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Wistaria Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 19 July 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

Wistaria Dental Practice is located in the market town of Crediton, Devon. The practice provides Primary Dental Care services for people who require dental procedures. The practice provides private patient care. There are two dental surgeries situated on the ground floor of the premises with level access from the street. Approximately 1,500 patients are registered at the practice. The majority of patients are adults.

The staff structure of the practice consists of one dentist and two dental hygienists. There is a practice manager, two dental nurses and a trainee dental nurse. Dental nurses also act as reception staff. The practice also employs an oral health educator.

The practice is open from Monday to Thursday, with Saturday morning sessions on one day per month. Clinical sessions are not available on Fridays; however the practice reception opens between 9am to 12pm on Fridays. There is an answerphone message directing patients to emergency contact numbers when the practice is closed.

The owner and dentist is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Summary of findings

The inspection took place over one day and was carried out by a CQC inspector who had access to remote advice from a specialist advisor.

Thirty patients provided feedback directly to CQC about the service. Twenty nine patients were positive about the care they received from the practice. They were complimentary about the friendly, professional and caring attitude of the dental staff and the dental treatment they had received. Negative feedback was received from an anonymous source. We looked into these concerns raised regarding cleanliness and staff attitudes and found the concerns were unsubstantiated.

Our key findings were:

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were effective systems in place to reduce and minimise the risk and spread of infection.
- There was a lead staff member for safeguarding patients. All staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- Patients indicated that they felt they were listened to and that they received good care from the practice team.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- Patients could access treatment and urgent and emergency care when required.
- Patients could book appointments up to 12 months in advance.
- Appointment text/phone reminders were available on request 48 hours prior to appointments.
- Patients benefitted from access to an oral health educator on the premises.
- The provider had a clear vision for the practice and staff told us they were well supported by the management team.

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

- Review at appropriate intervals the training, learning and development needs of individual staff members and have an effective process established for the on-going assessment of all staff.
- Review the practice's recruitment policy and procedures to ensure character references for new staff are requested and recorded suitably.
- Review the governance processes for formally recording and communicating outcomes from internal staff meetings effectively.
- Develop systems to publicise the action taken by the practice as a result of patient feedback.

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?

No action

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

The practice had systems in place to minimise the risks associated with providing dental services. The practice had policies and protocols, which staff were following, for the management of medical emergencies. There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members.

Staff had good awareness of safeguarding issues, which were informed by and supported by practice policies. There was an annual training plan to ensure staff training in safeguarding was appropriately maintained. Additional safeguarding training for lead staff was being arranged. Infection control processes were safely managed. Staff recruitment was robust; however, one file did not contain sufficient character references for a recent change in job role.

We found the equipment used in the practice was checked for effectiveness. However, we found that some bandages in first aid kits were out of date. This was rectified during the inspection and the practice manager put in place a more robust system for monitoring the first aid boxes contents.

Are services effective?

No action

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

The practice provided evidence-based care in accordance with relevant, published guidance, for example, from the General Dental Council (GDC). The practice monitored patients' oral health and gave appropriate health promotion advice. Patients benefitted from access to an oral health educator at the practice to advise on dental related dietary advice, tooth brushing technique advice and smoking cessation advice.

Staff explained treatment options to ensure that patients could make informed decisions about any treatment. The practice worked well with other providers and followed up on the outcomes of referrals made to other providers.

Staff engaged in continuous professional development (CPD) and were meeting the training requirements of the General Dental Council (GDC). New staff had received an induction and were engaged in a probationary process to review their performance and understand their training needs.

Are services caring?

No action

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

We received positive feedback from 29 patients and a negative comment about staff attitude from one patient. The practice received 19 comments from their own patient survey carried out from March to July 2016. All patient survey results were complimentary about the practice staff and treatment received. Patient survey results said that the staff were kind and caring and that they were treated with dignity and respect at all times.

Summary of findings

We found that dental care records were stored securely and patient confidentiality was well maintained.

Are services responsive to people's needs?

No action

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

Patients had good access to appointments, including emergency appointments, which were available on the same day.

There was a complaints policy in place. The practice had received one complaint, about fees, in the past year. This was addressed in a timely way and resolved to the satisfaction of the complainant. We received one additional piece of anonymous negative feedback about the practice cleanliness and staff attitudes, which we looked into and found was unsubstantiated. Systems were in place for receiving more general feedback from patients, with a view to improving the quality of the service. This included a comments book in the practice reception area, patient emails directly to the practice and patient surveys. Systems had not yet been developed to promote a response from the practice to what had been done as a result of patient feedback.

