Care Quality Commission

Mr Avron Smith

# Marsh Road Dental Practice

## Inspection Report

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## Overall summary

We carried out an announced comprehensive inspection on 20 June 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**

Marsh Road Dental Practice is a mixed dental practice providing NHS and private general and orthodontic treatment for both adults and children. The practice is situated in a converted domestic property. The practice had seven dental treatment rooms and a separate decontamination room for cleaning, sterilising and packing dental instruments. There was also a reception and waiting area on the ground and first floor.

The practice is open 8.00am - 5.00pm Monday to Thursday, Friday 8.00am to 4.30pm. The practice has four general dentists, a specialist orthodontist and a dentist with a special interest in periodontology. They are supported by five dental nurses, a trainee dental nurse, an orthodontic therapist and three dental hygienists. Other staff included a practice manager an assistant practice manager and five receptionists.

The practice manager 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.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice. We received

# Summary of findings

feedback from 31 patients. These provided a completely positive view of the services the practice provides. Patients commented on the high quality of care, the caring nature of all staff, the cleanliness of the practice and the overall high quality of customer care.

**Our key findings were:**

- We found that the practice ethos was to provide patient centred dental care in a relaxed and friendly environment.
- Strong and effective leadership was provided by an empowered practice manager.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice appeared very clean and well maintained.
- Infection control procedures were robust and the practice followed published guidance.
- The practice had a safeguarding lead with effective processes in place for safeguarding adults and children living in vulnerable circumstances.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- Dentists provided dental care in accordance with current professional and National Institute for Health and Care Excellence (NICE) guidelines.
- The practice had fully embraced the concept of skill mix to assist in the delivery of effective dental care to patients.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Patients could access treatment and urgent and emergency care when required.
- Staff recruitment files were organised and complete.
- Staff had received training appropriate to their roles and were supported in their continued professional development (CPD) by the practice manager.
- Staff we spoke with felt well supported by the practice manager and were committed to providing a quality service to their patients.
- Information from 31 completed Care Quality Commission (CQC) comment cards gave us a positive picture of a friendly, caring, professional and high quality service.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

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

The practice had robust arrangements for essential areas such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found that all the equipment used in the dental practice was well maintained. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents. There were sufficient numbers of suitably qualified staff working at the practice. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

**No action** ✓

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals. The staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration

**No action** ✓

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

We collected 31 completed Care Quality Commission patient comment cards on the day of our visit and these provided a positive view of the service the practice provided. All of the patients commented that the quality of care was very good. Patients commented on friendliness and helpfulness of the staff and dentists were good at explaining the treatment that was proposed.

**No action** ✓

**Are services responsive to people's needs?**
We found that this practice was providing responsive care in accordance with the relevant regulations.

The service was aware of the needs of the local population and took those these into account in how the practice was run. Patients could access treatment and urgent and emergency care when required. The practice provided patients with written information in language they could understand and had access to telephone interpreter services when required. The practice had several ground floor treatment rooms and level access into the building for patients with mobility difficulties and families with prams and pushchairs.

**No action** ✓

# Summary of findings

**Are services well-led?**

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

Strong and effective leadership was provided by an empowered practice manager and practice owner. The dentists, practice manager and other staff had an open approach to their work and shared a commitment to continually improving the service they provided. There was a no blame culture in the practice. The practice had robust clinical governance and risk management structures in place. Staff told us that they felt well supported and could raise any concerns with the practice manager. All the staff we met said that they were happy in their work and the practice was a good place to work.

**No action** 

Care Quality Commission

# Marsh Road 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.

The inspection was carried out on 20 June 2016 by a CQC inspector who was supported by a specialist dental adviser. Prior to the inspection, we asked the practice to send us some information that we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, and the details of their staff members including proof of registration with their professional bodies.

During the inspection, we spoke with a dentist, dental hygienist, orthodontic therapist, practice manager, dental nurses and receptionist and reviewed policies, procedures and other documents. We reviewed 31 comment cards that we had left prior to the inspection, for patients to complete, about the services provided at 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.

