

## One 4 One Partnership

# One 4 One Partnership

## 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**

One 4 One partnership is a dental practice located in the London Borough of Wandsworth. The premises are situated in a converted residential building with treatment rooms on the first floor. There are two treatment rooms, a dedicated decontamination room, a waiting room with reception area, an X-ray area and a patient toilet.

The practice provides NHS and private services to adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers, extractions, crowns and bridges and some minor orthodontic treatments.

The staff structure of the practice consists of three associate dentists, three dental nurses, a trainee dental nurse and a practice manager. On the day of the inspection, a clinical compliance auditor, who worked for the provider, was also visiting the practice.

The practice opening hours are from 9.00am to 5.30pm on Monday, Wednesday, Thursday and Friday, from 9.00am to 7.00pm on Tuesday, and from 9.00am to 1.00pm on Saturday.

One of the associate dentists was the registered manager. A registered manager is a person who is registered with the CQC to manage the service. Like registered providers,

# Summary of findings

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.

The inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

Seven people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

## **Our key findings were:**

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were effective systems in place to reduce and minimise the risk and spread of infection.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Staff knew how to report incidents and forms were available to keep a record of any incident which could be used by the practice for shared learning.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- The provider had a clear vision for the practice and staff told us they were well supported by the management team.
- Governance arrangements and audits were effective in improving the quality and safety of the services.

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

- Review stocks of medicines and equipment and the system for identifying and disposing of out-of-date stock.

# 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 systems in place to minimise the risks associated with providing dental services. There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. The practice had policies and protocols, which staff were following, for the management of infection control, medical emergencies and dental radiography. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse.

We found the equipment used in the practice was generally well maintained and checked for effectiveness. Systems for checking stock and equipment could be improved as we noted some out-of-date items; these were disposed of on the day of the inspection. .

### **Are services effective?**

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

The practice provided evidence-based care in accordance with relevant, published guidance, for example, from the General Dental Council (GDC). The practice monitored patients' oral health and gave appropriate health promotion advice. Staff explained treatment options to ensure that patients could make informed decisions about any treatment. The practice worked well with other providers and followed up on the outcomes of referrals made to other providers.

Staff engaged in continuous professional development (CPD) and were working towards meeting all of the training requirements of the General Dental Council (GDC). Staff had received appraisals within the past year to discuss their role and identify additional training needs.

### **Are services caring?**

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

We received positive feedback from patients through comment cards and by speaking with patients on the day of the inspection. Patients felt that the staff were kind and caring; they told us that they were treated with dignity and respect at all times. We found that dental care records were stored securely and patient confidentiality was well maintained.

### **Are services responsive to people's needs?**

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

Patients generally had good access to appointments, including emergency appointments, which were available on the same day. The culture of the practice promoted equality of access for all. The needs of people in the local area had been considered and staff spoke a range of languages. The practice was not fully wheelchair accessible as the treatment rooms were situated on the first floor of the building. The practice had explored options for improving access and were now actively seeking to relocate the practice to a fully accessible building in the local area. In the meantime, alternative arrangements with other, fully accessible, local providers had been made.

There was a complaints policy in place; we were told no complaints had been received in the past year. Patient feedback, through the use of a monthly patient satisfaction survey, was used to improve the quality of the service provided.

# Summary of findings

## **Are services well-led?**

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

The practice had clinical governance and risk management structures in place. These were well maintained and disseminated effectively to all members of staff. A system of audits was used to monitor and improve performance.

Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the practice manager. They were confident in the abilities of the practice manager to address any issues as they arose.

# One 4 One Partnership

## 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.

We carried out an announced, comprehensive inspection on 10 March 2016. The inspection took place over one day and was carried out by a CQC inspector and a dentist specialist advisor.

We reviewed information received from the provider prior to the inspection. During our inspection we reviewed policy documents and spoke with six members of staff. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. Two of the dental nurses demonstrated how they carried out decontamination procedures of dental instruments.

Seven people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

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

There was a system in place for reporting and learning from incidents. There had not been any significant events related to patients in the past year. There was a written policy which described what types of events might need to be recorded and investigated. We discussed the investigation of incidents with the practice manager and associate dentists. They confirmed that if patients were affected by something that went wrong, they were given an apology and informed of any actions taken as a result.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had been one accident recorded in the past 12 months. This had been appropriately recorded and practice protocols had since been updated to prevent a recurrence.

