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Basildon Dental Practice

Inspection Report

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Date of inspection visit: 22 January 2015
Date of publication: 23/04/2015

Overall summary

The inspection took place on 22 January 2015 as part of our national programme of comprehensive inspections. This practice had not previously been inspected. This practice was registered in April 2014 and this was the first inspection undertaken since that date.

Basildon Dental Centre provides primary dental care mainly for NHS patients but dental treatment is available for a small number of private patients. The practice team includes three dentists, supported by a number of full and part-time dental nurses, a practice manager and two receptionists.

The practice shares the building with another dental practice, separately registered with the Care Quality Commission. This is an entirely separate entity but both practices do share the decontamination facilities. The reception desk is shared but it operated by staff from each practice. Clear signs are displayed and different uniforms worn by each practice.

Prior to our inspection we left some CQC comment cards for patients to complete about their experience of the practice. We reviewed the 48 that had been completed. Patients had made positive comments about the practice and were very satisfied with the care and treatment received from the dentists and the way they were treated by all of the staff working there. Patients we spoke with on the day of the inspection said that staff were kind and caring, explanations about care and treatment options were clearly described to them.

The practice had carried out a patient survey in May 2014. This reflected that patients thought the services provided were either good or very good and felt that the practice was clean and hygienic.

We found that the practice provided safe care and treatment that met patient's needs. The premises, equipment and infection control procedures were effective and followed published guidance. Staff were kind and caring and the dentists and dental nurses provided effective treatment that met their needs.

We found that staff responded to patients needs and provided individualised care and clear explanations. The practice responded to the needs of patients and tailored their services accordingly. The practice was well-led with staff aware of their responsibilities and how their role linked to the vision and objectives of the practice. Staff working there felt supported and said that it was a nice place to work.

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?

There were systems to identify, investigate and analyse patient safety incidents and learning from them was cascaded to staff. Infection control procedures were robust and the premises were clean, tidy and uncluttered throughout. Instruments were cleaned in line with guidance issued in the Department of Health Technical Memorandum Decontamination in primary care dental practices (HTM 01:05). X-ray equipment in use at the practice had been serviced and maintained correctly and only qualified staff were permitted to use it. The practice monitored risks to patients and staff and were able to manage medical emergencies. Equipment in use was serviced and maintained regularly. Staff recruitment procedures were effective.

Are services effective?

Consultations took place in line with current National Institute for Health and Care Excellence (NICE) guidelines. Patients were provided with advice to help them maintain healthy teeth and literature was available for them to read. Where referrals were required these were completed in a timely manner. Treatments were followed up and reviewed to ensure they were effective. Staff were aware of the way to obtain consent whether it be verbal or written. They were aware of the guidance in the Mental Capacity Act 2005 for those patients who may not have had the capacity to make treatment decisions. Staff were trained appropriately and a robust recruitment process was in place.

Are services caring?

Patients were treated with dignity and respect and their privacy was maintained. Patient information was treated confidentially and dentists and other clinical staff involved patients in decisions about their care and treatment. Explanations about care and treatment were clear and options were explained in a way that patients understood. Patient surveys reflected that patients were satisfied with the way they were treated at the practice.

Are services responsive to people's needs?

The practice provided mainly NHS treatment with a small number of patients being able to access private treatment. Both NHS and private treatments met the needs of patients. They provided a range of dental services including an on-site denture laboratory. The appointments system was effective and patients were satisfied with it. The practice opened during the week and on Saturday mornings which offered a service to those who worked during the week. The practice was accessible for patients with a disability or limited mobility. Several languages were spoken by dental staff and vulnerable patients were welcome at the practice. Comments and complaints were dealt with effectively and where ideas for improvement had been identified these were actioned. The practice responded to patient views from the practice survey.

Are services well-led?