# Are services safe?

## Our findings

**Reporting, learning and improvement from incidents**

The practice had an incident reporting system in place if something went wrong; this system also included the reporting of minor injuries for patients and staff. The practice reported that there was one incident during 2016 that required investigation. The records we saw demonstrated that the reporting forms were completed in full with details of how the incidents could be prevented in future. The practice received national patient safety alerts such as those issued by the Medicines and Healthcare products Regulatory Agency (MHRA). Where relevant these alerts were sent to all members of staff by the practice manager. The practice manager explained that relevant alerts were also discussed during staff meetings to facilitate shared learning. These meetings occurred every six weeks or so.

**Reliable safety systems and processes (including safeguarding)**

We spoke to a dental nurse about the prevention of needle stick injuries. Their explanation of the treatment of sharps and sharps waste was in accordance with the current EU directive with respect to safe sharp guidelines, thus protecting staff against blood borne viruses. The practice used a system whereby needles were not manually resheathed using the hands following administration of a local anaesthetic to a patient. The dentists were responsible for ensuring safe recapping of a contaminated needle using a special rubber guard and its subsequent disposal. Staff were also able to explain the practice protocol in detail should a needle stick injury occur. The systems and processes we observed were in line with the current EU directive on the use of safer sharps.

We asked a dentist how they treated the use of instruments used during root canal treatment. They explained that these instruments were single patient use only. They also explained that root canal treatment was carried out where practically possible using a rubber dam. In those instances where a rubber dam could not be used other safety measures were used to prevent swallowing or inhalation of a root canal file. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). Patients can be assured that the practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam.

The practice manager acted as the safeguarding lead and acted as a point of referral should members of staff encounter a child or adult safeguarding issue. A policy and protocol was in place for staff to refer to in relation to children and adults who may be the victim of abuse or neglect. Training records showed that all staff had received appropriate safeguarding training for both vulnerable adults and children. Information was available in the practice that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities.

**Medical emergencies**

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Staff had received training in how to use this equipment. The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had access to oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines and oxygen we saw were all in date and stored in a central location known to all staff. The practice held training sessions each year for the whole team so that they could maintain their competence in dealing with medical emergencies. Staff we spoke with demonstrated they knew how to respond if a person suddenly became unwell.

**Staff recruitment**

All of the dentists (including the orthodontist), the orthodontic therapist, dental hygienists and dental nurses had current registration with the General Dental Council, the dental professionals' regulatory body.The practice had a recruitment policy that detailed the checks required to be

# Are services safe?

undertaken before a person started work.For example, proof of identity, a full employment history, evidence of relevant qualifications, adequate medical indemnity cover, immunisation status and references. The systems and processes we saw were in line with the information required by Regulation 18, Schedule 3 of Health & Social Care Act 2008 (Regulated Activities) Regulations 2015.

Staff recruitment records were stored securely to protect the confidentiality of staff personal information. We saw that all staff had received appropriate checks from the Disclosure and Baring Service (DBS). These are 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 adults who may be vulnerable.

**Monitoring health & safety and responding to risks**

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice maintained a comprehensive system of policies and risk assessments which included radiation, fire safety, general health and safety and those pertaining to all the equipment used in the practice. A business continuity plan was in place to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service. The practice had a well-maintained Control of Substances Hazardous to Health (COSHH) file. This file contained details of how substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients.

**Infection control**

There were effective systems in place to reduce the risk and spread of infection within the practice. The practice had in place an infection control policy that was regularly reviewed. It was demonstrated through direct observation of the cleaning process and a review of practice protocols that HTM 01 05 (national guidance for infection prevention control in dental practices') Essential Quality Requirements for infection control were being met. It was observed that audit of infection control processes carried out in February 2016 confirmed compliance with HTM 01 05 guidelines.

We saw that the seven dental treatment rooms, waiting area, reception and toilets were clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available including liquid soap and paper towel dispensers in each of the treatment rooms, the decontamination room and toilet. Hand washing protocols were also displayed appropriately in various areas of the practice and 'bare below the elbow' working was observed.

The drawers of two treatment rooms were inspected and these were clean, ordered and free from clutter. Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

The dental nurse we spoke with described to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. They demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings) they described the method they used which was in line with current HTM 01 05 guidelines. We saw that a Legionella risk assessment had been carried out at the practice by a competent person in April 2015. The recommended procedures contained in the report were carried out and logged appropriately. These measures ensured that patients' and staff were protected from the risk of infection due to Legionella.

