Mr Ross Cutts

Stow-on-the-Wold Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 23 January 2017 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 this practice was providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Stow on the Wold Dental Practice is situated in a purpose built practice just off the central square of the town with easy access to local parking and bus routes. This well established dental practice provides a safe and 'fit for purpose' environment for the treatment of patients in line with current requirements. The practice provides private general dental services to children and adults and also 'in house' orthodontic and implant services for those patients who require such treatment.

Fees are displayed in information leaflets available in the practice for patients and on the website. The practice has good access for patients with mobility difficulties and pushchairs. There are two treatment rooms, one of which is on the ground floor, one waiting room and a decontamination room. The practice has a team of three dentists, a dental therapist two dental nurses one of whom was a trainee dental nurse, a practice manager and receptionist.

Summary of findings

The principal dentist is the registered provider. 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.

The practice is open Monday – Thursday - 9.00am to – 5.00pm, Friday 8.00am – 4.00pm

The practice is closed at weekends but the out of hours emergency arrangements are displayed on their website. Contact information is available from the practice telephone answering service.

We reviewed three CQC comment cards that had been left for patients to complete prior to our visit. In addition we spoke with three patients on the day of our inspection.

Feedback from patients was positive about the care they received from the practice. They commented the staff put them at ease and listened to their concerns. They also reported they felt proposed treatments were fully explained them so they could make an informed decision which gave them confidence in the care provided. Patients we spoke with and the comment cards told us staff were kind, caring, competent and put patients at their ease ,

Our key findings were:

- There were systems in place to help ensure the safety of staff and patients. These included safeguarding children and adults from abuse, maintaining the required standards of infection prevention and control and responding to medical emergencies.
- The dental practice had effective clinical governance and risk management processes in place; including health and safety and the management of medical emergencies.
- Patient care and treatment was delivered in line with evidence-based guidelines, best practice and current legislation. Patient dental records were electronic, detailed and comprehensive.
- The practice had a comprehensive system to monitor and continually improve the quality of the service; including through a detailed programme of clinical and non-clinical audits.
- The use of digital radiographs to help explain necessary treatment to patients while in the chair.
- Premises appeared well maintained and visibly clean. Good cleaning and infection control systems were in place. The treatment rooms were well organised and equipped, with good light and ventilation.
- There were systems in place to check all equipment had been serviced regularly, including the air compressor, autoclave, fire extinguishers, oxygen cylinder and the X-ray equipment.
- There were sufficient numbers of suitably qualified staff who maintained the necessary skills and competence to support the needs of patients.
- Staff were up to date with current guidelines, supported in their professional development and the practice was led by a proactive new principal dentist.

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

- Review the storage of local anaesthetic cartridges and day box instruments in dental surgeries in relation to national guidance.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

There were systems in place to help ensure the safety of staff and patients. These included safeguarding children and adults from abuse, maintaining the required standards of infection prevention and control and responding to medical emergencies. The practice carried out and reviewed risk assessments to identify and manage risks.

There were clear procedures regarding the maintenance of equipment and the storage of medicines in order to deliver care safely and in an emergency. In the event of an incident or accident occurring the practice documented, investigated and learnt from it.

Are services effective?

No action

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

The practice kept detailed electronic records of the care given to patients including comprehensive information about patients' oral health assessments, treatment and advice given. They monitored any changes in the patient's oral health and made referrals to as appropriate to primary care providers such as a nearby dedicated orthodontic practice and to secondary care such as hospital specialist services for further investigations or treatment as required.

The practice was proactive in providing patients with advice about preventative care and supported patients to ensure better oral health in line with Public Health England publication 'Delivering better Oral Health 3rd edition. (DBOH) Comments received via the CQC comment cards and patients interviewed reflected patients were very satisfied with the assessments, explanations, the quality of the dentistry and outcomes they experienced. In the waiting room we saw evidence of health promoting information including a poster highlighting the sugar content of some popular soft drinks.

Staff we spoke with told us they had accessed specific training in the last 12 months in line with their professional development plan and in line with General dental Council requirements for registrants.

Are services caring?

No action

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

We reviewed three completed CQC comments and received feedback on the day of the inspection from three patients about the care and treatment they received at the practice. The feedback was positive with patients commenting on the excellent service they received, professionalism and caring nature of the staff and ease of accessibility in an emergency. Patients commented they felt involved in their treatment and that it was fully explained to them.

