Bewdley Dental Practice

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Inspection Report

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Overall summary

Bewdley Dental Practice is owned by two dentist partners and also has three associate dentists who work part time, eight qualified dental nurses who are registered with the General Dental Council (GDC), four dental hygienists, a practice manager and a part time receptionist. The practice's opening hours are from 8.15am to 5.30pm Monday to Thursday and from 8.15am to1pm on Friday. The practice is closed between the hours of 1pm to 2pm Monday to Thursday.

Bewdley Dental Practice provides NHS and private treatment for adults and children. The practice is situated in a converted property. The practice has five dental treatment rooms; two on the first floor and three on the second floor and a separate decontamination room for cleaning, sterilising and packing dental instruments. There is also a reception and two waiting areas, one on each floor.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice. We collected 36 completed cards and spoke with three patients.

Our key findings were:

- The practice had mechanisms in place to record significant events and accidents.
- The practice had systems to help ensure patient safety. These included safeguarding children and adults from abuse, responding to medical emergencies and maintaining equipment.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Patients were treated with dignity and respect and their confidentiality was maintained.
- The practice was visibly clean and well maintained.
- Options for treatment were identified and explored and patients said they were involved in making decisions about their treatment.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- Health promotion advice was given to patients appropriate to their individual needs such as smoking cessation or dietary advice.
- Patients' care and treatment was planned and delivered in line with evidence based guidelines, best practice and current legislation
- Staff received training appropriate to their roles and told us they felt well supported to carry out their work.

Summary of findings

- There was an effective complaints system and the practice was open and transparent with patients if a mistake had been made.

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

- Review procedures to ensure learning points from incidents and complaints are shared with all relevant staff and any improvements demonstrated.
- Register with the MHRA to receive medicine safety alerts and ensure that any alerts relevant to the practice are discussed with staff and actions taken as appropriate.
- Review the storage arrangements for temperature sensitive medicines ensuring they are stored in line with manufacturers 'instructions.
- Review that the practice's infection control practices to ensure that when staff are manually cleaning dental instruments they visually inspect all items under an illuminated magnifier to ensure they are clean in line with the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control.
- Review documentation use for fire safety checks at the practice and ensure that staff who complete these checks sign to confirm that they have done so.
- Undertake reviews and audits of consent and provide consent records that contain full details of conversations held.
- Implement a stock control system with documentation to enable staff to be aware of medicines available at the practice at all times.
- Establish and operate an effective staff appraisal system which enables to staff to raise issues or concerns and to receive feedback about their work at the practice. Personal development plans should be included within the appraisal process.
- Implement a system to ensure that dental care record audits are undertaken to help improve the quality of service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

Systems were in place for recording and reporting significant events and accidents and staff were aware who to report incidents and accidents to within the practice. There were systems in place to help ensure the safety of staff and patients. These included safeguarding children and adults from abuse and responding to medical emergencies. The practice carried out and reviewed risk assessments to identify and manage risk. Sufficient quantities of equipment to meet patients' needs were in use at the practice. However fridge temperatures where medicines were stored were not monitored and some practices compromised good infection control.

Are services effective?

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

Staff assessed patients' needs and dental care provided was evidence based and focussed on the needs of the patients. Patients' dental care records contained details of treatment carried out and information about any past treatment. The practice used current national professional guidance including those from the National Institute for Health and Care Excellence (NICE) to guide their practice. Patients were referred to other services appropriately.

Staff had the skills, knowledge and experience to deliver effective care and treatment and received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

Are services caring?

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

Staff treated patients with kindness and respect and were aware of the importance of confidentiality. We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection. Patients told us that staff were professional and caring. Those patients we spoke with who said that they were anxious about dental treatment told us that staff made them feel relaxed. We were told that the quality of care was good.

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. Patients confirmed that they were made aware of treatment options.

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 appointments each day. Patients confirmed that they had good access to treatment and urgent care stating that urgent appointments were always available on the day that they phoned the practice.

There was a procedure in place for responding to patients' complaints The practice's complaints policy was available to patients in the waiting room. We saw that formal written complaints had been acknowledged, investigated and responded to in writing.

Are services well-led?

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

Summary of findings

There were some governance arrangements and an effective management structure in place. The practice regularly audited clinical and non-clinical areas as part of a system of continuous improvement and learning. Although there had been no clinical record audit since 2013.