The practice had a separate decontamination room for instrument processing. The dental nurse we spoke with demonstrated the process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a system of manual scrubbing and an ultra-sonic cleaning bath for the initial cleaning process, following inspection with an illuminated magnifier the instruments were placed in an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilized, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines. We were shown the systems in place to ensure that the autoclaves used in the decontamination process were working effectively. It

# Are services safe?

was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were always complete and up to date. Recommended tests including weekly protein and soil tests for the ultra-sonic cleaning baths were carried out in accordance with current guidelines, the results of which were recorded in an appropriate log book.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained and was in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. This was stored in a separate locked location adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection. Patients' could be assured that they were protected from the risk of infection from contaminated dental waste.

**Equipment and medicines**

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclaves had been serviced and calibrated in accordance with the Pressure Vessel Regulations 2000, with inspections taking place for the three autoclaves in April 2016, August 2015 and June 2016. The practices' X-ray machines had been serviced and calibrated as specified under current national regulations in June 2013 and were due to be serviced and calibrated again June 2016. Portable appliance testing (PAT) had been carried out in January 2016.

We observed that the practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid and mercury spillage The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records.

The practice dispensed some of their own medicines as part of a patients' dental treatment. These medicines included a range of antibiotics. The dispensing procedures were in accordance with current dispensing regulations and medicines were stored according to manufacturer's instructions. These medicines were stored securely for the protection of patients. We saw that the practice had a logging system to account for the medicines dispensed to prevent inappropriate prescribing or loss of these medicines. We also found that the practice stored NHS prescription pads in a secure cabinet to prevent loss due to theft. The practice had a prescription logging system to account for these prescriptions to prevent inappropriate prescribing or loss of prescriptions.

**Radiography (X-rays)**

We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination packs along with the annual and three yearly maintenance logs and a copy of the local rules. The maintenance logs were within the current recommended interval of three years.

We saw that a radiological audit had been carried out in March 2016. Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured. These findings showed that practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. We reviewed training records that showed all staff where appropriate had received training for core radiological knowledge under IRMER 2000 Regulations.

# Are services effective?

(for example, treatment is effective)

## Our findings

**Monitoring and improving outcomes for patients**

The dentists we spoke with carried out consultations, assessments and treatment in line with recognised general professional guidelines. The dentists described to us how they carried out their assessment of patients for routine care. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained in detail.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

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

The practice used an orthodontic therapist to improve the outcomes for patients (Orthodontic therapists are registered dental professionals who carry out certain parts of orthodontic treatment under prescription from a dentist). They worked within their scope of practice to prescriptions provided by the orthodontist. The therapist showed to us several examples of detailed treatment plans provided by the orthodontist which the therapist followed to complete each patient's treatment plan. Dental care records that were shown to us by the orthodontist demonstrated that the findings of the assessment and details of the treatment carried out were recorded appropriately. The records were comprehensive, detailed and well maintained.

To monitor the quality of the orthodontic treatment provided the practice used a system known as peer assessment rating or PAR scoring. The PAR index is a fast, simple and robust way of assessing the standard of orthodontic treatment that an individual provider is achieving. The orthodontic therapist explained that the practice was achieving a high level of improved outcomes for patients when judged by an independent scoring assessor.

**Health promotion & prevention**

The practice was very focussed on the prevention of dental disease and the maintenance of good oral health. To facilitate this aim the practice appointed three dental hygienists to work alongside the dentists in delivering preventative dental care. Dentists we spoke with explained that children at high risk of tooth decay were identified and offered fluoride varnish applications or the prescription of high concentrated fluoride tooth paste to help keep their teeth in a healthy condition. They also placed fissure sealants (special plastic coatings on the biting surfaces of permanent back teeth in children) who were particularly vulnerable to dental decay. Other preventative advice included tooth brushing techniques explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health: an evidence based toolkit for prevention.'

We observed a sample of dental care records which demonstrated dentists had given appropriate oral health advice to patients. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area. Underpinning this was a range of leaflets explaining how patients could maintain good oral health. There was also a digital screen in reception which gave information on some of the treatments offered at the practice as well as the prevention, causes and consequences of gum disease.