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection. Policies and procedures in relation to data protection and security and confidentiality were in place and staff were aware of these.

Summary of findings

Are services responsive to people's needs?

No action

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

The practice offered routine and emergency appointments each day. There were clear instructions for patients requiring urgent care when the practice was closed.

There was level access into the building for patients with limited mobility, prams and pushchairs. There was a waiting room and two treatment rooms of which one was on the ground floor level, and the area was spacious enough to manoeuvre a wheelchair; and a treatment room upstairs. We observed the reception desk was compliant with the Equality Act 2010 and had information and forms available in large print if needed.

There was a procedure in place for acknowledging, recording, investigating and responding to complaints and concerns made by patients or their carers.

Are services well-led?

No action

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

The practice assessed risks to patients and staff and carried out a programme of audits as part of a system of continuous improvement and learning. There were clearly defined leadership roles within the practice and staff told us they felt well supported.

The practice had accessible and visible leadership with structured arrangements for sharing information across the team, including holding regular meetings which were documented for those staff unable to attend. Staff told us they felt well supported and could raise any concerns with the practice owner and practice manager.

The practice had systems in place to seek and act upon feedback from patients using the service.

Stow-on-the-Wold Dental Practice

Detailed findings

Background to this inspection

This inspection took place on the 23 January 2017. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Prior to the inspection we reviewed information we held about the provider. We also reviewed information we asked the provider to send us in advance of the inspection. This included their latest statement of purpose describing their values and objectives, a record of any complaints received in the last 12 months and details of their staff members together with their qualifications and proof of registration with the appropriate professional body.

During the inspection we toured the premises and spoke with practice staff including, all three dentists the practice manager, receptionist and both the dental nurse and the trainee dental nurse. 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 systems in place to learn from and make improvements following any accidents or incidents. The practice had accident and significant event reporting policies which included information and guidance about the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Clear procedures were in place for reporting adverse drug reactions and medicines related adverse events and errors.

The practice maintained a significant event folder. There had been four incidents in the previous 12 months. We saw the documentation for incident recording included sections for a detailed description, the learning that had taken place and the actions taken by the practice as a result.

The principal dentist and practice manager told us if there was an incident or accident that affected a patient; they would give an apology and inform them of any actions taken to prevent a recurrence.

This was in accordance with the Duty of Candour principle. [Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity].

The principal dentist and practice manager knew when and how to notify CQC of incidents which cause harm. Staff reported there was an open and transparent culture at the practice which encouraged candour and honesty.

The practice responded to national patient safety and medicines alerts that affected the dental profession. The principal dentist and practice manager told us they reviewed all alerts and spoke with staff to ensure they were acted upon. A record of the alerts was maintained and accessible to staff.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding adults. This included contact details for the local authority safeguarding team, social services and other agencies including the Care Quality Commission. Staff had completed safeguarding training and demonstrated to us, when asked, their knowledge of how to recognise the signs and symptoms of abuse and neglect. There was a documented reporting process available for staff to use if anyone made a disclosure to them.

Staff demonstrated knowledge of the whistleblowing policy and were confident they would raise a concern about another staff member's performance if it was necessary.

Both the dentists we spoke with confirmed that a latex free rubber dam was used where possible when performing root canal treatments.

We discussed this with the dentists and practice staff, and were shown the relevant entry in specific dental care records and the equipment in place in the treatment rooms. The dentist described what alternative precautions were taken to protect the patient's airway during the treatment when a rubber dam was not used and showed us the risk assessment written in the dental care record.

[A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured].

The practice had safety systems in place to help ensure the safety of staff and patients. These included clear guidelines about responding to a sharps injury (needles and sharp instruments).

Staff files contained evidence of immunisation against Hepatitis B (a virus contracted through bodily fluids such as; blood and saliva) and there were adequate supplies of personal protective equipment (PPE) such as face visors, gloves and aprons to ensure the safety of patients and staff.

Medical emergencies

The practice had suitable emergency resuscitation equipment in accordance with guidance issued by the Resuscitation Council UK. This included an automated

Are services safe?

external defibrillator (AED). (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm).

Oxygen and other related items, such as manual breathing aids, were also available in line with recommended guidelines. We saw a range of medicines to manage more common medical emergencies. The emergency medicines and equipment were stored in a central location, clearly labelled and known to all staff.