The practice had an effective leadership structure with the practice manager monitoring the services they provided and driving improvements. Staff were aware of their roles and responsibilities and how they impacted on the overall vision of the practice. Staff were encouraged to identify improvement areas and these were actioned where relevant. Appraisals were in place for all staff, training and development was available if required and performance was monitored. Risks to both patients and staff had been identified and these were monitored and reviewed. The practice assessed and monitored the services they provided through patient feedback, audits and monitoring complaints.

Basildon 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 and to pilot a new inspection process being introduced by the CQC.

- This inspection was carried out on 22 January 2015 by an inspector from the Care Quality Commission.
- Prior to the inspection we reviewed information that we held about the provider and by other organisations. We also viewed information that we asked the provider to send us in advance of the inspection. This included their latest statement of purpose describing their values and their objectives. We also viewed complaints they had received in the last 12 months.
- During the inspection we spoke with two of the dentists, a dental nurse, the practice manager and a member of the reception staff. We also observed staff interaction with patients. We looked around the premises and spoke with four patients to obtain their views about the staff and the services provided. We reviewed a range of policies and procedures and other documents.
- We viewed the comments made by patients on comment cards that we left for them to complete prior to the inspection. We looked at the results of the latest patient survey carried out in May 2014.

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

Learning and improvement from incidents

The practice had effective systems in place to learn and improve when significant events, accidents and near misses took place. Where incidents had occurred they had been recorded, analysed and investigated.

We viewed three records where accidents had happened at the practice over the last 12 months. We found that they had been recorded in detail and investigated appropriately. One such accident reflected that a member of staff had been supported and provided with guidance about their health which had been monitored. Improvement areas had been identified for all three incidents and it was clear that action had been taken to reduce the risk of a recurrence.

We spoke with three members of staff on the day of our inspection and they had all been made aware of the learning from the incidents and told us this was either passed on to them informally or at team meetings. Although we were satisfied that this had been taking place it had not been formally recorded. The practice have agreed to include this in future minutes of the meetings they hold.

Reliable safety systems and processes including safeguarding

The practice had a lead for safeguarding who was one of the dentists and a policy was in place for staff to follow. Staff we spoke with were aware of safeguarding procedures and knew the signs of abuse and how to report any suspected incident. Contact details of external organisations responsible for investigating safeguarding issues were available for staff to access. All staff had received safeguarding training which was the subject of refresher training at suitable intervals.

National Patient Safety Alerts and notifications from the Medicine and Healthcare Regulatory Agency were acted on appropriately. The practice was a member of the British Dental Association and updates about the latest guidance in dentistry were received from them and cascaded to staff if relevant to their roles. They also followed academic publications such as the British Dental Journal. On receipt of information systems and processes were reviewed to ensure patients received the most up to date and effective treatment and medicines to keep them safe. The information was always reviewed by the practice manager and a clinical member of staff. The practice had a clear audit trail from receipt of the information to appropriate action as this had been recorded effectively in records we viewed.

One particular example of following current guidance was information supplied to the practice in relation to patients taking warfarin (blood thinning medicine). A flow-chart had been placed on the wall for clinical staff to follow and this helped keep patients safe.

Patients attending the practice were asked about their medical history and this was recorded and updated at subsequent visits. This included whether the taking of an x-ray might put patients at risk. This ensured that the dentist was aware of all medical conditions, medicines and allergies prior to providing care and treatment. An audit process was in place to monitor the effectiveness of their system. Patients we spoke with confirmed that their medical history had been taken and updated and they felt safe at the practice. Where patients suffered an adverse reaction to any medicine or treatment it was noted in their dental care record.

The practice was aware of the requirement to report certain accidents to the Health and Safety Executive. A system and recording procedure was in place for this purpose.

Infection control

An infection control lead had been appointed at the practice and this was the practice manager. A written policy was in place for staff to follow, including an infection control risk assessment. The policy covered such areas as the cleaning of instruments, needle stick injuries, general cleanliness of the practice, hand washing techniques and the disposal of clinical waste. The policy had been reviewed and was up to date. The relevant guidelines were regularly monitored to ensure the most current guidance was included in their policy. A system was in place to ensure staff were aware of its contents.

