Horn Hill Care Services Limited

Horn Hill Dental Surgery

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 9 June 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

Horn Hill Dental Surgery is situated in Millom, Cumbria. It offers a mixture of private and NHS dentistry in a ratio of 60% private and 40% NHS. The services include preventative advice and treatment, routine restorative dental care, minor oral surgery and conscious sedation.

The practice has three surgeries, a decontamination room, a sterilisation room, two waiting areas and a reception area. The reception area, one waiting area, the sterilisation room and one surgery are on the ground floor. The other two surgeries and the decontamination room are on the first floor. There are accessible toilet facilities on the ground floor of the premises.

There are three dentists (one of whom is on maternity leave), a dental hygienist, seven dental nurses, two receptionists, a practice manager and a cleaner.

The opening hours are Monday from 9-00am to 7-00pm, Tuesday and Wednesday from 9-00am to 5-30pm, Thursday from 9-00am to 7-00pm and Friday from 9-00am to 5-30pm.

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.

Summary of findings

During the inspection we received feedback from 51 patients. The patients were positive about the care and treatment they received at the practice. Comments included that the premises were clean and pleasant, the staff were always polite and caring and that they received excellent care and service.

Our key findings were:

- The practice appeared clean and hygienic.
- The practice had systems in place to assess and manage risks to patients and staff including infection prevention, control and health and safety and the management of medical emergencies.
- Dental care records were detailed and showed that treatment was planned in line with current best practice guidelines.
- Oral health advice and treatment were provided in-line with the 'Delivering Better Oral Health' toolkit (DBOH).
- We observed that patients were treated with kindness and respect by staff.
- Patients were involved in making decisions about their treatment and were given clear explanations about their proposed treatment including costs, benefits and risks.
- Patients were able to make routine and emergency appointments when needed.
- Staff from the practice visited local schools and children's centres to provide oral hygiene advice.
- The practice was well-led and staff felt involved and supported and worked well as a team.
- The governance systems were effective.

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

- Review the staff's safeguarding training ensuring all staff are trained to an appropriate level for their role and aware of their responsibilities.
- Review the availability of buccal midazolam in the emergency drug kits.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

Staff told us they felt confident about reporting incidents, accidents and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Staff were familiar with the signs of abuse and the process for reporting it. Not all staff were trained to the appropriate level.

Staff were suitably qualified for their roles and the practice had undertaken the relevant recruitment checks to ensure patient safety.

Patients' medical histories were obtained before any treatment took place. The dentists were aware of any health or medication issues which could affect the planning of treatment. Staff were trained to deal with medical emergencies. All emergency equipment and medicines were in date and generally in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines.

The decontamination procedures were effective and the equipment involved in the decontamination process was regularly serviced, validated and checked to ensure it was safe to use.

Are services effective?

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

Patients' dental care records provided comprehensive information about their current dental needs and past treatment. The practice monitored any changes to the patient's oral health and made referrals for specialist treatment or investigations where indicated.

The practice followed best practice guidelines when delivering dental care. These included Faculty of General Dental Practice (FGDP), National Institute for Health and Care Excellence (NICE) and guidance from the British Society of Periodontology (BSP).

Staff were encouraged to complete training relevant to their roles and this was monitored by the registered provider.

Referrals were made to secondary care services if the treatment required was not provided by the practice. Referrals were also accepted for minor oral surgery procedures.

Are services caring?

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

During the inspection we received feedback from 51 patients. Patients commented that staff were polite and caring. Patients also commented that they felt listened to and their needs were responded to.

We observed the staff to be welcoming and caring towards the patients. It was evident that patients felt comfortable within the practice.

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection.

Staff explained that enough time was allocated in order to ensure that the treatment and care was fully explained to patients in a way which they understood.

Summary of findings

Are services responsive to people's needs?

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

The practice had an efficient appointment system in place to respond to patients' needs. There were vacant appointments slots for urgent or emergency appointments each day.

Patients commented they could access treatment for urgent and emergency care when required. There were clear instructions for patients requiring urgent care when the practice was closed.

There was a procedure in place for responding to patients' complaints. This involved acknowledging, investigating and responding to individual complaints or concerns. Staff were familiar with the complaints procedure.

The practice had made reasonable adjustments to enable patients in a wheelchair or with limited mobility to access treatment.

Staff from the practice visited local schools and children's centres to provide oral hygiene advice.

Are services well-led?