Staff spoken with showed us documentary evidence which demonstrated regular checks were done to ensure the equipment and emergency medicines were in date and safe to use. Records showed all staff had completed on site training in emergency resuscitation and basic life support. Staff spoken with demonstrated they knew how to respond in the event of a medical emergency.

We saw one member of staff had also completed First Aid at work training.

In discussion with the principal dentist and practice manager we suggested they review the system for checking the first aid kit and logging it.

Staff recruitment

The practice had systems in place for the safe recruitment of staff which included seeking references, proof of identity and checking qualifications, immunisation status and professional registration. It was the practice policy to carry out Disclosure and Barring service (DBS) checks for all newly appointed 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. Records confirmed these checks were in place. We looked at the recruitment files for three members of staff and found they contained appropriate recruitment documentation.

The practice manager told us newly employed and agency staff had been taken through an induction process to ensure they were familiarised with the way the practice operated. This was corroborated with documentary evidence which had been signed to demonstrate completion of the process.

However when agency staff were used they were not always asked for their certificates and photographic identity. The practice manager told us they would review their arrangements. We were told all newly employed staff met with the practice manager to ensure they felt supported to carry out their role.

The practice had a system in place for monitoring staff had up to date medical indemnity insurance and professional registration with the General Dental Council (GDC) The GDC registers all dental care professionals to make sure they are appropriately qualified and competent to work in the United Kingdom. Records we looked at confirmed these were up to date and ongoing.

Monitoring health & safety and responding to risks

The practice had systems to monitor health and safety and deal with foreseeable emergencies. There were comprehensive health and safety policies and procedures in place to support staff, including for the risk of fire and patient safety. Records showed that fire detection and firefighting equipment such as smoke detectors and fire extinguishers were regularly tested.

The practice had a comprehensive risk management process, including a detailed log of all risks identified, to ensure the safety of patients and staff members. For example, we saw a fire risk assessment which had been completed in 2014 and a practice risk assessment which had been completed in 2017. The practice had a comprehensive file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including substances such as disinfectants, blood and saliva.

The practice had a detailed business continuity plan to support staff to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service. The plan included staffing, electronic systems and environmental events.

Infection control

There were effective systems in place to reduce the risk and spread of infection. There was a written infection control policy which included minimising the risk of blood-borne virus transmission and the possibility of sharps injuries, decontamination of dental instruments, hand hygiene, segregation and disposal of clinical waste.

The practice had followed the guidance about decontamination and infection control issued by the Department of Health, the 'Health Technical Memorandum 01-05 decontamination in primary care dental practices

Are services safe?

(HTM01-05)' and complied with the requirements of the DOH publication 'Code of Practice' July 2015. These documents and the practice policy and procedures for infection prevention and control were accessible to staff. We were shown the recent audits of infection control processes carried out in 2016 which confirmed compliance with HTM 01-05 guidelines.

There was a dedicated decontamination room in the practice which was used for cleaning, sterilising and packing instruments. There was clear separation of clean and dirty areas in the treatment room and the decontamination room however there was no signage to reinforce this. These arrangements met the HTM01- 05 essential requirements for decontamination in dental practices.

We observed the decontamination process and noted suitable containers were used to transport dirty and clean instruments between the treatment rooms and decontamination room. The practice used a washer disinfector for the initial cleaning process, then following inspection with an illuminated magnifier the instruments were then placed into an autoclave (a device for sterilising dental and medical instruments).

When the instruments had been sterilised, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines. However in the downstairs surgery we saw instruments for routine appointments stored together in one box in the dentists drawer. We discussed these arrangements with the principal dentist who agreed to review it in the light of HTM01-05 guidelines.

We were shown the systems in place to ensure the autoclaves used in the decontamination process were working effectively. It was observed the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were complete and up to date. All recommended tests utilised as part of the validation of the washer disinfector were carried out in accordance with current guidelines, the results of which were recorded in an appropriate log file.

We observed how waste items were disposed of and stored securely until collection. The practice had an on-going contract with a clinical waste contractor. We saw the differing types of waste were appropriately segregated.

Staff confirmed to us their knowledge and understanding of single use items and how they should be used and disposed of according to the guidance.