The practice had a dedicated decontamination room that was set out according to the Department of Health's guidance, Health Technical Memorandum 01:05 (HTM 01:05): Decontamination in primary care dental practices.

We found that instruments were being cleaned and sterilised in line with published guidance (HTM 01:05) and staff with responsibilities for the cleaning of instruments

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were aware of the procedures. A dental nurse demonstrated the decontamination process to us using the correct procedures. Clearly defined dirty and clean zones were in operation 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 cleaned their instruments manually prior to the sterilisation process. The washer/disinfector in use was temporarily faulty and awaiting repair. Once cleaned the instruments were examined visually with a magnifying glass and then sterilised in an autoclave. At the end of the sterilising procedure instruments not required for use on the same day were packaged, sealed, dated and stored correctly. Instruments required for use on the same day were placed in a clean box and used in the surgeries. If unused at the end of the day they were then sealed in packages and dated. We discussed this with the practice on the day who were made aware that unused instruments should again go through a decontamination process and not be packaged. They have agreed to change their system to ensure guidance is followed. We examined several drawers of sealed instruments and all were in date.

The equipment used for cleaning and sterilising was maintained and serviced as set out by the manufacturers. Daily, weekly and monthly records were kept of decontamination cycles and tests and when we checked those records it was clear that the equipment was in working order and being effectively maintained.

The other areas we visited in the practice were clean and well maintained. We noted that

sharps bins were properly sited, signed and dated. Hand washing techniques were clearly displayed and liquid soaps and paper towels were readily available.

Staff were well presented and wore clean uniforms. All staff had received up-to-date training in infection control procedures. They told us that they wore personal protective equipment when cleaning instruments and treating people who used the service. Staff were also protected from infection through inoculations received against Hepatitis B and received regular blood tests to check the effectiveness of that inoculation.

Cleaning schedules were in place for the premises and Control of Substances Hazardous to Health (COSHH) guidance was being followed. A contract cleaner was employed to clean the premises, including the floors of the dental surgeries and checklists were in use. The cleaning policy clearly described the areas to be cleaned and the frequency and the quality of the cleaning was monitored regularly by the practice manager.

An infection control audit had been carried out in June 2014 and one was due in the immediate future. Records we viewed reflected that the audit was effective. Where areas for improvement had been identified these had been actioned and completed. Follow-up audits revealed no repeat concerns or issues.

Staff and patients were protected from the risk of the legionella bacteria. (legionella is a bacteria found in the environment which can contaminate water systems in buildings). A legionella risk assessment had been carried out and a contracted external company attended to carry out periodic testing of the hot and cold water supply. We viewed the most recent records and found that there were no concerns identified.

The practice used osmosis water for their dental unit water lines rather than the mains supply so this did not require testing for legionella. They followed the guidance from the manufacturer by changing the water daily and flushing the system through at the end of the working day.

Clinical waste was stored correctly and collected by an appropriate contractor. The various types of waste had been sorted and packaged in line with guidelines and kept safely and secure in a locked bin area until collection by a contracted waste disposal company. This was also the subject of regular audit.

Dental surgeries were visibly clean, tidy and uncluttered. Cleaning schedules and checklists were in place for each room and records kept. It was evident that the cleaning was being undertaken as described in the schedules, including between each patient. The flooring was made of the recommended material and design so that it could be cleaned easily. Dental chairs were in a satisfactory condition and there were no rips or tears in the fabric. They were also covered partially with a protective plastic cover that allowed for easy cleaning.

Staff we spoke with were aware of infection control procedures and had received training appropriate to their

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role. Patients we spoke with thought the practice was clean and hygienic and commented that clinical staff always wore their personal protective equipment when providing the dental services.

Equipment and medication

Equipment in use at the practice was regularly maintained. This included x-ray machines, a compressor, dental equipment and a blood/glucose monitor for patients with diabetes. Records we viewed confirmed that equipment in use was serviced and checked in line with the manufacturers guidance. Portable appliance testing (PAT) took place on all electrical equipment. Where faults or repairs were required these were actioned in a timely fashion. Fire extinguishers were also checked and serviced regularly.

