following the guidelines on managing the water lines in the treatment rooms to prevent Legionella. Legionella is a term for particular bacteria which can contaminate water systems in buildings. A risk assessment process for Legionella was carried out in August 2014 by an external agency.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as the X-ray sets, pressure vessels and autoclaves.

There were three autoclaves (sterilisers) present at the practice but one was out of use. Historically, this was used for sterilising the equipment required for implant surgery. We were told that the implantologist now brought their own sterilised instruments.

Are services safe?

Regular Portable Appliance Testing (PAT) is required to confirm that portable electric items used at the practice are safe to use. The practice previously had PAT carried out in 2013. The practice had already booked a contractor to carry out the PAT two days after our visit.

The practice kept a log of prescriptions given and dispensed medicines so they could ensure that all prescriptions were tracked and safely given.

There was a separate fridge for the storage of medicines and dental materials. We saw evidence that the temperature was being monitored on a daily basis.

We were told that the batch numbers and expiry dates for local anaesthetics were always recorded in patients' dental care records. All dental materials we viewed were within their expiry date.

Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. Equipment was present to enable the taking of orthopantomograms (OPG). An OPG is a rotational panoramic dental radiograph that allows the clinician to view the upper and lower jaws and teeth. It is normally a two-dimensional representation of these.

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. Local rules were available in the practice for all staff to reference if needed.

We saw evidence of notification to the Health and Safety Executive (HSE). Employers planning to carry out work with ionising radiation are required to notify HSE and retain documentation of this.

The most recent X-ray audit was carried out in December 2015. Audits are central to effective quality assurance, ensuring that best practice is being followed and highlighting improvements needed to address shortfalls in the delivery of care. We saw evidence that several X-ray audits were carried out throughout 2015.

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 assessments in line with recognised guidance from the Faculty of General Dental Practice (FGDP). However, improvements were needed with regard to their record keeping processes. One example of this included the lack of recording consent (although we were assured that they had processes in place for gaining consent).

We talked to three dentists about the oral health assessments, treatment and advice given to patients and corroborated what they told us by looking at patient care records. Clinical records included details of the condition of the teeth, soft tissues lining the mouth, gums and any signs of mouth cancer. Medical history checks were updated by each patient at each visit. This included an update on their health conditions, current medicines being taken and whether they had any allergies.

The Basic Periodontal Examination (BPE) is a screening tool which is used to quickly obtain an overall picture of the gum condition and treatment needs of an individual. We saw that the practice was recording the BPE. Patients with gum disease had the option of visiting the dental hygienist.

The practice used other guidelines and research to improve their system of clinical risk management. For example, following clinical assessment, the dentist told us they 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 was recorded and reports on the X-ray findings were available in the dental care records.

Staff told us that treatment options and costs (where applicable) were discussed with the patient and this was corroborated when we spoke with patients.

Health promotion & prevention

The medical history form patients completed included questions about their smoking and alcohol consumption. We were told that the practice carried out preventative care and supported patients to ensure better oral health. We were told that the practice referred to guidance in The Delivering Better Oral Health Toolkit (DBOH). This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. We saw a policy relating to this which all staff members had signed to indicate they had read and understood it.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. We were told a telephone induction was arranged with the organisation's dedicated induction team.

Staff told us 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 and dental technicians. All clinical staff members were registered with the GDC (apart from the trainee dental nurses as only qualified staff can register).

The practice manager monitored staffing levels and planned for staff absences to ensure the service was uninterrupted. We were told that dental nurses were often transferred from the organisation's other local practices and staff were happy to travel between the two locations if required.

Dental nurses were supervised by the dentists and supported on a day to day basis by the practice manager. Staff told us the practice manager was readily available to speak to at all times for support and advice. We saw evidence that staff members were receiving annual appraisals and reviews of their professional development.

Two of the dental nurses had carried out further training which enabled them to assist the dentist during dental implant surgery.