We looked at the consultation and treatment rooms where patients were examined and treated and observed the rooms and all equipment appeared clean, uncluttered and well-lit with good ventilation. Staff told us the importance of good hand hygiene was included in their infection control training. A hand washing poster was displayed near the sink to ensure effective decontamination. There were good supplies of protective equipment for patients and staff members. The practice uses latex free disposable gloves for the protection of patients and staff.

We reviewed the last detailed legionella risk assessment report from 2016 which was carried out by an external organisation. The practice had appropriate processes in place to prevent legionella contamination such as flushing of dental unit water lines with an appropriate disinfectant and monthly testing of the hot and cold sentinel taps in the practice as required by the HSE publication ACOP L8.

These processes ensured the risks of Legionella bacteria developing in water systems within the premises had been identified and preventive measures taken to minimise risk of patients and staff developing Legionnaires' disease. (Legionella is a bacterium found in all potable water and which if not controlled can put staff and patients at risk of contracting Legionnaires disease which can be fatal.)

There was a good supply of cleaning equipment which was colour coded and stored appropriately. It followed published National Patient Safety Association (NPSA) guidance about the cleaning of dental primary care premises. The practice had a cleaning schedule in place that covered all areas of the premises and detailed what and where equipment should be used.

The practice had a process for staff to follow if they accidentally injured themselves with a needle or other sharp instrument. The practice manager had a system for monitoring the immunisation status of each member of staff for the safety and protection of patients and staff.

Equipment and medicines

There were systems in place to check all equipment had been serviced regularly, including the compressor, autoclaves, X-ray equipment and fire extinguishers. Records showed contracts were in place to ensure annual servicing

Are services safe?

and routine maintenance work occurred in a timely manner. A portable appliance test (PAT – this shows electrical appliances are routinely checked for safety) had been carried out annually by an appropriately qualified person to ensure the equipment was safe to use.

The practice had policies and procedures regarding the prescribing, recording, use and stock control of the medicines used in clinical practice. The batch numbers and expiry dates for local anaesthetics were recorded in patients' dental care records. In one surgery we saw that vials of local anaesthetic had been removed from their original packaging and placed together in plastic containers in a drawer which was not in line with recommended practice for the storage of such vials. In discussion with the principal dentist they told us they would take action to remedy this immediately.

The local anaesthetic cartridges were stored safely and staff kept a detailed record of stock in each treatment room. Private prescriptions were provided as needed.

Radiography (X-rays)

The practice radiation protection file was maintained in line with the Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). It was detailed and up to date with an inventory of all X-ray equipment and maintenance records**.** X-rays were digital and images were stored within the patient's dental care record.

We found there were suitable arrangements in place to ensure the safety of the equipment and its operation. We were shown how the practice had a process for ongoing monitoring of the quality of radiographs as required by the IRMER regulations. We also observed in the patient clinical records that radiographs were taken in line with The Faculty of General Dental Practice (FGDP) guidance and the clinicians justified, quality assured and reported upon each radiograph taken. Local rules relating to each X-ray machine were maintained; a radiation risk assessment was in place to ensure patients did not receive unnecessary exposure to radiation.

Staff authorised to carry out X-ray procedures were clearly named in all documentation and records showed they had attended appropriate training.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept detailed electronic records of the care given to patients. We reviewed the information recorded in patient dental care records to corroborate information received from the dentists. We found they provided comprehensive information about patients' oral health assessments, treatment and advice given. They included details about the condition of the teeth, soft tissues lining the mouth and gums and an extra oral assessment. For example, we saw details of the condition of patients gums were recorded using the basic periodontal examination (BPE) scores. The BPE 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 reviewed at each examination in order to monitor any changes in the patient's oral health.

Medical history checks were updated at every visit and patient care records we looked at confirmed this. This included an update about patients' health conditions, current medicines being taken and whether they had any allergies. Comments received via CQC comment cards reflected patients were very satisfied with the assessments, explanations, the quality of the dentistry and outcomes.

We saw the practice sought to ensure patient safety through the use of 'Loupes'. These enable the clinician to have a magnified view of the operation site thus enabling accuracy of treatment and better outcomes from treatment for the patient.

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' (Delivering better oral health' is an evidence based toolkit to support dental teams in improving their patient's oral and general health published by Public Health England). The dental therapist/ hygienist provided oral health education and appointments for this were offered over two days a week.

The medical history form patients completed included questions about smoking and alcohol consumption. Patients were given advice appropriate to their individual needs such as smoking cessation, alcohol consumption or dietary advice.