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

There was a clearly defined management structure in place and all staff felt supported and appreciated in their own particular roles. The practice owner and the practice manager were responsible for the day to day running of the practice.

Effective arrangements were in place to share information with staff by means of monthly practice meetings which were well minuted for those staff unable to attend.

The practice regularly audited clinical and non-clinical areas as part of a system of continuous improvement and learning.

They conducted patient satisfaction surveys, were currently undertaking the NHS Friends and Family Test (FFT) and there was a comments box in the waiting room for patients to make suggestions to the practice.

Horn Hill Dental Surgery

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 registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

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

During the inspection we received feedback from 51 patients. We also spoke with two dentists, the dental hygienist, two dental nurses, two receptionists and the practice manager. To assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had clear guidance for staff about how to report incidents and accidents. Staff were familiar with the importance of reporting significant events. We reviewed the significant events which had occurred in the last 12 months. These had been well documented and analysed. Any accidents or incidents would be reported to the practice manager and would also be discussed at staff meetings in order to disseminate learning.

The practice manager understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR) and was aware of notifications which need to be made to the CQC.

The practice received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) that affected the dental profession. These were actioned if necessary and were the stored for future reference.

Reliable safety systems and processes (including safeguarding)

The practice had child and vulnerable adult safeguarding policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff. Staff had access to contact details for both child protection and adult safeguarding teams. The practice manager was the safeguarding lead for the practice and had undertaken level two safeguarding training. All staff had undertaken safeguarding training but not all of the dentists had completed level two training.

The practice had systems in place to help ensure the safety of staff and patients. These included the use of a safe sharps system, a protocol that only the dentists handle sharps and guidelines about responding to a sharps injury (needles and sharp instruments).

Rubber dam (this is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth) was used in root canal treatment in line with guidance from the British Endodontic Society.

We saw that patients' clinical records were computerised and password protected to keep people safe and protect them from abuse. Any paper documentation relating to the dental care records were locked away in secure cabinets when the practice was closed.

Medical emergencies

The practice had procedures in place which provided staff with clear guidance about how to deal with medical emergencies. Staff were knowledgeable about what to do in a medical emergency and had completed training in emergency resuscitation and basic life support within the last 12 months. Staff who were involved in the provision of conscious sedation had also completed additional training in relation to maintaining an airway. This was in line with the 2015 guidelines published by The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care'.

The emergency resuscitation kits were stored in one of the upstairs surgeries. Each surgery had its own emergency drug kit. Staff knew where the emergency kits were kept. We noted that the emergency drug kits contained intravenous midazolam. The BNF states that the buccal variety of midazolam should be available for the treatment of an epileptic seizure.

The practice had an Automated External Defibrillator (AED) to support staff in a medical emergency. (An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm).

Records showed weekly checks were carried out on the oxygen cylinders, emergency drug kits and the AED. These checks ensured that the oxygen cylinder was full and the emergency medicines were in date.

Staff recruitment

The practice had a policy and a set of procedures for the safe recruitment of staff. This included requesting a CV, a structured interview, seeking references, proof of identity, checking relevant qualifications and professional registration. We reviewed a sample of staff files and found the recruitment procedure had been followed. The practice manager told us they carried out Disclosure and Barring Service (DBS) checks for all newly employed staff. These

checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. We reviewed records of staff recruitment and these showed that all checks were in place.

All clinical staff at this practice were qualified and registered with the General Dental Council (GDC). There were copies of current registration certificates and personal indemnity insurance (insurance professionals are required to have in place to cover their working practice).

Monitoring health & safety and responding to risks

A health and safety policy and risk assessment was in place at the practice. This identified the risks to patients and staff who attended the practice. The risks had been identified and control measures put in place to reduce them.

There were policies and procedures in place to manage risks at the practice. These included infection prevention and control, fire evacuation procedures, the use of latex and risks associated with Hepatitis B. For example, we saw weekly check lists for the smoke alarms and annual fire drills.

The practice maintained a file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including substances such as disinfectants, and dental materials in use in the practice. The practice identified how they managed hazardous substances in its health and safety and infection control policies and in specific guidelines for staff, for example in its blood spillage and waste disposal procedures. The COSHH folder was reviewed every year to ensure all substances used within the practice were included and no new hazards had been identified.