Medicines in use at the practice were stored and disposed of in line with published guidance. There were sufficient stocks available for use and these were rotated regularly. The ordering system was effective. A system was in place to monitor stocks and expiry dates of medicines. We checked a number of medicines in use at the practice and found them all to be in date. Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities.

Monitoring health & safety and responding to risks

A health and safety policy and risk assessment was in place at the practice. This covered the risk to patients and staff who attended the practice. The risks identified were graded and control measures put in place to reduce them. A checklist was in use and this was the subject of a regular audit to ensure the practice was safe. Where issues had been identified remedial action had been taken in a timely manner.

There were also other policies and procedures in place to manage risks at the practice. These included infection prevention and control, a legionella disease risk assessment, fire evacuation procedures and risks associated with hepatitis B. Processes were in place to monitor and reduce these risks so that staff and patients were safe.

The staff induction process also covered safety and risks and new staff were required to familiarise themselves with relevant practice guidance.

Medical emergencies

There were arrangements in place to deal with foreseeable emergencies. The dentists and staff were all qualified in basic life support including the use of a defibrillator (used to start a person's heart in an emergency). Both adult and child pads were available to use with this equipment. Training was kept under review and refresher courses were available periodically.

Emergency medicines and oxygen were readily available if required. This was in line with the 'Resuscitation Council UK' guidelines. Emergency medicines were all in date, stored correctly and their expiry dates monitored. Latest guidance was being followed about the types of emergency medicines that should be available in the event of a medical emergency.

Staff spoken with told us they had received basic life support training and displayed an awareness of how to respond to an emergency. They knew the location of all the emergency equipment in the practice and how to use it.

Staff recruitment

The practice had an up to date recruitment policy that included the requirement to obtain references, check qualifications and experience, be registered with an appropriate professional body and to obtain proof of identity It also included the requirement for new staff to go through an induction process to familiarise themselves with the way the practice ran, before being allowed to work unsupervised.

We viewed three staff files on the day of our inspection. We found that all of them contained relevant documentation in line with their recruitment policy. We found evidence that staff files contained appropriate recruitment documentation. All staff had received a Disclosure and Barring Service check to ensure it was safe for them to work with vulnerable adults and children. Even staff who had been employed there before this resource existed had received checks to ensure they were currently assessed as suitable to work at the practice. Staff we spoke with told us they had been through a recruitment procedure including a period of induction.

Dentists currently working at the practice were all registered correctly with their professional body and had the necessary qualifications, skills and experience to work

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there. Where locum dentists were used, appropriate checks had been undertaken prior to working at the practice, including references and experience. They were also required to undertake an induction process.

Radiography

X-ray equipment was situated in suitable areas and x-rays were carried out safely and in line with local rules that were relevant to the practice and equipment. A radiation protection advisor and a radiation protection supervisor had been appointed to ensure that the equipment was operated safely and by qualified staff only. This protected people who required x-rays to be taken as part of their treatment.

The practice's radiation protection file contained the necessary documentation demonstrating the maintenance of the x-ray equipment at the recommended intervals. Records we viewed reflected that the x-ray equipment was regularly tested, serviced and repairs undertaken when necessary.

An x-ray audit had taken place in 2014. This included ensuring that pregnant patients were identified and risks considered, that patients only received x-rays when necessary and that the quality of them was of the required standard. This ensured that patients were not subjected to unnecessary levels of radiation and kept them safe.

X-rays were carried out by qualified staff only and in a safe, controlled environment to prevent the risk of radiation exposure to staff and patients.

Dental x-rays were prescribed according to current selection criteria guidelines from the Faculty of General Dental Practice, with the practice having their own written protocol in place. When x-rays were taken, the records showed that the reasons for taking the x-rays and the findings were recorded.

Are services effective?