The practice provided health promotion information to support patients in looking after their general health using leaflets, posters, a patient information file and via their noticeboard situated in the waiting room. This included making patients aware of the early detection of oral cancer. Patients reported they felt well informed about every aspect of dental care and treatment pertaining to the health of their teeth and dental needs.

Staffing

The practice manager planned ahead to ensure there were sufficient staff to run the service safely and meet patient needs.

The practice manager kept a record of all training completed by staff to ensure they had the right skills to carry out their work. Mandatory training included basic life support and infection prevention and control had been completed by all staff within the last 12 months. New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. Dental nurses received day to day supervision from the dentists and support from the practice manager.

Staff had access to policies which contained information that further supported them in the workplace. All clinical staff were required to maintain an on-going programme of continuing professional development as part of their registration with the General Dental Council. Records showed professional registration was up to date for all staff.

There was an effective appraisal system in place which was used to identify training and development needs. Staff we spoke with told us they had accessed specific training in the last six months in line with their professional needs.

Working with other services

The practice worked with other professionals where this was in the best interest of the patient. For example, referrals were made to hospital dental services for further investigations or specialist treatment and to the dental hygienist service within the practice for patients with complex periodontal issues. The practice completed a detailed proforma and referral letter to ensure the specialist service had all the relevant information required.

Dental care records contained details of the referrals made and the outcome of the specialist advice.

Consent to care and treatment

Are services effective?

(for example, treatment is effective)

Staff explained to us how valid consent was obtained for all care and treatment. The practice consent policy provided staff with guidance and information about when consent was required and how it should be recorded.

Staff were aware of the principles of the Mental Capacity Act 2005 (MCA) and their responsibilities to ensure patients had enough information and the capacity to consent to dental treatment. Staff explained how they would consider the best interests of the patient and involve family members or other healthcare professionals responsible for their care to ensure their needs were met.

Staff had not yet undertaken specific MCA training which was planned within the next two months. However in discussion with staff they demonstrated a good working knowledge of its application in practice. All staff understood consent could be withdrawn by a patient at any time.

The staff we spoke with were also aware of and understood the use of the Gillick competency test in relation to young persons (under the age of 16 years). 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.

We reviewed dental care records to corroborate our information. Treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. Consent to treatment was recorded. Feedback in CQC comment cards and from patients spoken with confirmed patients were provided with sufficient information to make decisions about the treatment they received.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We reviewed three completed CQC comments cards and spoke with three patients during the inspection. Comments from patients were consistently positive about how they were treated by staff at the practice. Patients commented they were treated with respect and dignity and that staff were friendly and reassuring. We observed positive interactions between staff and patients during the inspection.

The principal dentist told us they would act upon any concerns raised by patients regarding their experience of attending the practice.

To maintain confidentiality electronic dental care records were password protected and paper records were securely stored. The design of the reception desk ensured any paperwork and the computer screen could not be viewed by patients booking in for their appointment. Policies and procedures in relation to data protection, security and confidentiality were in place and staff were aware of these.

All treatment room doors remained closed during consultations.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients commented they felt fully involved in making decisions about their treatment, were at ease speaking with the dentists and felt listened to and respected. Staff described to us how they involved patient's relatives or carers when required and ensured there was sufficient time to explain fully the treatment options. Dental care records we looked at corroborated and reflected this.

Patients were given a copy of their treatment plan and associated costs. This gave patients clear information about the different elements of their treatment and the costs relating to them. They were given time to consider options before returning to have their treatment. Patients signed their treatment plan before treatment began.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided patients with information about the services they offered in the practice leaflet and on their website. The services provided included prevention advice and treatment alongside the specialist dental care available**.**

Patients' feedback demonstrated they had flexibility and choice to arrange appointments in line with other commitments. Patients booked in with the receptionist on arrival and they kept patients informed if there were any delays to appointment times.

Patients we talked with advised they had been able to obtain emergency treatment when needed and we observed space was left daily in the appointment book of clinicians so they could provide urgent care when required.

Tackling inequity and promoting equality

The practice had a comprehensive equality, diversity and human rights policy in place and provided training to support staff in understanding and meeting the needs of patients.

They had completed a Disability and Discrimination Act (DDA) assessment and made adjustments, for example to accommodate patients with limited mobility. There was wheelchair access to the waiting area and to facilities on the ground floor. The receptionist told us large print leaflets and forms were available if required.