The culture of the practice promoted equality of access for all. The practice staff told us that if patients visited with support dogs for assistance with a visual or a hearing impairment, the dogs would be welcomed. The facilities for people with limited mobility were restricted by the listed status of the premises, however, all surgeries were on the ground floor, with level access from the street.

Are services well-led?

No action

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

The practice had clinical governance and risk-management structures in place. Regular staff meetings took place, however meetings were not consistently formalised and meeting minutes were not recorded. Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the management team (practice manager and principle dentist). Not all staff had received an annual appraisal, however, they were confident in the abilities of the managers to address any issues as they arose.

Wistaria 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 19 July 2016. The inspection was led by a CQC inspector who had access to remote advice from a specialist advisor.

We reviewed information received from the provider prior to the inspection. During our inspection we reviewed policy documents and spoke with six members of staff (one dentist, the practice manager, two additional dental nurses/receptionists, one dental nurse trainee and one dental hygienist). We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. A dental nurse demonstrated how they carried out decontamination procedures of dental instruments.

Thirty patients provided feedback about the service. We also saw three written comments about the practice and the most recent practice survey results from 19 patients. Patients were positive about the care they received from the practice. They were complimentary about the friendly, professional and caring attitude of the dental staff. Patients commented that they were likely to recommend the practice.

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.

No action

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There was a system in place for reporting and learning from incidents. There had been no significant events related to patients in the past year.

We discussed the investigation of incidents with the practice manager. They confirmed that if patients were affected by something that went wrong, they were given an apology and informed of any actions taken as a result. Practice staff were aware of their responsibilities under the Duty of Candour.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any such incidents in the past 12 months.

Staff team meetings were held at least monthly, however, these were informal and minutes were not recorded. It was therefore unclear how actions resulting from staff meetings were effectively monitored and shared with the whole staff team. The practice manager told us they would review the processes and structure for staff meetings. They told us they planned to start ensuring that meetings had a written agenda, were minuted and that minutes were circulated to the staff team, including those unable to attend the meetings.

Reliable safety systems and processes (including safeguarding)

The dentist was the named practice lead for child and adult safeguarding. They were able to describe the types of behaviour a child might display that would alert them to possible signs of abuse or neglect. They also had a good awareness of the issues around vulnerable elderly patients who presented with dementia.

The practice had a safeguarding policy reviewed in the last 12 months. The policy referred to national and local guidance. Information about the local authority contacts for safeguarding concerns was held in a file in the staff room. The staff we spoke with were aware of the location of this information. There was evidence in staff files showing that staff had been trained in safeguarding adults and children to level two. The dentist told us that they would arrange for additional recommended training for themselves and the practice manager in child protection to level three.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, we asked staff about the prevention of needle stick injuries. The practice had a current policy on the re-sheathing of needles, written in July 2016, giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Staff were aware of the contents of this policy. The staff we spoke with demonstrated a clear understanding of the practice policy and protocol with respect to handling sharps and needle stick injuries. The practice welcomed patient assistant dogs. There was a risk assessment in place for the presence of dogs at the practice which considered infection control risk and general risk to other patients.

The practice followed other national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments 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).

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. The practice had an oxygen cylinder, and other related items, such as manual breathing aids and portable suction, in line with the Resuscitation Council UK guidelines. An automated external defibrillator (AED) was situated in the principal's surgery with the rest of the emergency equipment. This was available for the dental practice to use; the staff were aware of its location and how to use it. (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).

The practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. The emergency medicines were all in date and stored securely with emergency oxygen in a location known to all staff. There was no notice of oxygen storage

signposted in the case of an emergency. However, the practice manager took immediate action during the inspection and ordered a notice to display on the door of the room where the oxygen was stored.

Staff received annual training in using the emergency equipment. The staff we spoke with were all aware of the location of the emergency equipment. This equipment was checked for safe use each day the practice was open.

We found that some bandages in first aid kits were out of date. This was rectified during the inspection and the practice manager put in place a more robust system for monitoring the first aid boxes contents.

Staff recruitment

The staff structure of the practice consisted of one dentist, two dental hygienists, three dental nurses/receptionists (one of whom is the practice manager), a trainee dental nurse and an oral health educator.

Many of the staff had been in post for a number of years. There was a recruitment policy in place which stated that all relevant checks would be carried out to confirm that any person being recruited was suitable for the role. This included the use of an application form, interview, review of employment history, evidence of relevant qualifications, the checking of references and a check of registration with the General Dental Council. One member of staff had recently changed their role by commencing on a dental nurse training programme. Previously their role had been as a receptionist. We reviewed this staff file; records were complete with the exception of sufficient references for the change in post. The practice manager said they would seek additional character references to satisfy themselves of the staff member's suitability for their new role.