(for example, treatment is effective)

Our findings

Consent to care and treatment

The practice had a consent policy for staff to refer to. It contained information about the various types of consent including implied, verbal and written and when each was required. It explained how to take consent from a patient if their mental capacity was such that they might be unable to fully understand the implications of their treatment. This followed the guidelines of the Mental Capacity Act 2005.

Clinical staff we spoke with had a clear understanding of consent issues. Reception staff also had a working knowledge of the issues and if in doubt would refer the matter to a more senior member of staff. All staff understood that consent could be withdrawn by a patient at any time. However, reception staff were not aware of Gillick competence. This is a test used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. The practice have agreed to provide some training in relation to this guidance.

Consent for treatment was recorded in the patient's record. This was often in written form when appropriate and usually for the more complex types of treatment. A consent form was available for that purpose.

The practice did have patients with learning disabilities and were able to display to us that they understood the provisions of the Mental Capacity Act in relation to obtaining the views of parents, guardians or advocates, then making decisions in the best interests of the patient.

Monitoring and improving outcomes for people using best practice

Patients attending the practice for a consultation received an assessment of their dental health after supplying a medical history covering health conditions, current medicines being taken and whether they had any allergies. There was also consideration made whether the patient required an x-ray and whether this might put them at risk, such as if a patient may be pregnant.

The assessments were carried out in line with recognised guidance from the National Institute for Health and Care Excellence (NICE) and General Dental Council (GDC) guidelines. This assessment included an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment.

We were told by staff that following a clinical assessment a diagnosis was discussed with the patient and treatment options explained. Where relevant, preventative dental information was given in order to improve the outcome for the patient and this included smoking cessation advice, alcohol consumption guidance and general dental hygiene procedures. The patient notes were then updated with the proposed treatment after discussing options with the patient.

Where necessary patients were referred to the dental hygienist and follow-up appointments arranged to monitor the effectiveness of treatments. In the more complex cases patients were referred to other dental specialists in a timely manner.

Patients we spoke with and feedback received from patients on comment cards reflected that patients were very satisfied with the consultations and treatment they received at the practice.

Working with other services

Where patients had complex dental issues the practice referred patients to other healthcare providers using the local referral process. This included conscious sedation as the practice did not provide this service.

Appointments for patients requiring a referral were usually sent to them within two weeks or sooner if urgent. Patients were supported to choose and book a specialist of their choice.

Health promotion & prevention

The waiting room and reception area at the practice contained literature in leaflet form that explained the services offered at the practice. This included information about effective dental hygiene and how to reduce the risk of poor dental health. The practice had a range of products that patients could purchase that were suitable for both adults and children.

The practice also had a television screen that played a presentation about the services offered at the practice and practical advice and guidance on dental health.

Are services effective?

(for example, treatment is effective)

Adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. Tooth brushing techniques were explained to them in a way they understood and dietary, smoking and alcohol advice was also given to them. Patients at high risk of tooth decay were identified and advised to use toothpaste with high fluoride levels to keep their teeth in a healthy condition.

Staffing

The practice employed three full time dentists all supported by dedicated dental nurses. The ratio of dentists to dental nurses was one to one. Dental staff were appropriately trained, qualified and registered with their professional body. Staff were encouraged to maintain their continual professional development (CPD) to maintain their skill levels and records held in staff files reflected that they were on course to undertake their required number of training hours over a five year period. This was monitored by the practice manager who viewed certificates and maintained records.

Non-clinical staff were appropriately trained to carry out their duties and training was the subject of regular monitoring at the practice. A training record was in place that identified the types of training that were required and the frequency of them. Records we viewed reflected that staff training was up to date and met the needs of the patients.

All staff received appraisals that included training and development opportunities and an overall assessment of their competency. Staff spoken with felt valued and thought they were effectively trained. They told us they were encouraged and supported to undertake training that supported patient needs. We looked at three staff files and saw that appraisals had taken place over a number of years.

Staff new to the practice went through an induction process to ensure they were familiar with the way the practice ran and before being allowed to work unsupervised. This also ensured they were able to display sufficient skills and experience for the role.