Information was in English but translation services could be utilised if necessary via access to a language line.

Access to the service

The practice displayed its opening hours on the website, in the waiting room and in leaflets.

The emergency contact numbers to be used when the practice was closed were displayed on their website. Contact information was also available from the practice telephone answering service. If patients had an emergency and called before 10am, the practice would try to see them the same day. Saturday appointments were available.

The three CQC comment cards seen, and patients spoken with, reflected patients felt they had good access to the service and appointments were flexible to meet their needs.

Concerns & complaints

The practice had a complaint policy which provided staff with clear guidance about how to handle a complaint. The policy explained the process to follow, and included other agencies to contact if the complaint was not resolved to the patients satisfaction. This included the Dental Complaints Service. Staff told us if they raised any formal or informal comments or concerns with the practice manager or principal dentist they ensured these were responded to appropriately and in a timely manner.

The practice had not received any complaints in the last 12 months. We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients.

We found there was a system in place which ensured a timely response, sought to address the concerns promptly and efficiently and effect a satisfactory outcome for the patient. The practice manager told us that should any complaints be made these would be investigated and the outcome discussed amongst the team and implemented for the safety and well-being of patients.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately. We saw risk assessments and the control measures in place to manage those risks, for example fire and infection control. Staff we spoke with were aware of their roles and responsibilities within the practice.

Health and safety and risk management policies were in place including processes to ensure the safety of patients and staff members. We looked in detail at how the practice identified, assessed and managed clinical and environmental risks related to the service provided. We saw risk assessments and the control measures in place to manage those risks for example fire, use of equipment and infection control. Lead roles, for example in infection control and safeguarding supported the practice to identify and manage risks and helped ensure information was shared with all team members.

There were relevant policies and procedures in place to govern activity. There was a full range of policies and procedures in use at the practice and accessible to staff on the practice computers and in paper files. Staff were aware of the policies and procedures and acted in line with them.

These included guidance about confidentiality, record keeping, inoculation injuries and patient safety. There was a clear process in place to ensure all policies and procedures were reviewed as required to support the safe running of the service. There were monthly practice meetings to discuss practice arrangements and audit results as well as providing time for educational activity. We saw minutes from meetings where issues such as complaints, incidents, infection control and patient care had been discussed and a training topic had been covered. Minutes demonstrated staff meetings were held with staff from the principal dentist's other practice which ensured all staff working at either practice received the same information.

Leadership, openness and transparency

We saw from minutes of staff meetings, they were at regular intervals and staff told us how much they benefited from these meetings. The practice had a statement of purpose that described their vision, values and objectives. Staff reported there was an open and transparent culture at the practice which encouraged candour and honesty. Staff felt confident they could raise issues or concerns at any time with the practice manager and / or principal dentist who would listen to them.

We observed, and staff told us, the practice was a relaxed and friendly environment to work in and they enjoyed coming to work at the practice. Staff felt well supported by the practice manager and principal dentist and worked as a team toward the common goal of delivering high quality care and treatment.

The service was aware of and complied with the requirements of the Duty of Candour. Staff we spoke with told us the principal dentist encouraged a culture of openness and honesty. Patients were told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result.

Learning and improvement

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council (GDC). Records showed professional registrations were up to date for all staff and there was evidence continuing professional development was taking place.

We saw there was a comprehensive system to monitor and continually improve the quality of the service; including through a detailed programme of clinical and non-clinical audits. These included for example, audits of record keeping, radiographs, the cleanliness of the environment, and consent. Where areas for improvement had been identified in the audits, action had been taken. For example through discussion and training at practice meetings.

Improvements could be made to re-audit dental records in a timely way to address some shortfalls. The principal dentist and practice manager told us they would take immediate action to rectify these areas.

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

The practice had systems in place to seek and act upon feedback from patients using the service.

Are services well-led?

The practice gathered feedback from patients through their own internal systems which were analysed every month and the results displayed. They also had a compliments book, Facebook page and complaints system for feedback.

Results of the most recent patient satisfaction review indicated that 100% of patients who completed the survey were happy with the quality of care provided by the practice and patients were likely to recommend the practice to family and friends.

The practice regularly asked patient feedback at the end of treatment and the results seen corroborated the comments received from patients we spoke with and as seen on the CQC comment cards.