It was practice policy to carry out a Disclosure and Barring Service (DBS) check for all members of staff prior to employment and periodically thereafter. We saw evidence that all members of staff had a DBS check. (The 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). With the change on role for one staff member the standard level of DBS check was no longer sufficient. The practice manager told us they would apply for an additional DBS at the recommended enhanced level relevant to the role change.

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety policy in place. The practice had considered the risk of fire, had clearly marked exits and an evacuation plan. There were also fire extinguishers situated in the reception area. The last fire risk assessment of the premises had been reviewed in June 2016.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. COSHH products were securely stored.

The practice had a system in place for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS).

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. There was an infection control policy, which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. The lead infection control nurse carried out bi-annual audits of infection control processes at the practice using a recognised industry assessment tool.

We observed that the premises appeared clean, tidy and clutter free. Clear zoning demarked clean from dirty areas in all of the treatment rooms. Hand-washing facilities were available, including wall-mounted liquid soap, hand gels and paper towels in each of the treatment rooms and decontamination room. We noted that paper towels were not available in the staff/patient toilet. There was an electronic hand drier, but this had to be switched on before entering the toilet. The dentist took immediate action and ordered a paper towel dispenser for the toilet during the inspection. Hand-washing protocols were also displayed appropriately in the practice.

We asked a dental nurse to describe to us the end-to-end process of infection control procedures at the practice. The protocols described demonstrated that the practice

followed the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)'.

The dental nurse explained the decontamination of the general treatment room environment following the treatment of a patient. Staff described the process they followed to ensure that the working surfaces, dental units and dental chairs were decontaminated. This included the treatment of the dental water lines. Environmental cleaning was carried out in accordance with the national colour coding scheme by the cleaning staff employed to work throughout the building.

We checked the contents of the drawers in one of the treatment rooms. These were well stocked, clean, ordered and free from clutter. All of the instruments were pouched. Each treatment room had the appropriate personal protective equipment, such as gloves and aprons, available for staff and patient use.

The practice cleaned and sterilised dental instruments inside surgery rooms. There was no dedicated separate decontamination room. Inside the surgeries there was a well-defined system of zoning from dirty through to clean.

Instruments were manually cleaned in the treatment room then inspected under a light magnification device and then placed in an autoclave (steriliser). When instruments had been sterilised, they were pouched and stored appropriately until required. Pouches were dated with a date of sterilisation and an expiry date in accordance with HTM 01-05.

The practice carried out checks of the autoclave to assure that it was working effectively. Twice daily checks when the practice was open included the automatic control test and steam penetration test. A log book was used to record the essential daily validation checks of the sterilisation cycles.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained. The practice used a contractor to remove dental waste from the practice. Waste was stored in a separate, locked location within the practice prior to collection by the contractor. Waste consignment notices were available for inspection.

Staff files showed that staff regularly attended training courses in infection control. Clinical staff were also required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. (People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections.)

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). The practice manager described the method they used which was in line with current HTM 01-05 guidelines. A Legionella risk assessment had been carried out by an external contractor in 2015. The practice was following recommendations to reduce the risk of Legionella, for example, through the regular testing of the water temperatures. The practice kept a record of the outcome of these checks on a monthly basis.

Equipment and medicines

We found that the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor, fire equipment and X-ray equipment had all been inspected and serviced. Certificates for pressure equipment had been issued in accordance with the Pressure Systems Safety Regulations 2000. Portable appliance testing (PAT) had been completed in accordance with current guidance and was next due by June 2017. PAT is the name of a process during which electrical appliances are routinely checked for safety every two years as a minimum.

The expiry dates of medicines, oxygen and equipment were monitored using daily, weekly and monthly check sheets to support staff to replace out-of-date medicines and equipment promptly. Dental care products requiring refrigeration were stored in a fridge in line with the manufacturer's guidance.

Radiography (X-rays)

There was a radiation protection file, which was in the process of being completed at the time of the inspection, in line with the Ionising Radiation Regulations (IRR) 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor

No action

Are services safe?

as well as the documentation pertaining to the maintenance of the X-ray equipment. We saw that the X-ray equipment had been serviced in March 2016, within the three yearly recommended maintenance cycle.

We saw evidence that the dentist had completed radiation training in the last 12 months.

No action

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Dentists and hygienists carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. We spoke with one dentist and one hygienist and asked them to describe to us how they carried out their assessment. The assessment began with the patient completing a medical history update covering any health conditions, medicines being taken and any allergies suffered. We saw patients being asked to complete a medical history when they booked in for their appointment to give to the dentist. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were made aware of the condition of their oral health and whether it had changed since the last appointment.