Staff numbers were the subject of monitoring and staff shortages planned in advance wherever possible. Where the use of locum dentists or agency staff was required, appropriate processes were in place to ensure they were suitably qualified and experienced. This included checking whether clinical staff were appropriately registered with their professional body.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We found that all staff at the practice treated patients with dignity and respect and maintained their privacy. The reception area was open plan and we were told that when a confidential issue arose patients could be taken to a private room to discuss any issue.

A confidentiality policy was in place of which staff were aware. This covered disclosure of patient information and their conditions and the secure handling of patient information. We observed the inter-action between staff and patients and found that staff were careful not to discuss patient details within the hearing of other patients at the practice. Records were held securely.

Patients we spoke with felt that practice staff were kind and caring. They told us they treated them with dignity and respect and were helpful. Patients who were nervous about seeing the dentist were reassured to make their experience less stressful. Patients who had completed CQC comment cards commented that all staff were polite and friendly and treated them with in a polite and caring way.

A patient survey that took place in May 2014 reflected that patients were satisfied with the way they were spoken to and the dignity and respect they were afforded.

Involvement in decisions about care and treatment

Patients spoken with felt involved with their care and treatment. They told us that the clinical staff provided them with clear explanations about the consultation and the options for treatment. They said that they felt listened to and they did not feel rushed. Costs were made clear to them and they were given time to decide on the treatment proposed.

The practice provided NHS and private treatment and patients were provided with a written treatment on forms designed for the purpose. Where treatment involved more extensive dental work, patients were given time to consider the treatment suggested and felt involved in the decisions relating to it.

A patient survey that took place in May 2014 reflected that patients were satisfied with their involvement in their care and treatment. CQC comment cards that had been completed by patients prior to our inspection reflected that explanations about care and treatment were clearly explained to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice leaflet and website explained the range of services offered to patients. This included regular check-ups (including x-rays and teeth cleaning), fillings, extractions, root canal, dentures, bridges and crowns. The practice undertook NHS and private treatments and costs were clearly explained.

The practice had their own on-site dental laboratory where they were able to make and repair dentures. Most repairs were undertaken on the same day. The practice website had a facility for patients to make contact with them by email to make general enquiries about the services they provided.

The practice provided continuity of care to their patients by ensuring they saw the same dentist each time they attended. When this was not possible they were able to see one of the other dentists.

Patients new to the practice were required to complete a patient questionnaire so that the practice could conduct an initial assessment and respond to their needs. This included a medical history form.

The practice undertook a patient survey annually and the results of it were analysed for improvement areas. We found that the practice was responsive to the needs of patients and where relevant changes made to the services provided to improve patient care and experience. The survey that took place in May 2014 identified that some patients would like the practice to be open early in the morning and late in the evening on occasions. The practice are considering this suggestion. The survey results were displayed in the reception area for patients to view.

Tackling inequity and promoting equality

The practice was accessible for those patients with a disability, mobility issues and those using wheelchairs. The practice benefited form a large private car park at the rear of the practice for the use of their patients.

The reception area, waiting room and consulting rooms were all situated on the ground floor and accessible for all patients, regardless of their mobility. A support rail was available at the entrance to the premises along with an automatic door and this helped patients with mobility issues to access the practice.

Patients who were vulnerable were welcome at the practice and a new patient questionnaire invited them to identify their social background. We were told by the dentist that they had recently taken on patients seeking asylum and a homeless person who had been suffering with dental problems.

Dentists at the practice were fluent in four languages so could translate for many of their patients. Where language was an issue, patients often attended with a relative or friend that could translate for them.

Access to the service

The practice was open from 9am to 4:30pm on Monday and Friday, 9am to 5:30pm Tuesday to Thursday and 9:30am to 12:30pm on a Saturday. The practice had an answer phone for patients to use that gave them a number of options for identifying the type of service they required. The opening hours of the practice were clear on their website. On-site parking was available for all patients.