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

The practice manager was the named practice lead for child and adult safeguarding. They were able to describe the types of behaviour a child might display that would alert them to possible signs of abuse or neglect. They also had a good awareness of the issues around vulnerable elderly patients who presented with dementia.

The practice had a well-designed safeguarding policy which referred to national guidance. Information about the local authority contacts for safeguarding concerns were kept behind the reception desk. The staff we spoke with were aware of the location of this information. There was evidence in all of the staff files we checked that staff had been trained in safeguarding adults and children.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, we asked staff about the prevention of needle stick injuries. One member of staff had been exposed to a needle stick injury in July 2015. They had taken appropriate actions and consulted with an external occupational health agency for advice. The practice had also reviewed and updated its prevention strategy within the past month. All staff had received additional training in the prevention of sharps injuries. The practice already used a rubber needle guard and also

introduced the use of mosquito forceps for the handling of local anaesthetic needles. The staff we spoke with demonstrated a clear understanding of the practice policy and protocol with respect to handling sharps and needle stick injuries. There was also a written risk assessment, in line with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

The practice followed other national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments in line with guidance from the British Endodontic Society. (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. Rubber dam should be used when endodontic treatment is being provided. On the 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).

### Medical emergencies

The practice had arrangements in place to deal with medical emergencies. The practice had an automated external defibrillator (AED), oxygen and other related items, such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines (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). However, we also noted that although there was an in-date oxygen cylinder, there was also a second cylinder without any dates or service history. The practice manager assured us that this cylinder would now be disposed of appropriately.

The practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. The emergency medicines were all in date and stored securely with emergency oxygen in a location known to all staff. Staff received annual training in using the emergency equipment. The staff we spoke with were all aware of the location of the emergency equipment.

### Staff recruitment

The staff structure of the practice consists of three associate dentists, three dental nurses, a trainee dental nurse and a practice manager.

# Are services safe?

The practice had not recruited any new staff since the new provider took over the practice in December 2014. However, there was a recruitment policy in place which stated that all relevant checks would be carried out to confirm that any person being recruited was suitable for the role. This included the use of an application form, interview, review of employment history, evidence of relevant qualifications, the checking of references and a check of registration with the General Dental Council.

It was practice policy to carry out a Disclosure and Barring Service (DBS) check for all members of staff prior to employment and periodically thereafter. We saw evidence that all members of staff had a DBS check. (The DBS 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).

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

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety policy in place. The practice had been assessed for risk of fire and we observed that the fire extinguishers were serviced on the day of the inspection.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. COSHH products were securely stored. Staff were aware of the COSHH file and of the strategies in place to minimise the risks associated with these products.

The practice had a system in place to respond promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. MHRA alerts, and alerts from other agencies, were received by the practice by post. These were disseminated at staff meetings, where appropriate.

There was an arrangement in place to direct patients to another local practice, which was run by the same provider, for emergency appointments in the event that the practice's own premises became unfit for use. Key contacts for services in the local area were kept up to date on the provider's computer intranet system in the event that a maintenance problem occurred at the premises.

## **Infection control**

There were effective systems in place to reduce the risk and spread of infection within the practice. There was an infection control policy which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. Staff records showed that staff regularly attended training courses in infection control. The practice had carried out practice-wide infection control audits at six-month intervals and had worked to improve standards throughout the practice during the past year.

We observed that the premises appeared clean and tidy. Clear zoning demarked clean from dirty areas in all of the treatment rooms. Hand-washing facilities were available, including wall-mounted liquid soap, hand gels and paper towels in the treatment rooms and toilet. Hand-washing protocols were also displayed appropriately in various areas of the practice. However, the decontamination room did not have a separate hand-washing sink, but was supplied with disinfectant hand gel. We discussed this process with the practice manager and compliance auditor. They reviewed with us their discussions around the use of the two sinks in the decontamination room and demonstrated that it was not possible to designate one for handwashing as it would be located in the 'dirty' zone. We were satisfied by this explanation.