The patient's dental care record was updated with the proposed treatment after discussing options with the patient. Treatment plans were printed for each patient on request, which included information about the costs involved. Patients were referred to the practice information leaflet, or website for cost information on routine treatments. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

We checked a sample of four dental care records to confirm the findings. These showed 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 and soft tissues lining the mouth were noted using the basic periodontal examination (BPE) scores. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). These were carried out, where appropriate, during a dental health assessment.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. We spoke with one dentist and one hygienist who told us they discussed oral health with their patients, for example, around effective tooth brushing. They were aware of the need to discuss a general preventive agenda with their patients. They told us they held discussions with their patients, where appropriate, around smoking cessation, sensible alcohol use and diet. The dentists also carried out examinations to check for the early signs of oral cancer. The practice also employed an oral health educator who was able to provide oral health advice to patients away from the clinical environment of the surgeries, in a calm and relaxing patient waiting area.

We observed that there were health promotion materials displayed in the reception area. These could be used to support patients' understanding of how to prevent gum disease and how to maintain their teeth in good condition.

Staffing

Staff told us they received appropriate professional development and training. We checked the staff recruitment files and saw that this was the case. The training covered the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, safeguarding, infection control and X-ray training.

There was a written induction programme for new staff to follow and evidence in the staff files that this had been used at the time of their employment.

Many of the staff employed had worked at the practice for a number of years. One member of staff had changed roles in the practice in the last 12 months, from a clerical role to a primarily clinical role. They told us there had been a comprehensive induction course which included training on safeguarding, health and safety, infection control and information governance.

Working with other services

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients.

Staff at the practice explained how they worked with other services, when required. The dentist and hygienists were able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. For example, the practice made referrals to other specialists for complex orthodontic work.

We reviewed the systems for referring patients to specialist consultants in secondary care. A referral letter was prepared and sent to the hospital with full details of the dentist's findings and a copy was stored on the practice's

No action

Are services effective?

(for example, treatment is effective)

records system. We looked at two examples of referral letters. These were comprehensively completed and referrals took place in a timely way to avoid delay to treatment. The receptionists kept an electronic record noting the dates when referrals were made, when the appointment had been completed and further actions required for follow up. They contacted other providers to check on the progress of their patients and kept the referring dentist informed about the outcomes.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. We spoke to the dentist about their understanding of consent issues. They explained that individual treatment options, risks, benefits and costs were discussed with each patient. Patients were asked to sign formal written consent forms for specific treatments. We looked at four patient electronic records and saw consent to treatment was suitably recorded in the patient dental care records.

All of the staff were aware of the Mental Capacity Act 2005. (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). Clinical staff had completed formal training in relation to the MCA in 2015. The dentist could describe scenarios for how they would manage a patient who lacked the capacity to consent to dental treatment. They noted that they would involve the patient's family, check for appropriate lasting power of attorney authorisation to act on a person's behalf, along with other professionals involved in the care of the patient, to ensure that the best interests of the patient were met.

No action

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The 29 comments cards we received all made positive remarks about the staff's caring, professional and helpful attitude. Patients indicated that they felt comfortable and relaxed with their dentist and that they were made to feel at ease during consultations and treatments. We also observed staff were welcoming and helpful when patients arrived for their appointment or made enquiries over the phone. We received negative feedback about cleanliness and staff attitudes at the practice directly to CQC from one anonymous source. We looked into the concerns and found these were unsubstantiated.

Staff were aware of the importance of protecting patients' privacy and dignity. The treatment rooms were situated away from the main waiting area and we saw that doors were closed at all times when patients were having treatment. Conversations between patients and the dentist/hygienist could not be heard from outside the rooms, which protected patients' privacy.

Staff understood the importance of data protection and confidentiality and had received training in information governance. Patients' dental care records were stored in a paper format in a dedicated lockable staff only area. There were also electronic records for X-rays and charting. Computers were password protected and regularly backed up.

Involvement in decisions about care and treatment

The practice detailed information about services on the practice website. This gave details of the range of services available, dental charges or fees and payment options (such as membership of private dental schemes).

We spoke with all six of the staff on duty on the day of our inspection. All of the staff told us they worked towards providing clear explanations about treatment and prevention strategies. We saw evidence in the records that the dentists recorded the information they had provided to patients about their treatment and the options open to them.