There were arrangements in place to share information with staff by means of monthly practice meetings which were minuted for those staff unable to attend. Staff said that they felt well supported and could raise any issues or concerns with the registered manager. Not all staff that we spoke with were aware that minutes of staff meetings were available for review.

Bewdley Dental Practice

Detailed findings

Background to this inspection

We carried out an announced comprehensive inspection on 19 January 2016 as part of our planned inspection of all dental practices. The inspection took place over one day and was carried out by a lead inspector and a dental specialist adviser.

We informed NHS England area team that we were inspecting the practice, they did not have any concerns to report.

During our inspection visit, we reviewed policy documents and staff records. We spoke with seven members of staff, including the management team. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and computer system that supported the patient treatment records and patient dental health education programme. We reviewed comment cards completed by patients and spoke with three patients. Patients gave very positive feedback about their experience at the practice.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

We looked at accident books and significant event records. The accident books demonstrated that any accidents at the practice were recorded and action taken. We saw that there had been two recorded within the last 12 months. Action taken and advice given following any accident was recorded. We saw that a staff meeting had been arranged regarding one accident at the practice, learning points were recorded and details of action taken to prevent this type of accident in the future were recorded.

We were told that there had been one significant event at the practice which had occurred the day prior to our inspection. The practice manager had recorded details of the event and the preventative action considered to reduce the risk of the incident reoccurring. This was recorded in detail. Staff spoken with were aware of the significant event. We were told that this would be discussed at a future practice meeting. Staff were not completing significant event reporting forms, although the practice manager was recording information. We saw that there was a policy for reporting and managing untoward incidents. The practice manager was the named lead for events and accidents and staff spoken with were aware who the lead was. The policy had been reviewed on an annual basis. Staff had signed a document to confirm that they had read and would work to the policy.

We discussed the reporting of injuries, diseases or dangerous occurrences (RIDDOR). We saw that guidance was available for staff about RIDDOR regulations. There had been no incidents reported under RIDDOR regulations.

The practice manager told us that they had until recently received national alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) regarding patient safety through NHS channels. The practice manager confirmed that they would register to receive these alerts direct from the MHRA in future.

Reliable safety systems and processes (including safeguarding)

A joint child protection and vulnerable adult safeguarding policy was available on file. This recorded the name of the safeguarding lead at the practice and contact details for external child and vulnerable adult protection authorities.

Staff we spoke with were aware who to speak to within the practice if they had any safeguarding concerns and we saw that external agency contact details were also on display in the reception area. Staff had signed to confirm that they had read and would work to the safeguarding policies. We were told that there had been no safeguarding issues reported at the practice.

We were told that only one member of staff had undertaken safeguard training; the practice manager confirmed that this training would be booked for all staff. We saw records to demonstrate that a dental nurse had also undertaken safeguarding training as part of their continuous professional development (CPD) and they had undertaken regular refresher training. Following the inspection the practice sent email confirmation that staff had undertaken safeguarding training at a level appropriate to their role.

We asked about the instruments and equipment which were used during root canal treatment. We were told that root canal treatment was carried out using a rubber dam. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work. The practice was following the guidance from the British Endodontic Society in relation to the use of rubber dams.

We spoke to the principal dentist about the prevention of needle stick injuries. The practice used a system whereby needles were re-sheathed by the dentist following administration of a local anaesthetic to a patient. Dental nurses we spoke with confirmed that the responsibility for disposal of sharps instruments rested with the dentist. In addition the practice used disposable matrix bands. These are thin metal strips that are positioned around the tooth during placement of certain fillings, they can be very sharp and so the use of disposable bands mitigates the risk involved in changing the bands. These measures were in accordance with the Health and Safety (Sharp Instruments in Healthcare) 2013 guidance.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. Oxygen and other emergency equipment such as an automated external defibrillator (AED -a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver

an electrical shock to attempt to restore a normal heart rhythm) were available. These were checked regularly to ensure they were in good working order and were within their expiry dates. We noted that there was no spacer device for inhaled bronchodilators available. The practice placed an order during the inspection to obtain this equipment.

