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Cleobury Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 10 March 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

Cleobury Dental Practice is a mixed dental practice providing NHS and private treatment for both adults and children. The practice is situated in a converted commercial property. The practice had five dental treatment rooms and a separate decontamination room for cleaning, sterilising and packing dental instruments. Also included were a reception and waiting area.

The practice is open 9.00am - 5.00pm Monday to Thursday, Friday 9.00am - 2.00pm and some Saturday mornings by appointment. The practice has six dentists working over the course of a week and are supported by five dental nurses, a trainee dental nurse, a dental therapist, a dental hygienist a clinical dental technician and a practice manager who is also a trained dental nurse. Other staff include a receptionist and a cleaner.

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 feedback from 27 patients. These provided a completely

Summary of findings

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 the principal dentist and 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 Care Excellence (NICE) guidelines.
- Conscious sedation was carried out in accordance with current 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 principal dentist and practice manager.
- Staff we spoke with felt well supported by the principal dentist and practice manager and were committed to providing a quality service to their patients.
- Information from 27 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.

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.

Are services caring?

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

We collected 27 completed Care Quality Commission patient comment cards and obtained the views of a further seven patients on the day of our visit. 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.

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 ground floor treatment rooms and level access into the building for patients with mobility difficulties and families with prams and pushchairs.

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 the principal dentist and an empowered practice manager. The principal dentist, 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 principal dentist and practice manager. All the staff we met said that they were happy in their work and the practice was a good place to work.

Cleobury 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 10 March 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.

We informed NHS England area team that we were inspecting the practice; however, we did not receive any information of concern from them.

During the inspection, we spoke with the principal dentist, practice manager, a dentist on duty, dental nurses and receptionist and reviewed policies, procedures and other documents. We also obtained the views of nine patients on the day of our visit. We reviewed 27 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 manager demonstrated a good awareness of RIDDOR (The reporting of injuries diseases and dangerous occurrences regulations). The practice had an incident reporting system in place when something went wrong; this system also included the reporting of minor injuries to patients and staff. The practice reported that there were three incidents 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 Regulatory Authority (MHRA). Where relevant these incidents were sent to all members of staff by the practice manager. The practice manager explained that relevant alerts would also be discussed during staff meetings to facilitate shared learning these meetings occurred every month.

Reliable safety systems and processes (including safeguarding)

We spoke to a dental nurse about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current EU directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne diseases. The practice used a system whereby needles were not manually resheathed using the hands following administration of a local anaesthetic to a patient. Dentists were also responsible for the disposal of used sharps and needles. A practice protocol was in place 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 the principal 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. This was confirmed by the dental nurses we spoke with. (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 principal dentist 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 the dental therapist, dental hygienist 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 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 regulations. Staff recruitment records were stored securely in a locked cabinet 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. The practice had a business continuity plan to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service. The practice had in place a well-maintained Control of Substances Hazardous to Health (COSHH) file. This file contained details of the way 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 a robust 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 exceeded. It was observed that audit of infection control processes carried out in January 2016 confirmed compliance with HTM 01 05 guidelines.

We saw that the five 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 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 a treatment room 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 June 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

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. All recommended tests utilised as part of the validation of the ultra-sonic cleaning bath 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.

Environment cleaning was carried out by an external cleaner. We saw an extensive file that contained detailed cleaning plans for each treatment room and other areas of the practice. We saw that the practice carried out a regular audit of these procedures, the audits contained action plans for the cleaner to follow to improve the standard of environmental cleaning.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the two autoclaves had been serviced and calibrated in August 2015. The practices' X-ray machines had been serviced and calibrated as specified under current national regulations in February 2016. Portable appliance testing (PAT) had been carried out in November 2015.The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored securely for the protection of patients. We found that the practice stored prescription pads in a safe overnight to prevent loss due to theft. The practice also had a prescription logging system to account for the prescriptions issued to prevent inappropriate prescribing or loss of prescriptions. We saw that there was a recording system for the prescribing and recording of medicines used in the provision of conscious sedation this included the reversal agent for the sedative medicine. We found that the recording of dose and amount of medicines prescribed along with the batch number and expiry date was always recorded. There was a robust written system of stock control and storage for the medicines used in intravenous sedation which was demonstrated to us. 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.

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 for each X-ray set along with the 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 for each dentist had been carried out in November 2015. 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 saw 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.

One of the dentists carried out intra-venous sedation at the practice for patients who were very nervous of dental treatment and required complex dental treatment such as the provision of dental implants. We found that the provider had put into place robust governance systems to underpin the provision of conscious sedation. The systems and processes we observed were in accordance with the new guidelines recently published by the Royal College of Surgeons and Royal College of Anaesthetists in April 2015.

The governance systems supporting sedation included pre and post sedation treatment checks, emergency equipment requirements, medicines management, sedation equipment checks, personnel present, patient's checks including consent, monitoring of the patient during treatment, discharge and post-operative instructions and staff training.