We asked one of the dental nurses to describe to us the end-to-end process of infection control procedures at the practice. The protocols described demonstrated that the practice had followed the guidance on 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)'.

The dental nurse explained the decontamination of the general treatment room environment following the treatment of a patient. We saw that there were written guidelines for staff to follow for ensuring that the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

We checked the contents of the drawers in the treatment rooms. These were well stocked, clean, ordered and free from clutter. All of the instruments were pouched. It was



# Are services safe?

obvious which items were for single use and these items were clearly new. The treatment room had the appropriate personal protective equipment, such as gloves and aprons, available for staff and patient use.

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). The practice manager described the method they used which was in line with current HTM 01-05 guidelines. A Legionella risk assessment had been carried out by one of the principal dentists in March 2016. The practice was following recommendations to reduce the risk of Legionella, for example, through the regular testing of the water temperatures. A record had been kept of the outcome of these checks on a monthly basis.

The practice used a decontamination room for instrument processing. In accordance with HTM 01-05 guidance, an instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which ensured the risk of infection spread was minimised. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

Instruments were manually cleaned prior to inspection under a light magnification device. Items were then placed in an autoclave (steriliser). When instruments had been sterilized, they were pouched and stored appropriately, until required. All of the pouches we checked had a date of sterilisation and an expiry date.

We saw that there were systems in place to ensure that the autoclave was working effectively. These included, for example, the automatic control test and steam penetration test. It was observed that the data sheets used to record the essential daily validation checks of the sterilisation cycles were complete and up to date.

The segregation and storage of dental 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. The practice used a contractor to remove dental waste from the practice. Waste was stored in a locked bin prior to

collection by the contractor. Waste consignment notices were available for inspection. Environmental cleaning was carried out using cleaning equipment in accordance with the national colour coding scheme.

Clinical staff were also required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. (People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections.) We noted that one member of staff had supplied vaccination history, but also needed to provide evidence regarding their immune status. The practice manager assured us that this check would now be carried out.

## Equipment and medicines

We found that the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor, fire equipment and X-ray equipment had all been inspected and serviced. Portable appliance testing (PAT) had been completed in accordance with good practice guidance in 2015. PAT is the name of a process during which electrical appliances are routinely checked for safety.

The expiry dates of medicines and equipment were monitored using monthly check sheets which supported the staff to replace out-of-date drugs and equipment promptly. However, we found one oxygen cylinder whose service history could not be traced, and some out-of-date stock items in the drawers in the treatment rooms. The current equipment checking system had not identified this issue. We reviewed this with the practice manager who told us that they would now dispose of the oxygen cylinder and out-of-date items; they would also review the protocols in place for checking stock to prevent a recurrence.

## Radiography (X-rays)

There was a radiation protection file in line with the Ionising Radiation Regulations (IRR) 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor as well as the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for the X-ray set along



## Are services safe?

with the three-yearly maintenance logs and a copy of the local rules. We also saw evidence that staff had completed radiography and radiation protection training. Audits on X-ray quality were undertaken at regular intervals.

We observed that the Orthopantomogram (OPG) – (An OPG (or orthopantomogram) is a rotational panoramic dental radiograph that allows the clinician to view the upper and

lower jaws and teeth. It is normally a 2-dimensional representation of these.) machine was located in a lead-lined corner, off the main corridor, but this was not a fully enclosed space. The direction of the X-ray was towards the back wall. We were told that there was an established protocol to check that the corridor was clear prior to taking the X-ray.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Monitoring and improving outcomes for patients

The clinical staff carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. We spoke with two of the associate dentists. They described to us how they carried out their assessments. The assessment began with the patient completing a medical history questionnaire covering 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 made aware of the condition of their oral health and whether it had changed since the last appointment.

The patient's 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 details of the costs involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

We checked a sample of dental care records to confirm the findings. These showed 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 were noted using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). These were carried out, where appropriate, during a dental health assessment.

### Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. The associate dentists told us they discussed oral health with their patients, for example, effective tooth brushing or dietary advice. They were aware of the need to discuss a general preventive agenda with their patients and referred to the advice supplied in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'. (This is

an evidence-based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting). They told us they held discussion with their patients, where appropriate, around smoking cessation and sensible alcohol use. The dentists also carried out examinations to check for the early signs of oral cancer.