The practice had in place the emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. We checked the emergency medicines and found that all were within their expiry dates. The expiry dates of medicines were monitored using a check sheet which enabled the staff to replace out of date medicines promptly. We saw that one medicine was not of the appropriate dosage strength. The appropriate strength medicine was made available during the inspection. The principal dentist explained there had been an error with the medicine delivered to them and would address this with their supplier. Glucagon is an emergency drug that is used to treat diabetics with low blood sugar. It needs to be stored between two and eight degrees Celsius in order to be effective until the expiry date. If stored at room temperature it can be used for 18 months from the date the medicine was removed from refrigerated storage provided the expiry date had not passed. We found that although this medicine was being stored appropriately at room temperature, the amendment to the expiry date had not been made to account for the fact that it was not stored in the fridge. We raised the concern with the practice manager who confirmed that the expiry date would be amended.

Staff we spoke with were aware of the location of the emergency equipment and medicine. Staff had attended training to maintain their competence in dealing with medical emergencies.

The practice had first aid kits available for use and two members of staff had been trained in first aid at work.

Staff recruitment

We discussed staff recruitment with the practice manager and looked at the recruitment files for four staff. There was a recruitment policy in place and although this did not record that disclosure and barring service (DBS) checks should be undertaken for some roles prior to employment, we saw evidence that these had been completed. 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.

We saw that appropriate pre-employment checks had been undertaken. Details of the immunisation status for each member of staff and confirmation of the staff member's professional registration were available on file.

There were enough staff to support the dentists and hygienist during patient treatment. Staff said that they had to book annual leave in advance and this and any unplanned absences were covered by part time staff working additional hours. Sufficient numbers of staff were on duty to ensure that the reception area was not left unmanned at any time. All dental nurses were expected to work on the reception and with dentists on a rotational basis. A duty rota was on display. Staff said that the practice manager was flexible and tried to accommodate urgent leave wherever possible.

Monitoring health & safety and responding to risks

A detailed health and safety policy was available for staff. This recorded the names of the people responsible for health and safety within the practice. We saw that a health and safety legislation poster was on display in the reception area.

Other arrangements in place to monitor health and safety and deal with foreseeable emergencies included a risk log which had been reviewed on an annual basis. This recorded information regarding risks such as pregnant mothers at the practice, non-response of staff to the Hepatitis B inoculation, trainee dental nurses and work experience students.

Fire safety information was available. We saw that fire extinguishers were next due for maintenance and service in May 2016. Records were kept of fire safety checks on a weekly, quarterly and annual basis. For example ensuring escape routes were clear and fire warning system working correctly. A tick list was used and the information had not been signed by the person who had completed the record. We saw records to confirm that emergency lighting was tested regularly and smoke detectors serviced annually.

Are services safe?

The practice had measures in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. Practices are required to keep a detailed record of all the substances used in the practice which may pose a risk to health.

Infection control

We noted that the five dental treatment rooms, waiting area, reception and toilets were visibly clean, tidy and clutter free. Patients spoken with and comment cards received confirmed that the practice was always generally clean. Hand washing facilities were available including wall mounted liquid soap and gels and paper towels in each of the treatment rooms and toilets. Signs reminding staff of appropriate hand washing techniques were available by each sink.

The practice had an infection control policy that outlined the procedure for all issues relating to minimising the risk and spread of infections. The policy had been reviewed on an annual basis with the next review due in 2017. Staff had signed a document to confirm that they had read and would work to the infection prevention and control policy. We saw that dental nurses had undertaken training regarding infection prevention and control and completed annual updates.

An infection control audit was completed on a regular basis at the practice; the last audit was completed in October 2015 by the head dental nurse. Some of the issues identified in the infection control audit related to the building which were difficult to rectify due to the Grade I listed status. However we saw carpet tiles in the seating area located inside three of the treatment rooms. This would make the floor in this area difficult to suitably clean to maintain infection prevention and control standards. Following this inspection the practice forwarded photographic evidence to demonstrate that they had replaced this flooring with appropriate easy cleanable floor covering.

Each treatment room had the appropriate routine personal protective equipment (PPE) available for staff and patient use. Patients we spoke with confirmed that dental staff wore PPE during any checks or treatment they carried out.

Staff spoken with were able to describe to us the end-to-end process of infection control procedures at the practice. They explained the cleaning of the general treatment room environment following the treatment of a patient, including cleaning of the working surfaces, dental unit and dental chair. Staff described the treatment of the dental water lines. Discussions with staff demonstrated that the management of dental water lines was appropriate and included disinfection and regular testing to prevent the growth and spread of legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings).