# Are services effective?

## (for example, treatment is effective)

**Staffing**

The practice had four dentists, a specialist orthodontist and a dentist with a special interest in periodontology. They were supported by five dental nurses, a trainee dental nurse, an orthodontic therapist and three dental hygienists. Other staff included a practice manager an assistant practice manager and five receptionists.

We observed a friendly atmosphere at the practice. Staff we spoke with told us the staffing levels were suitable for the size of the service. The staff appeared to be a very effective and cohesive team; they told us they felt supported by the practice manager. They told us they felt they had acquired the necessary skills to carry out their role and were encouraged to progress.

We confirmed that the dental nurses received an annual appraisal and had personal development plans. These appraisals were carried out by the practice manager. There was effective use of skill mix in the practice. This enabled the dentists to concentrate on providing care to patients whose needs were more complex. We saw the use of an orthodontic therapist in the provision of orthodontic care and dental hygienists who provided routine and more complex gum care and advice. The practice encouraged the development of the extended duty dental nurse role (EDDN). We found that several dental nurses had received additional training in the taking of dental X-rays and oral health education.

The practice manager showed us their system for recording training that staff had completed. These contained details of continuing professional development (CPD), confirmation of current General Dental Council (GDC) registration, and current professional indemnity cover where applicable.

**Working with other services**

Dentists were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. However the practice did not need to refer many patients to other centres because of the diverse range of clinicians working in the practice. This included a specialist orthodontist, and dentists who could provide complex gum treatments and dental implants.

The practice manager explained how they would work with other services when required. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as oral surgery or special care dentistry. This ensured that patients were seen by the right person at the right time.

The practice had an effective system in place for accepting orthodontic referrals from general dental practitioners and other services. Each patient's referring dentist was notified via a when a patient accepted or declined treatment. After patients had received their treatment they would be discharged back to their own dentist for further follow-up and monitoring.

**Consent to care and treatment**

We spoke with a dentist, dental hygienist and orthodontic therapist about how they implemented the principles of informed consent; all of the staff had a very clear understanding of consent issues. For example the dentist explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options. To underpin the consent process the practice had developed bespoke consent forms for more complex treatment such as dental implants.

The dentist went onto explain how they would obtain consent from a patient who suffered with any mental impairment that may mean that they might be unable to fully understand the implications of their treatment. If there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed. They went on to say they would involve relatives and carers if appropriate to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005. Staff were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

# Are services caring?

## Our findings

**Respect, dignity, compassion & empathy**

Treatment rooms were situated away from the main waiting areas and we saw that doors were closed at all times when patients were with dentists. Conversations between patients and dentists could not be heard from outside the treatment rooms which protected patient's privacy. Patients' clinical records were stored electronically and in paper form. Computers were password protected and regularly backed up to secure storage with paper records stored in lockable records storage cabinets. Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality.

Before the inspection, we sent Care Quality Commission (CQC) comment cards so patients could tell us about their experience of the practice. We collected 31 completed CQC patient comment cards; these provided a positive view of the service the practice provided. All of the patients commented that the quality of care was very good. Patients commented that treatment was explained clearly and the staff were caring and put them at ease. They also said that the reception staff were always helpful and efficient. During the inspection, we observed staff in the reception area. We observed that they were polite and helpful towards patients and that the general atmosphere was welcoming and friendly.

**Involvement in decisions about care and treatment**

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. A poster detailing NHS was displayed on the in the waiting areas and dental treatment rooms. Booklets were also available in the waiting area and on the practice website that detailed the costs of both NHS and private treatment. The dentists we spoke with paid particular attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them. This included information recorded on the standard NHS treatment planning forms for dentistry where applicable.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting patients' needs**

During our inspection we looked at examples of information available to people. We saw that the practice waiting area displayed a wide variety of information including the practice patient information leaflet and leaflets about the services the practice offered; how to make a complaint; fire procedures for patients to follow and the practices quality assurance policy. The patient information leaflet explained opening hours, emergency 'out of hours' contact details and arrangements, staff details and how to make a complaint. The practice website also contained useful information to patients such as information about different types of treatments and how to provide feedback on the services provided.