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. For example, referrals were made to hospitals and specialist dental services for further investigations or specialist treatment. We viewed two referral letters and noted that one was comprehensive to ensure the specialist services had all the relevant information required. The other letter lacked clinical details and we spoke with the

Are services effective?

(for example, treatment is effective)

practice manager about this. This was subsequently discussed with the dentist and they used this as a learning exercise and agreed that some areas required further information for clarity.

Some patients were also referred to the organisation's other dental practice if they requested certain specialist dental services such as periodontics (gums) or sedation (this is a technique in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation).

The practice understood the procedure for urgent referrals, for example, patients with a suspected oral malignancy. They followed these up with telephone calls to ensure the referral had been received.

Consent to care and treatment

Patients were given appropriate verbal information to support them to make decisions about the treatment they received. Staff ensured patients gave their consent before treatment began. The practice did not have dedicated consent forms for patients for all extensive items of dental treatment. We saw evidence of customised treatment plans when reviewing dental care records.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Twenty-seven patients provided feedback about the practice. We looked at comment cards patients had completed prior to the inspection and we also spoke with three patients on the day of the inspection. Overall the information from patients was complimentary. Patients were positive about their experience and they commented that they were treated with respect. They said that staff were polite and friendly.

We observed privacy and confidentiality were maintained for patients who used the service on the day of the inspection. For example, the doors to the treatment rooms were closed during appointments and confidential patient details were not visible to other patients. We observed staff members were helpful, discreet and respectful to patients. Staff members we spoke with were aware of the importance of providing patients with privacy. Staff told us if a patient wished to speak in private an empty room was available to speak with them. We were told that all staff had individual passwords for the computers where confidential patient information was stored. Staff told us they all logged out of the system whenever the computers were unattended. Confidential patient information was stored in a secure area.

We were told that the practice appropriately supported anxious patients using various methods. The practice booked longer appointments so that patients had ample time to discuss their concerns with the dentist. Anxious patients were advised to bring a friend or family member with them for additional support. New patients were encouraged to visit the practice as they gave them the opportunity to meet the staff outside the clinical areas. They also had the choice of several dentists, including male or female dentists.

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. Patients were also informed of the range of treatments available. Patients commented that the cost of treatment was discussed with them and this information was also provided to them in the form of a customised written treatment plan.

Examination and treatment fees were displayed in the waiting room.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We conducted a tour of the practice and we found the premises and facilities were appropriate for the services that were planned and delivered. Patients with mobility difficulties were able to access the practice as there were two treatment rooms on the ground floor.

The practice had an appointment system in place to respond to patients' needs. If the dentist was running late, we were told that the receptionist would inform the patient so that they had the opportunity to rebook the appointment if this was more convenient for them. However, some feedback from patients confirmed that this was not always the case. Patient feedback stated that they were not always informed when the dentist was running late and that this was a recurrent problem.

Staff told us the majority of patients who requested an urgent appointment would be seen within 24 hours.

Patient feedback confirmed that the practice was providing a good service that met their needs. The practice sent appointment reminders via text message alerts and telephone calls to all patients who had consented. Some patients commented they had to wait beyond their scheduled appointment time and were unhappy that they were not always kept informed of any delays. We discussed with the practice manager and they assured us they would investigate this. They told us they would carry out an audit of waiting times.

Tackling inequity and promoting equality

The practice had an equality and diversity policy to support staff in understanding and meeting the needs of patients. The practice appeared to recognise the needs of different groups in the planning of its services. The practice did not have audio loop systems or signs in Braille for patients who might have hearing or visual impairments respectively. However, the practice was able to communicate with these patients using various methods so that patients could still access the services. An example of this included the practice's access to sign language interpreters for patients who are deaf or partially deaf.

Patients told us that they received information on treatment options to help them understand and make an informed decision of their preference of treatment.