Infection control

There was an infection control policy and procedures to keep patients safe. These included hand hygiene, safe handling of instruments, managing waste products and decontamination guidance. The practice followed the guidance about decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 -Decontamination in primary care dental practices (HTM 01-05)'. One of the dental nurses was the infection control lead within the practice.

Staff had received training in infection prevention and control. We saw evidence that staff were immunised against blood borne viruses (Hepatitis B) to ensure the safety of patients and staff.

We observed the treatment rooms, the decontamination room and the sterilisation room to be clean and hygienic. Work surfaces were free from clutter. Staff told us they cleaned the treatment areas and surfaces between each patient and at the end of the morning and afternoon sessions to help maintain infection control standards. There was a cleaning schedule which identified and monitored areas to be cleaned and staff signed a log book to confirm this had been done. There were hand washing facilities in the treatment rooms and staff had access to supplies of personal protective equipment (PPE) for patients and staff members. Posters promoting good hand hygiene and the decontamination procedures were clearly displayed to support staff in following practice procedures. Sharps bins were appropriately located, signed and dated and not overfilled. We observed waste was separated into safe containers for disposal by a registered waste carrier and appropriate documentation retained.

Decontamination procedures were carried out in two separate rooms. These were a decontamination room and a sterilisation room. An instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms, the decontamination room and the sterilisation room which minimised the risk of the spread of infection.

The infection control lead showed us the procedures involved in disinfecting, inspecting and sterilising dirty instruments; packaging and storing clean instruments. The practice routinely used a washer disinfector to clean the used instruments, examined them visually with an illuminated magnifying glass, and then sterilised them in a validated autoclave (a device for sterilising dental and medical instruments). Staff wore appropriate PPE during the process and these included disposable gloves, aprons and protective eye wear.

The practice followed HTM 01-05 guidelines with regards to storing clean instruments. Some high use instruments were stored in the sterilisation room unbagged. Each week all of the high use instruments were re-sterilised to ensure that none were left there for more than one week. Any instruments which were not likely to be used within one week were bagged and stamped with a use by date.

Are services safe?

The practice had systems in place for daily and weekly quality testing the decontamination equipment and we saw records which confirmed these had taken place. There were sufficient instruments available to ensure the services provided to patients were uninterrupted.

The practice had been carrying out an Infection Prevention Society (IPS) self- assessment audit every six months relating to the Department of Health's guidance on decontamination in dental services (HTM01-05).This is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. The audit showed the practice was meeting the required standards. We saw evidence that improvements had been made from previous audits.

Records showed a risk assessment for Legionella had been carried out (Legionella is a term for particular bacteria which can contaminate water systems in buildings). The practice undertook processes to reduce the likelihood of legionella developing which included running the water lines in the treatment rooms at the beginning and end of each session, monitoring cold and hot water temperatures each month, the use of reverse osmosis water and the use of a water conditioning agent in the water lines. Some staff had also attended additional training with respect to Legionella.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as X-ray sets, the autoclaves and the compressor. The practice manager maintained a comprehensive list of all equipment including dates when maintenance contracts which required renewal. We saw evidence of validation of the autoclave and the compressor. Portable appliance testing (PAT) had been completed in September 2014 (PAT confirms that portable electrical appliances are routinely checked for safety). PAT testing was completed every three years in line with the guidance from the British Dental Association.

Prescriptions were stamped only at the point of issue and were kept locked away when not needed to ensure their safe use. Drugs used in the provision of conscious sedation were also kept locked away to ensure their safe use.

Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. Records we viewed demonstrated that the X-ray equipment was regularly tested, serviced and repairs undertaken when necessary. A Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure that the equipment was operated safely and by qualified staff only. We found there were suitable arrangements in place to ensure the safety of the equipment. Local rules were available in all surgeries and within the radiation protection folder for staff to reference if needed. We saw that a justification, grade and a report was documented in the dental care records for all X-rays which had been taken.

X-ray audits were carried out every month. This included assessing the quality of the X-rays which had been taken. The results of the most recent audit undertaken confirmed they were compliant with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). Each audit had an action plan in place to continuously strive for the optimum quality of X-rays.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept up to date detailed electronic and paper dental care records. They contained information about the patient's current dental needs and past treatment. The dentists carried out an assessment in line with recognised guidance from the Faculty of General Dental Practice (FGDP). This was repeated at each examination in order to monitor any changes in the patient's oral health. The dentist used NICE guidance to determine a suitable recall interval for the patients. This takes into account the likelihood of the patient experiencing dental disease such as decay, gum disease or cancer. This was documented and also discussed with the patient.