A legionella risk assessment was completed in 2011; this report stated that the next assessment was due not later than August 2013. Recommendations and requirements from this report were recorded as having been carried out. During the inspection the practice manager showed us an email to demonstrate that an external company had been booked to undertake a legionella risk assessment at the practice on 21 January 2016.

Decontamination of dental equipment took place in a dedicated decontamination area which had a dirty room and clean room linked by a doorway. There were two sinks plus hand washing sinks. One of the dental nurses gave a demonstration of the decontamination process. This included use of ultra-sonic baths, washer disinfectors and placing in an autoclave (a machine used to sterilise instruments). We were told that only the dental hygienists instruments were placed in washer disinfectors prior to going in to the autoclave as the hygienists did not require instruments as quickly as dentists. Ultrasonic baths were used to clean instruments required by dentists. We were also told that the illuminated magnifier was not used regularly (used to visually check for any remaining contamination). This was not in accordance with the practice's infection prevention and control procedure. Instruments were pouched and date stamped at the end of each session.

We saw that test strips were used to demonstrate that the ultra-sonic bath, washer disinfector and autoclaves were working effectively for every cycle. These strips were dated and stored for future reference.

We observed that clinical waste bags were securely stored away from patient areas. Consignment notices demonstrated that clinical waste was removed from the premises on a regular basis by an appropriate contractor.

Equipment and medicines

We saw records to demonstrate that equipment was regularly maintained and serviced in line with the

Are services safe?

manufacturers' recommendations. Evidence was available to demonstrate that servicing and pressure vessel testing of the autoclaves and compressor was being carried out in accordance with the manufacturers' instructions. For example the practice's two autoclaves were serviced in August 2015. We also saw records to confirm that washer disinfectors and ultrasonic baths had been serviced.

Records were available to demonstrate that a portable appliance test (PAT) had been carried out in July 2015, in accordance with current guidelines to make sure they were safe to use.

We saw that the batch numbers and expiry dates of medicines were always recorded in dental care records. Medicines kept at the practice were securely stored; however there were no methods to demonstrate stock control at the practice. NHS prescription pads were securely stored to prevent loss of prescriptions due to theft but when prescriptions were issued prescription numbers were not recorded on patient records.

The fridge which held some medicines and dental materials was not monitored to check it was at the correct temperature. The practice manager purchased a fridge thermometer and put this in place immediately following our inspection. We were told that fridge temperatures would be monitored on a daily basis.

Radiography (X-rays)

The practice had in place a Radiation Protection Adviser and a Radiation Protection Supervisor in accordance with the Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). The radiation protection file did not contain all information in line with these regulations. The were four X-ray units at the practice. We saw the current maintenance log for three of the X-ray units. We were told that the practice had recently purchased an X-ray unit and maintenance was not yet required. We saw a copy of the notification letter to the Health and Safety Executive, dated January 2016, informing them of this new machine. We were shown one critical examination and acceptance test report. We were told that paperwork was awaited for the new machine and documentation was not available for the other two X-ray units at the practice. Following our inspection we were sent copies of the critical examination and acceptance test reports for the X-ray units at the practice.

Local rules were available in the radiation protection folder and in each surgery for staff to reference if needed. Records showed that those authorised to carry out X-ray procedures had attended the relevant training and updates.

The records we saw also showed that dental X-rays were justified, reported on and quality assured every time. The decision to take X-rays was guided by clinical need, and in line with the Faculty of General Dental Practitioners' directive.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Our discussions with the dentist showed that that they carried out consultations, assessments and treatment in line with recognised general professional guidelines. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines for antibiotic prescribing, to determine how frequently to recall patients, and regarding removal of lower wisdom teeth.

Patients spoken with told us that they had completed a medical history form which asked for information about health conditions, medicines being taken and any allergies suffered. We saw evidence of medical history on dental care records which had been updated at subsequent visits to the practice.

Dental care records showed that details of the condition of the gums using the basic periodontal examination (BPE) were recorded. 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. The dentist referred patients to one of the practice's dental hygienists for more complex periodontal treatment. Records also recorded an assessment of oral and facial soft tissues to assess changes that may indicate oral cancer.