We observed that the appointment diaries were not overbooked and that this provided capacity each day for patients with dental pain to be fitted into urgent slots for each dentist. The dentists, dental hygienist and orthodontic therapist decided how long a patient's appointment needed to be and took into account any special circumstances such as whether a patient was very nervous, had a disability and the level of complexity of treatment.

**Tackling inequity and promoting equality**

The practice had made reasonable adjustments to help prevent inequity for patients that experienced limited mobility or other issues that hamper them from accessing services. The practice used a translation service, which they arranged if it was clear that a patient had difficulty in understanding information about their treatment. Several staff spoke other languages including Polish and Urdu. To improve access the practice had level access and treatment rooms on the ground floor for those patients with a range of disabilities and infirmity as well as parents and carers using prams and pushchairs.

We observed the toilet facilities were not accessible to people using wheelchairs. We discussed this with the practice manager who told us they planned to address this in the practice development plan. The practice had taken some improvement actions in response to feedback from patients with limited mobility. This included making the front door accessible and the addition of a door bell which people could use if they required further assistance.

**Access to the service**

The practice is open 8.00am - 5.00pm Monday to Thursday and Friday 8.00am to 4.30pm. The practice used the NHS 111 service to give advice in case of a dental emergency when the practice was closed. This information was publicised in the practice information leaflet, practice website and on the telephone answering machine when the practice was closed.

**Concerns & complaints**

The practice had a complaints policy and a procedure that set out how complaints would be addressed, who by, and the time frames for responding. Information for patients about how to make a complaint was seen in the patient leaflet, poster in the waiting area and patient website.

The practice had received two complaints during 2016. We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was an effective system in place which ensured a timely response. We saw that the complaints had been managed according to the practices' policy.

# Are services well-led?

## Our findings

**Governance arrangements**

The governance arrangements of the practice were developed through a process of continual learning and improvement. The governance arrangements for this location consisted of the practice manager who was responsible for the day to day running of the practice. The practice maintained a comprehensive system of policies and procedures. All of the staff we spoke with were aware of the policies and how to access them. We noted management policies and procedures were kept under review by the practice manager on a regular basis.

**Leadership, openness and transparency**

Strong and effective leadership was provided by an empowered practice manager. The practice ethos focussed on providing patient centred dental care in a relaxed and friendly environment. The comment cards we saw reflected this approach. The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said they felt comfortable about raising concerns with the practice manager or the principal dentist. There was a no blame culture within the practice. They felt they were listened to and responded to when they did raise a concern.

We found staff to be hard working, caring and committed to the work they did. All of the staff we spoke with demonstrated a firm understanding of the principles of clinical governance in dentistry and were happy with the practice facilities. Staff reported that the practice manager were proactive and resolved problems very quickly. As a result, staff were motivated and enjoyed working at the practice and were proud of the service they provided to patients.

**Learning and improvement**

We saw evidence of systems to identify staff learning needs which were underpinned by an appraisal system and a programme of clinical audit. For example we observed that the dental nurses and receptionists received an annual appraisal; these appraisals were carried out by the practice manager and were followed up by a mid-year review to check if the staff were on course to meet their appraisal objectives.

We found there was a rolling programme of clinical audits taking place at the practice. These included infection control, clinical record keeping and X-ray quality. The audits demonstrated a comprehensive process where the practice had analysed the results to discuss and identify where improvement actions may be needed.

Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. Staff told us that the practice ethos was that all staff should receive appropriate training and development. The practice manager encouraged staff to carry out professional development wherever possible. As a result dental nurses had taken additional qualifications in dental radiography and oral health education.

The practice used a variety of ways to ensure staff development including internal training and staff meetings as well as attendance at external courses and conferences. The practice ensured that all staff underwent regular mandatory training in cardio pulmonary resuscitation (CPR), infection control, child protection and adult safeguarding, dental radiography (X-rays). We saw that the practice manager maintained a comprehensive record of all staff's training records.

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

There was a system in place to act upon suggestions received from patients using the service.

The practice conducted regular staff meetings. Staff members told us they found these were a useful opportunity to share ideas and experiences which were listened to and acted upon.