During the course of our inspection we discussed patient care with the dentists and checked dental care records to confirm the findings. Clinical records were comprehensive and included details of the condition of the teeth, soft tissue lining the mouth, gums and any signs of mouth cancer. If the patient had more advanced gum disease then a more detailed inspection of the gums was undertaken. During the inspection we noted that the dentists used dental loupes during examinations and whilst providing treatment. Dental loupes provide a dentist with a degree magnification which improves visual acuity and aids correct diagnosis and treatment of dental conditions.

Records showed patients were made aware of the condition of their oral health and whether it had changed since the last appointment. Medical history checks were updated by each patient every time they attended for treatment and entered in to their electronic dental care record. This included an update on their health conditions, current medicines being taken and whether they had any allergies.

The practice used current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, following clinical assessment, the dentists followed the guidance from the FGDP before taking X-rays to ensure they were required and necessary. Justification for the taking of an X-ray, quality assurance of each x-ray and a detailed report was recorded in the patient's care record. The dentists were also aware of current guidelines from NICE with regards to the extraction of wisdom teeth.

The practice also provided conscious sedation. This was both relative analgesia (conscious sedation using a mixture of nitrous oxide gas and oxygen) and intravenous sedation. The dentist carried out a full pre-operative assessment of the patient. This included checking the patient's blood pressure, oxygen saturation and heart rate. At this appointment the dentist also discussed different options which were available for anxiety control. Patients were then provided with a written pre-operative instruction sheet which gave details of the sedation procedure. Patients were asked to sign the instruction sheet to confirm that they were aware of the risks related to the sedation procedure. Patients were informed that they needed an escort present if they were undergoing conscious sedation. The dose of the sedative (nitrous oxide or midazolam) was titrated to effect to ensure the patient was not over sedated. During the procedure the patient's oxygen saturation and heart rate were monitored. The reversal agent for midazolam was always available in case it was ever needed. After the procedure both the patient and the escort were provided with post-operative instruction sheets. These included emergency contact details and the "Do's and don'ts" for the remainder of the day. The dentist was responsible for discharging the patient as and when they were stable. The dentist maintained records of the sedation procedure which was in line with the Society for the Advancement of Anaesthesia in Dentistry (SAAD).

Health promotion & prevention

The practice had a strong focus on preventative care and supporting patients to ensure better oral health in line with the 'Delivering Better Oral Health' toolkit (DBOH). DBOH is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. For example, the dentist applied fluoride varnish to children who attended for an examination. Fissure sealants were also applied to children at high risk of dental decay. High fluoride toothpastes were prescribed for patients at high risk of dental decay.

The practice had a selection of dental products on sale in the reception area to assist patients with their oral health.

The practice had made a display in the reception area which showed how much sugar was in different amounts of sweets. They were also taking part in the Oral Health Foundation's National Smile Week.

Are services effective?

(for example, treatment is effective)

One of the dental nurses also conducted visits to the local schools and children's centres to provide oral hygiene advice. We felt that this is notable practice as it provides support to the local community in order to improve oral hygiene awareness.

The medical history form patients completed included questions about smoking and alcohol consumption. We were told by the dentist and saw in dental care records that smoking cessation advice and alcohol awareness advice was given to patients where appropriate. Patients were made aware of the synergistic effects of smoking and alcohol with regards to oral cancer. There were health promotion leaflets available in the waiting room to support patients. The practice website also contained several information sheets which had advice with regards to maintaining a healthy advice. These included decay prevention and the causes of dental erosion.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. The induction process included getting the new member of staff aware of the location of emergency medicines, arrangements for fire evacuation procedures, safeguarding, infection control, confidentiality and health and safety. We saw evidence of completed induction checklists in the recruitment files. Staff told us that the induction process was very comprehensive. For example, the two receptionists had started in October 2015. The previous receptionist had been involved in the induction process which the new receptionists found very helpful.

Staff told us they had good access to on-going training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). The practice manager kept a log of when training needed to be updated. Records showed professional registration with the GDC was up to date for all staff and we saw evidence of on-going CPD. This CPD included sedation, infection control and medical emergencies.

Some of the dental nurses had undertaken additional training in oral health education, radiography and fluoride application.