The patient feedback we received on the day of the inspection confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

No action

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' dental needs. The dentist and hygienists decided on the length of time needed for their patient's consultation and treatment according to patient need. The feedback we received from patients indicated that they felt they had enough time with the dentist and were not rushed.

Staff told us that patients could book an appointment in good time to see the dentist. The feedback we received from patients confirmed that they could get an appointment when they needed one, and that this included good access to emergency appointments on the day that they needed to be seen. On the day of our inspection we heard a patient request a same day appointment, which was accommodated.

During our inspection we looked at examples of information available to people. The practice website contained a variety of information, including opening hours and costs. There was also a printed patient information leaflet at the practice.

Tackling inequity and promoting equality

The practice recognised the needs of different groups in the planning of its service. There was an equality and diversity policy for staff to refer to. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. Reception staff showed us they provided written information for people who were hard of hearing and medical history forms could be downloaded in a preferred language (using and English template translation) for patients who spoke English as a second language.

Patients who used a wheelchair could access the practice from the ground level access and ground floor treatment rooms. The building was listed, this prevented internal works to build a large and accessible patient toilet. The practice staff told us that wheelchair users were advised of the building restrictions for disabled patients when they enquired about registering. Alternative dental practices were available locally.

Access to the service

The practice opening hours were from Monday to Thursday, with Saturday morning sessions on one day per month. Clinical sessions were not available on Fridays; however the practice reception opened between 9am to 12pm on Fridays. There was an answer phone message directing patients to emergency contact numbers when the practice is closed. There were also reciprocal arrangements with another private local dental practice for patients to receive treatment when the dentist was away on annual leave.

Patients could book appointments up to 12 months in advance. Appointment text/phone reminders were available on request 48 hours prior to appointments.

The receptionist told us that patients who needed to be seen urgently, for example because they were experiencing dental pain, were seen on the same day that they alerted the practice to their concerns. The feedback we received via comments cards confirmed that patients had good access to the dentist in the event of needing emergency treatment.

Concerns & complaints

Information about how to make a complaint was displayed in the reception area. There was a formal complaints policy describing how the practice handled formal and informal complaints from patients. There had been one complaint recorded in the past year. This was handled in a timely way and resolved to the satisfaction of the patient complaining.

Patients were also invited to give feedback through a comments book in the reception area. Patients could also send comments via the practice email. The practice also used patient surveys, in which patients could remain anonymous. However, systems had not yet been developed to publicise the action taken by the practice as a result of patient feedback.

No action

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements and a management structure. There were relevant policies and procedures in place. Staff were aware of these and acted in line with them.

There were arrangements for identifying, recording and managing risks through the use of risk assessment processes.

Regular informal staff meetings took place at the practice. It was therefore unclear how effective the meetings were and how the staff team monitored action plans as a result of staff meetings. We spoke with the practice manager who told us they would introduce a system of formalising staff meetings by documenting staff meeting agenda and meeting minutes. They planned to circulate minutes within the staff team.

The practice manager told us about the governance structures and protocols at the practice. A systematic process of induction and staff training was in place which ensured that staff were aware of, and were following, the governance procedures.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said that they felt comfortable about raising concerns with the senior managers at the practice. They felt they were listened to and responded to when they did so.

We found staff to be dedicated in their roles and caring towards the patients. We found the dentist provided effective clinical leadership to the dental team.

Staff told us they enjoyed their work and were supported by the senior managers. We noted that not all staff had received a documented appraisal in the last 12 months. The practice manager told us they would schedule and carry out annual appraisals for all staff.

Learning and improvement

The management had a clear vision for the practice which included plans for improving the premises and equipment. For example, there was an upgrade plan for the premises decoration and refurbishment.

Staff kept up to date with current practice though in-house training sessions, on-line training and by attending external training events. For example, the whole staff team had recently attended dementia awareness training, recognising the needs of a patient group that had a percentage of older and learning disability patients.

Not all staff had received an annual appraisal. The practice manager told us that they would schedule and carry out appraisals for all staff.

Staff were being supported to meet their professional standards and complete continuing professional development (CPD) standards set by the General Dental Council (GDC). We saw evidence that the clinical staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the GDC.

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

The practice gathered feedback though the use of verbal engagement with the patients, email, and patient surveys. Principally the former. If a patient felt strongly about an issue their record was annotated so that compliance with those wishes was achieved. If it was something that could be generally applied and welcomed by the patients then the team would discuss this and implement it if appropriate. Actions had been taken as a result, for example, a review of the number of urgent same day appointments.

Staff told us that the management team were open to feedback regarding the quality of the care. All staff were aware of the practice whistleblowing policy and felt they could raise concerns, which would be acted upon by the management team.