We observed that there were health promotion materials displayed in the waiting area and treatment rooms. These could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition.

### Staffing

Staff told us they received appropriate professional development and training. We checked seven staff files and saw that this was the case. The training covered all of the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, infection control and radiography and radiation protection training.

There was an induction programme for new staff to follow to ensure that they understood the protocols and systems in place at the practice.

Staff told us they had been engaged in appraisal and supervision processes which reviewed their performance and identified their training and development needs. We reviewed some of the notes kept from these meetings and saw that each member of staff had the opportunity to put a development plan in place.

### Working with other services

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients.

The associate dentists explained how they worked with other services, when required. The dentist was able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. For example, the practice made referrals to other specialists for more complicated extractions, orthodontics and implants. The practice made both in-house referrals to other practice's owned by the same provider and external referrals to consultants in secondary care.

We reviewed the systems for referring patients to specialist consultants in secondary care. A referral letter was

# Are services effective?

(for example, treatment is effective)

prepared and sent to the hospital with full details of the dentist's findings and a copy was stored on the practices' records system. When the patient had received their treatment they were discharged back to the practice. Their treatment was then monitored after being referred back to the practice to ensure patients had received a satisfactory outcome and all necessary post-procedure care. A copy of the referral letter was always available to the patient if they wanted this for their records.

## **Consent to care and treatment**

The practice ensured valid consent was obtained for all care and treatment. We spoke to the associate dentists about their understanding of consent. They explained that 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. Patients were asked to sign formal written consent forms for specific treatments.

All of the staff we spoke with were aware of the Mental Capacity Act 2005. (The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves). The associate dentists could describe scenarios for how they would manage a patient who lacked the capacity to consent to dental treatment. They noted that they would involve the patient's family, along with social workers and other professionals involved in the care of the patient, to ensure that the best interests of the patient were met.

# Are services caring?

## Our findings

### **Respect, dignity, compassion & empathy**

The comments cards we received, and the patients we spoke with, all made positive remarks about the staff's caring and helpful attitude. Patients indicated that they felt comfortable and relaxed with their dentist and that they were made to feel at ease during consultations and treatments. Patients who felt they were nervous about dental treatment indicated that their dentist was calm, worked with them, listened to their concerns, and gave them reassurance throughout the processes of the dental treatments. We also observed staff were welcoming and helpful when patients arrived for their appointment or made enquiries over the phone.

Staff were aware of the importance of protecting patients' privacy and dignity. The treatment rooms were situated away from the main waiting area and we saw that the doors were closed at all times when patients were having treatment. Conversations between patients and the dentist could not be heard from outside the rooms, which protected patient's privacy.

Staff understood the importance of data protection and confidentiality and had received training in information

governance. Patients' dental care records were stored in both paper and electronic formats. Paper records were stored in locked filing cabinets. Electronic records stored on computers were password protected and regularly backed up.

### **Involvement in decisions about care and treatment**

The practice displayed information in the waiting area and on its website which gave details of the private and NHS dental charges or fees.

We spoke with two of the associate dentists, two dental nurses, the practice manager and one of the provider's compliance auditors on the day of our inspection. All of the staff told us they worked towards providing clear explanations about treatment and prevention strategies. We saw evidence in the records that the dentists recorded the information they had provided to patients about their treatment and the options open to them.

The patient feedback we received via comments cards, and through speaking with patients on the day of the inspection, confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' dental needs. There were set appointment times for routine check-ups and more minor treatments. The dentists could also decide on the length of time needed for their patient's consultation and treatment, particularly in relation to more complex treatment plans. The feedback we received from patients indicated that they felt they had enough time with the dentist and were not rushed.

Staff told us that patients could book an appointment in good time to see the dentist. The feedback we received from patients confirmed that they could get an appointment when they needed one, and that this included good access to emergency appointments on the day that they needed to be seen.

During our inspection we looked at examples of information available to people. We saw that the practice waiting room displayed a variety of information including opening hours and guides to different types of dental treatments. The practice had a website which reinforced this information.

### Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. The practice manager told us they encouraged people to tell them what additional support they might need. They could provide written information for people who were hard of hearing and use large print documents for patients with some visual impairment. Staff spoke a range of different languages, which supported people to access the service.