The practice had access to an interpreting service and used it regularly. We were told that the practice treated a variety of ethnic groups and many patients were unable to speak fluent English. During our visit, we noted that a patient called to make an appointment for their young child. The parent was unable to speak fluent English and the receptionist arranged an interpreter to be present on the day of the scheduled appointment. The dentists, nurses and receptionists also spoke a variety of languages and we were told that they would often communicate with patients without requiring the assistance of an interpreter.

Access to the service

The practice displayed its opening hours on the premises. Patients could access care and treatment in a timely way and the appointment system met their needs.

The practice had a system in place for patients requiring urgent dental care when the practice was closed. The practice had an arrangement with local dental practices where patients could be seen for emergency dental treatment.

There was a rota present so that staff had a staggered lunch – this enabled the practice to remain open throughout the lunch period so that patients were not inconvenienced.

Opening hours are from 8am to 7.30pm on Mondays, 8am to 8pm on Tuesdays, Wednesdays, Thursdays and from 8am to 5.30pm on Fridays. The practice is also open on Saturdays from 9am to 2pm.

Concerns & complaints

We saw evidence that complaints received by the practice had been recorded, analysed, investigated and learning had been identified. We found that most complainants had been responded to in a timely manner. The practice identified one complaint where their own process could have been improved with regard to a more prompt response. Senior staff had identified that improvements were required and had implemented any changes so that future complaints could be dealt with more efficiently and effectively. Any learning identified was cascaded personally to team members.

The practice had a complaints process which provided staff with clear guidance about how to handle a complaint. Any formal or informal comments or concerns were passed on to the practice manager to ensure responses were made in

Are services responsive to people's needs?

(for example, to feedback?)

a timely manner. This information would then be passed on to any relevant staff members. Information for patients about how to make a complaint was available at the practice.

Patients had made comments on the NHS Choices website. The practice manager told us that staff at the organisation's head office were responsible for responding to any entries made on this website.

Are services well-led?

Our findings

Governance arrangements

The practice manager was in charge of the day to day running of the service. We saw they had systems in place to monitor the quality of the service. These were used to make improvements to the service. The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately. One example was their risk assessment of injuries from sharp instruments. We were told that the dentists always re-sheathed and dismantled needles so that fewer members of the dental team were handling used sharp instruments. This reduced the risk of injury to other staff members posed by used sharp instruments.

Leadership, openness and transparency

Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. All staff we spoke with were aware of whom to raise any issue with and told us the senior staff were approachable, would listen to their concerns and act appropriately. There were designated staff members who acted as dedicated leads for different areas, such as a safeguarding lead and infection control lead.

Learning and improvement

The practice manager monitored staff training to ensure essential staff training was completed each year. This was free for all staff members and included emergency resuscitation and immediate life support. The practice manager also monitored staff members' CPD records to ensure they were meeting GDC requirements.

Staff audited areas of their practice regularly as part of a system of continuous improvement and learning. These included audits of radiography (X-rays), dental care record keeping and infection control.

The practice manager told us that staff meetings had not been regularly held over the past year. However, we saw a plan for 2016 which showed that they had arranged to hold meetings every 4-6 weeks. We saw that staff meetings took place in June 2015 and January 2016. We noted that topics such as infection control and medical emergencies had been discussed and documented. The minutes of the meetings were made available for all staff. This meant that staff members who were not present also had the information and all staff could update themselves at a later date.

We were told that all staff members had regular appraisals where learning needs, concerns and aspirations could be discussed. The dental nurses and receptionists had their appraisals with the practice manager every six months. We also saw examples of procedures that were in place to improve staff performance. The dentists had monthly appraisals and we saw documents to confirm this.

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

Patients and staff we spoke with told us that they felt engaged and involved at the practice.

The practice had systems in place to involve, seek and act upon feedback from people using the service. The practice undertook patient satisfaction surveys and 100% of the feedback from patients in December 2015 was positive. A suggestions box for patients was available at the practice. The practice also undertook the NHS Family and Friends Test (FFT). The FFT captures feedback from patients undergoing NHS dental care.

Staff we spoke with told us their views were sought and listened to but there were no dedicated staff satisfaction questionnaires.