Patients we spoke with told us that the availability of appointments met their needs and they were rarely kept waiting. Some told us they had experienced delays recently, but these appeared to be isolated incidents. CQC comment cards reflected that patients were either satisfied or very satisfied with the appointment system.

The arrangements for obtaining emergency dental treatment were clearly displayed in the waiting room area, on the practice leaflet and the website. If there was an urgent need for a patient during surgery hours patients were provided with a consultation on the same day.

Concerns & complaints

The practice had a complaints procedure that was advertised on the practice website and on a notice board in the reception area. It explained to patients the procedure to follow, the timescales involved for investigation, the person responsible for handling the matter and details of other external organisations that a complainant could contact.

We viewed three records of complaints that had been reported to the practice in the last 12 months. They

Are services responsive to people's needs?

(for example, to feedback?)

contained the details of the complaint, the details of the investigation, whether an apology was appropriate, contact with the complainant and the outcome. If learning from the complaint had been identified, action had been taken and cascaded to staff at the practice either personally to the individuals concerned or discussed at team meetings. Replies to complaints had been made in writing and in one example the patient had been invited to the practice to discuss the issue with one of the dentists.

Patients we spoke with on the day of our inspection had not had any cause to complain but felt that staff at the practice would treat any matter seriously and investigate it professionally.

Are services well-led?

Our findings

Leadership, openness and transparency

The practice had a statement of purpose that described their vision, values and objectives. Staff we spoke with were aware of this vision and how they contributed to it. Clinical and governance leads had been identified and staff were aware of who they were and their own responsibilities. Staff job descriptions were written in a way that they linked to achieving the vision and values of the practice.

Staff told us that there was an atmosphere of openness and transparency and a 'no blame' culture. They told us they were encouraged to raise issues and concerns in order to make improvements. They said that it was a nice place to work and they were complimentary about the dental partners and practice manager for their leadership abilities.

It was evident that there was a clear leadership structure with regular monitoring and assessment of the services provided. Regular meetings took place with the dental partners and the practice manager and it was clear that there was a professional working relationship between them with the performance of the practice as a main feature.

Governance arrangements

The practice had identified a number of leads in relation to governance. These included health and safety, infection prevention control, the audit process, safeguarding, training and complaint handling. Leadership was provided by the practice manager and overseen and monitored by the partners at the practice.

A system was in place to regularly audit the services they provided. We looked at several audits on the day of our inspection. These included patient records, infection prevention control, x-rays, medical history forms, disability access and clinical waste management. We found that where improvements had been identified they had been actioned and completed. When the processes were re-audited repeat issues were not present which reflected that they had maintained improvements.

The practice also monitored the patients that failed to attend for their appointments. They had recently introduced a text message system to remind patients to attend and this had resulted in an improvement for the month of December 2014.

The practice had an effective system in place of monitoring the latest dental guidance and then implemented it at the practice to ensure patients received the most up to date clinical advice and treatment. The practice had achieved accreditation under the BDA (British Dental Association) 'Good Practice Scheme'.

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

The practice sought feedback from patients through a patient survey and by inviting comments and feedback through their practice website.

We looked at the results of the patient survey and found that patients were extremely satisfied with the services provided. They were complimentary about the clinical and non-clinical staff, the politeness of reception staff, the quality of the dentistry and the cleanliness of the practice. The results of the patient survey were displayed in the reception area for patients to view.

Staff we spoke with told us their views were sought at appraisals, team meetings and informally. They told us their views were listened to and ideas adopted.

Management lead through learning and improvement

The practice had an ethos of learning and improvement and this was evident when speaking with staff. The appraisal process was used to identify development, learning and training needs to improve staff performance. Where staff were not meeting acceptable standards a system was in place to manage this and to provide appropriate support.

Staff meetings were used to discuss performance issues and a regular cycle of audits took place across clinical and non-clinical areas. Where areas for improvement had been identified these had been actioned and monitored so that they could be maintained.

Complaints were treated professionally and with learning in mind and changes in procedures made if required.