We found that patients were appropriately assessed for sedation. We saw clinical records that showed that all patients undergoing sedation had important checks made prior to sedation this included a detailed medical history, blood pressure and an assessment of health using the American Society of Anaesthesiologists classification system in accordance with current guidelines. The records demonstrated that during the sedation procedure important checks were recorded at regular intervals which included pulse, blood pressure, breathing rates and the oxygen saturation of the blood. This was carried out using specialised equipment including a pulse oximeter which measures the patient's heart rate and oxygen saturation of the blood. Blood pressure was measured using a separate blood pressure monitor. The dentist carrying out sedation was supported by two appropriately trained nurses on each occasion. This was also recorded in the dental care records with details of their names. The measures in place ensured that patients were being treated safely and in line with current standards of clinical practise.

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 a dental therapist and a dental hygienist to work alongside of the dentists in delivering preventative dental care. One dentist we spoke with explained that children at high risk of tooth decay were identified and were offered fluoride varnish applications or the prescription of high concentrated fluoride tooth paste to 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

Are services effective?

(for example, treatment is effective)

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'. Dental care records we observed demonstrated that dentists had given 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.

Staffing

The practice had six dentists working over the course of a week and were supported by five dental nurses, a trainee dental nurse, a dental therapist, a dental hygienist a clinical dental technician and a practice manager who is also a trained dental nurse. Other staff include a dedicated receptionist and a cleaner.

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 principal dentist and 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 whilst the dental therapist and dental hygienist provided routine care and advice. The practice encouraged the development of the extended duty dental nurse role (EDDN). We found that dental nurses had received additional training in the taking of dental X-rays, oral health education, fluoride varnish applications and conscious sedation.

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. All of the patients we asked on the day of our visit said they had confidence and trust in the dentists. This was also reflected in the Care Quality Commission comment cards we received.

Working with other services

One of the dentists explained how they would work 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. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as oral surgery, special care dentistry and orthodontic providers. We noted the practice used a referral tracking system to monitor referrals from the practice. This ensured that patients were seen by the right person at the right time.

Consent to care and treatment

We spoke with dentists about how they implemented the principles of informed consent; all of the dentists had a very clear understanding of consent issues. They 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 including root canal treatment, surgical removal of teeth and dental implants.

The dentists 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 at various points in the practice. 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 27 completed CQC patient comment cards and obtained the views of nine patients on the day of our visit. 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 patient notice board in the waiting area. 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, results of the family and friends test, 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 leaflets about different types of treatments which patients could down load 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 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. 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. The practice was a designated dementia friendly practice by a local dementia charity to meet the needs of patients suffering from dementia.

Access to the service

The practice was open 9.00am - 5.00pm Monday to Thursday, Friday 9.00am - 2.00pm and Saturday mornings by appointment. 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 six complaints during 2015, these were around NHS administrative issues, there were no clinical complaints. 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. The absence of clinical complaints reflected the caring and compassionate ethos of the whole practice.

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 principal dentist and the practice manager who were 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 the principal dentist and 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 principal dentist and 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.

There was a system of peer review in place to facilitate the learning and development needs of the dentists. These were held on a quarterly basis and were chaired by the principal dentist. Subjects discussed at recent meetings included consent, the 'Francis Report' about the Mid Staff's affair, mouth cancer and the Mental Capacity Act.

The practice used the principle of the 'team huddle' which were carried out by the staff to increase their awareness of the particular needs and risks of patients including issues around their medical, social and clinical needs.

We found there was a rolling programme of clinical and non-clinical audits taking place at the practice. These included infection control, clinical record keeping and X-ray quality. We also saw that there was an audit of oral cancer awareness in patients. As a result of this audit one of the dentists had devised a patient information leaflet which we saw explaining the nature of the disease, its symptoms and how to reduce the risks of contracting oral cancer. 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 principle dentist encouraged staff to carry out professional development wherever possible. As a result dental nurses had taken additional qualifications in dental radiography, oral health education, fluoride varnish applications and conscious sedation. 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

The practice had gathered feedback from patients through the NHS Friends and Family test (FFT), NHS Choices, compliments and complaints. We saw that there was a robust complaints procedure in place, with details

Are services well-led?

available for patients in the waiting area, practice leaflet and on the website. Results of the Family and Friends Test (FFT) we saw indicated that 100% of patients who completed the survey were happy with the quality of care provided by the practice and patients were either highly likely or likely to recommend the practice to family and friends. Running in tandem with the FFT was the practices' own patient satisfaction survey programme. As a result of these surveys the practice had introduced improvements suggested by patients that included a patient information leaflet about cold sores and how they affect having dental treatment which is also available on the practice website.

Other improvements were opening slighty earlier times to prevent patients standing outside prior to the normal opening times and a telephone answering machine so that patients could leave messages.

Staff told us that the practice manager and principal dentist were very approachable and they felt they could give their views about how things were done at the practice. Staff confirmed that they had practice meetings every month; the minutes of these were made available if they could not attend. Staff described the meetings as good with the opportunity to discuss successes, changes and improvements. Staff we spoke with said they felt listened to.