Staff told us they had annual appraisals and training requirements were discussed at these. We saw evidence of completed appraisal documents. Staff also felt they could approach the practice manager at any time to discuss continuing training and development as the need arose. The practice owner blocked out time each month to spend time with the other dentist to go through cases, discuss any difficult treatments and provide support.

Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. For example, referrals were made to hospitals and specialist dental services for further investigations or specialist treatment including orthodontics and more complexed oral surgery procedures.

The dentists completed detailed proformas or referral letters to ensure the specialist service had all the relevant information required. A copy of the referral letter was kept in the patient's dental care records. Letters received back relating to the referral were first seen by the referring dentist to see if any action was required and then stored in the patient's dental care records.

The practice had a procedure for the referral of a suspected malignancy. This involved faxing a copy of the letter and also a telephone call to confirm the fax had arrived.

Consent to care and treatment

Patients were given appropriate information to support them to make decisions about the treatment they received. Staff were knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent. Staff described to us how valid consent was obtained for all care and treatment and the role family members and carers might have in supporting the patient to understand and make decisions. Staff were clear about involving children in decision making and ensuring their wishes were respected regarding treatment.

Staff had received training and had a good understanding of the principles of the Mental Capacity Act (MCA) 2005 and how it was relevant to ensuring patients had the capacity to consent to their dental treatment.

Staff ensured patients gave their consent before treatment began and a form was signed by the patient. We were told that individual treatment options, risks, benefits and costs were discussed with each patient. Patients would be given time to consider the treatment options and were not rushed into making a decision.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Feedback from patients was positive and they commented that they were treated with care, respect and dignity. Staff told us that they always interacted with patients in a respectful, appropriate and kind manner. We observed staff to be friendly and respectful towards patients during interactions at the reception desk and over the telephone.

We observed privacy and confidentiality were maintained for patients who used the service on the day of inspection. It was evident that staff were aware of the importance of confidentiality within the dental practice. Surgery doors were kept closed whilst patients were receiving treatment. Dental care records were not visible to the public on the reception desk. We observed the receptionists to be friendly, helpful, discreet and reassuring to patients. They were aware that no personal details should be discussed at the reception desk to ensure the dignity of patients. They also told us that if a patient wished to speak in private, an empty room would be found to speak with them.

Patients' electronic care records were password protected and regularly backed up to secure storage. Any paper documentation relating to dental care records were securely stored in locked cabinets.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients commented they felt involved in their treatment and it was fully explained to them. Staff described to us how they involved patients' relatives or carers when required and ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood. For example the dentist told us that they would speak to patients slowly and in a way that they would understand.

When treating children one of the dentists told us that they would use models, books and try to make it fun in order to help children overcome any anxieties.

The dentists were aware of Gillick competency. The Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. The dentists told us that they preferred to have parental involvement if they were doing a treatment which was irreversible.

Patients were also informed of the range of treatments available in the waiting area and on the practice website.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We found the practice had an efficient appointment system in place to respond to patients' needs. Staff told us that patients who requested an urgent appointment would be seen the same day. We saw evidence in the appointment book that there were dedicated emergency slots available each day for each dentist. If the emergency slots had already been taken for the day then the patient was offered to sit and wait for an appointment if they wished.

Patients commented they had sufficient time during their appointment and they were not rushed. We observed the clinics ran smoothly on the day of the inspection and patients were not kept waiting.

Tackling inequity and promoting equality

The practice had an equality and diversity policy to support staff in understanding and meeting the needs of patients. Reasonable adjustments had been made to the premises to accommodate patients with mobility difficulties. These included step free access to the premises and a ground floor accessible toilet. The ground floor surgery had been rearranged to ensure it was large enough to accommodate a wheelchair or a pram. We were told that the ground floor surgery was used for those patients who could not manage the stairs. We saw evidence that the clinicians swapped surgeries to accommodate their own patients who needed the ground floor surgery.

Access to the service

The practice displayed its opening hours in the premises and on the practice website. The opening hours are Monday from 9-00am to 7-00pm, Tuesday and Wednesday from 9-00am to 5-30pm, Thursday from 9-00am to 7-00pm and Friday from 9-00am to 5-30pm.

Patients told us that they were rarely kept waiting for their appointment. Patients could access care and treatment in a timely way and the appointment system met their needs. Where treatment was urgent patients would be seen the same day. The practice had a system in place for patients requiring urgent dental care when the practice was closed. There were details for patients of the out of hours service on the telephone answering machine. Information about the out of hours emergency dental service was also available within the practice information leaflet.