The practice was not wheelchair accessible as the treatment rooms were located on the first floor of the building. The practice had carried out a Disability Discrimination Act (DDA) audit within the past year with a view to exploring what adjustments could be made to the building to enable access. There were some adjustments

made, such as the use of a handrail on the stairs, to support those with limited mobility. However, the practice had concluded that other adjustments, such as the installation of a lift, were not feasible. The practice manager told us that they were now actively exploring moving to different premises, with a ground floor location, that would allow for full wheelchair access. In the meantime, if required, staff were referring people to other practices that were wheelchair accessible.

### Access to the service

The practice opening hours are from 9.00am to 5.30pm on Monday, Wednesday, Thursday and Friday, from 9.00am to 7.00pm on Tuesday, and from 9.00am to 1.00pm on Saturday.

We asked the practice manager about access to the service in an emergency or outside of normal opening hours. They told us that there was an answerphone message which directed patients to call the NHS '111' service for onward referral to other services in the local area.

The reception staff told us that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, were seen on the same day that they alerted the practice to their concerns. The feedback we received via comments cards confirmed that patients had good access to the dentist in the event of needing emergency treatment.

### Concerns & complaints

Information about how to make a complaint was displayed in a patient folder in the waiting area. The reception staff told us they would also direct patients to speak with the practice manager concerning any complaints. We viewed a copy of the complaints policy and saw that it described how the practice handled formal and informal complaints from patients. There had not been any complaints recorded in the past year.

Patients were invited to give feedback through a monthly patient satisfaction survey, and results from these surveys were displayed on a noticeboard in the waiting area. The information received demonstrated that patients were highly satisfied with their care.

# Are services well-led?

## Our findings

### Governance arrangements

The practice had governance arrangements and a clear management structure. There were relevant policies and procedures in place. Staff were aware of these and acted in line with them. Records, including those related to patient care and treatments, as well as staff employment, were kept accurately.

There were arrangements for identifying, recording and managing risks through the use of risk assessment processes. We noted one area where the monitoring systems had not been successful. This was in relation to the checking of out-of-date stock and equipment. The practice manager was responsive to our feedback on this topic on the day of the inspection. They told us that they would review their stock check protocols to improve performance in this area.

There were monthly staff meetings to discuss key governance issues. We reviewed minutes from meetings held in the past six months. We saw that topics such as staff training, infection control, record keeping, and patient feedback were discussed.

### Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said that they felt comfortable about raising concerns with the practice manager, associate dentists or clinical compliance auditor. They felt they were listened to and responded to when they did so.

We found staff to be hard working, caring towards the patients and committed to the work they did. The practice manager and head nurse were well-supported by the area manager and clinical supervision manager. The systems for accessing key information on the staff intranet were robust and well known to staff.

Staff told us they enjoyed their work and were supported by the practice manager, compliance auditor and clinical supervision manager. They received regular appraisals which commented on their own performance and elicited their goals for the future.

### Learning and improvement

The practice had a programme of clinical audit that was used as part of the process for learning and improvement. The compliance auditor carried out a full audit of a range of different aspects of the practice on a roughly yearly basis. These included audits for infection control, clinical record keeping, and X-ray quality. The practice manager demonstrated how the outcome of these audits had been used to improve the quality of the service, for example, in relation to infection control protocols. We also noted that the provider had implemented a new electronic record-keeping system and fully trained the associate dentists in its use with a view to improving the standard of dental care records. The records that we checked demonstrated that this improvement process had been successful.

The provider had a clear vision for the practice and the practice manager described plans for improving the practice over the coming year. The aim was to move to a more accessible location on the same road, or within the local area, and to fit this new location with a range of new equipment to support the provision of high-quality care.

All staff were supported to pursue development opportunities. We saw evidence that staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the General Dental Council (GDC).

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

The practice gathered feedback from patients through the use of a patient satisfaction survey. The results from this survey were analysed on a monthly basis. The majority of feedback had been positive and the results were displayed on a noticeboard in the waiting area.

Staff told us that the associate dentists and practice manager were open to feedback regarding the quality of the care. The appraisal system and staff meetings also provided appropriate forums for staff to give their feedback.