Concerns & complaints

The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. There were details of how patients could make a complaint available in the waiting room.

The practice manager was in charge of dealing with complaints when they arose. Staff told us they raised any formal or informal comments or concerns with the practice manager to ensure responses were made in a timely manner. We were told that they aimed to resolve complaints in-house initially. The practice had not received any complaints in the past 12 months. We reviewed a historical complaint and found that they had been dealt with in line with the practices policy and to the patient's satisfaction. The practice manager kept a detailed log of how the complaints had been dealt with. This included copies of any letters, e-mails or a written account of any verbal communications.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients. We found there was an effective system in place which helped ensure a timely response. This included acknowledging the complaint within two working days and providing a formal response within 10 working days. If the practice was unable to provide a response within 10 working days then the patient would be made aware of this.

Are services well-led?

Our findings

Governance arrangements

The practice was a member of the British Dental Association 'Good Practice' accreditation scheme. This is a quality assurance scheme that demonstrates a visible commitment to providing quality dental care to nationally recognised standards.

The practice was a member of Denplan Excel. This is a certification programme for dentists to demonstrate excellence in quality assurance, patient care and communication.

The practice owner and the practice manager were responsible for the day to day running of the service. There was a range of policies and procedures in use at the practice. We saw they had systems in place to monitor the quality of the service and to make improvements. The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately. The practice manager had implemented an effective system to arrange the practice's clinical governance files. They had used colour coded folders to indicate which topic a folder related to. For example, black folders for audits, turquoise folders for clinical matters, orange folders for clinical waste management and red folders for staff CPD folders.

The practice had an effective approach for identifying where quality or safety was being affected and addressing any issues**.** Health and safety and risk management policies were in place and we saw a risk management process to ensure the safety of patients and staff members. For example, we saw risk assessments relating to fire safety, the use of equipment and infection control.

There was an effective management structure in place to ensure that responsibilities of staff were clear. There was a management structure flow chart available which detailed the lines of accountability within the practice. Staff told us that they felt supported and were clear about their roles and responsibilities.

Leadership, openness and transparency

The culture of the practice encouraged candour, openness and honesty to promote the delivery of high quality care and to challenge poor practice. Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. These would be discussed openly at staff meetings where relevant and it was evident that the practice worked as a team and dealt with any issue in a professional manner.

The practice held monthly staff meetings. These meetings were minuted for those who were unable to attend. The minutes of the staff meetings were displayed in the office for staff to reference. During these staff meetings topics such as infection control, training requirements and audit results were discussed. If there was more urgent information to discuss with staff then an informal staff meeting would be organised to discuss the matter.

All staff were aware of whom to raise any issue with and told us that the practice owner and the practice manager were approachable, would listen to their concerns and act appropriately. We were told that there was a no blame culture at the practice and that the delivery of high quality care was part of the practice's ethos.

Learning and improvement

Quality assurance processes were used at the practice to encourage continuous improvement. The practice audited areas of their practice as part of a system of continuous improvement and learning. This included clinical audits such as dental care records, X-rays, sedation, failed appointments and infection control. We looked at the audits and saw that the practice was performing well. However, where improvements could be made these were identified and followed up by a repeat audit. Audit results were discussed with the individual in question to prevent exposure during practice meetings.

Staff told us they had access to training and this was monitored to ensure essential training was completed each year; this included medical emergencies and basic life support. Staff working at the practice were supported to maintain their continuous professional development as required by the General Dental Council. We were also told that staff were actively encouraged to complete additional training which was relevant to their roles. It was evident that staff training was part of the practice's ethos and we were told that the costs to attend training courses were covered by the practice.

The practice owner regularly attended local groups to keep up to date with current practice. These included the local oral surgery network, the regional deanery events and local study groups.

Are services well-led?

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

The practice had systems in place to involve, seek and act upon feedback from people using the service including carrying out annual patient satisfaction surveys and a comment box in the waiting room. The most recent patient survey undertaken in November 2015 showed a high level of satisfaction with the quality of the service provided. We were shown that as a result of patient feedback the layout of the ground floor surgery had been adapted to enable patients with limited mobility to get into the dental chair more easily.

The practice also undertook the NHS Friends and Family Test (FFT). The FFT is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. The latest results showed that 100% of patients asked said that they would recommend the practice to friends and family.