Health promotion & prevention

The waiting room at the practice contained leaflets and posters regarding dental health, for example regarding children's teeth, oral cancer, dental health and sugary foods. Free samples of toothpaste were also available. Dental hygienists worked at the practice providing a range of treatments including scaling and polishing and giving preventative advice and treatments. Patients that we spoke with confirmed that they were given advice appropriate to their individual needs regarding oral hygiene

Adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. Fluoride varnish was applied to children's teeth; high concentration fluoride tooth pastes were prescribed for adult patients at high risk from dental decay and disclosing tablets were used to explain to patients where improvements were required with their tooth brushing technique. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. However, the dental care records we observed did not demonstrate that dentists had given oral health education.

Staffing

Staff files contained continuing professional development logs (CPD). CPD is a requirement of registration with the General Dental Council (GDC) as a general dental professional. Staff told us that they were responsible for ensuring their CPD was up to date. Dental journals were provided by the practice as a source of learning for staff. Training certificates demonstrated that staff had undertaken basic life support training within the last 12 months. The practice used extended duty dental nurses for taking impressions and radiography, staff had received training regarding this.

The practice manager completed all appraisal meetings for dental nursing and reception staff. We saw appraisal documents for the previous three years. Very brief details were recorded in these documents and there were no personal development plans. However, staff spoken with confirmed that they were able to request training and the employees' comments section on the appraisal document could also be used for this purpose. We saw that some staff had requested to undertake a dental impressions course and we saw evidence that this training course had been completed. Staff spoken with said that they could discuss working practices, concerns or training needs with the practice manager at any time. Records showed professional registration with the GDC was up to date for all staff.

There was no documentary evidence that dental hygienist staff received an appraisal. The dental hygienist we spoke with could not remember having an appraisal.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves and always kept a copy of the referral. Templates of sample referral letters were available on the practice's computer system. A copy of the referral letter was always available to the patient if they wanted this for their records. We were told that there were no patients' complaints relating to referrals to specialised services.

Consent to care and treatment

Are services effective?

(for example, treatment is effective)

Patients we spoke with told us that they were provided with sufficient information during their consultation to enable them to make a decision about any treatment to be provided. We were told that options were discussed and patient views sought before any treatment was agreed. Staff told us that all patients were given a treatment plan, which they then signed to show that they were happy for the treatment to be given. We saw that consent forms were used for private orthodontic work but did not see evidence of these forms in use for other treatment. Although details of consent were often recorded in patient notes, details of discussions held were not recorded in sufficient detail. This particularly related to treatment provided by dental hygienists. The practice manager confirmed that patientswere advised to see a hygienist using a referral from the dentist. However the practice manager would make sure that the hygienist discussed consent with patients and that it was documented accordingly.

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. We spoke with staff and found they had a good understanding of MCA and its relevance in obtaining consent.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Staff were aware of the actions to take to ensure confidentiality was maintained. This included being careful to try and ensure that conversations held at the reception desk could not be overheard by patients in the waiting area. Treatment rooms were situated away from the main waiting area and we saw that doors were closed at all times when patients were with dentists. Conversations between patients and dentists could not be heard from outside the rooms which protected patients' privacy.

Staff told us that there was a room available to have confidential discussions with patients if required. The reception area was constantly staffed whilst the dental practice was open and staff were aware of the actions to take to keep patient information confidential.

We reviewed the 36 CQC comment cards patients had completed before the inspection and we spoke with three patients during the inspection. Patients told us that dental staff were professional, friendly and helpful and said that privacy and dignity was always maintained. Staff were aware of the support needs of those patients who may be fearful or anxious about dental treatment and patients commented that the dentist put them at ease.

We observed how staff interacted with patients and noted that patients were treated with dignity and respect. Staff appeared to know the patients well and had a good relationship with them. We were told that the majority of patients had been visiting the dental practice for many years.

Involvement in decisions about care and treatment

Patients were provided with a written treatment plan before treatment started. This included details of any costs. NHS costs were clearly displayed in the waiting area. Patients we spoke with confirmed that treatment options and associated costs were always explained to them. We were told that the dentist always explained everything in detail. Dental care records we reviewed demonstrated that clinicians recorded the information they had provided to patients about their treatment and the options open to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice's website described the range of services offered to patients which included general dentistry, orthodontics and dental implants. The practice provided NHS and private treatment. NHS treatment costs were clearly displayed in the waiting area. We were told that costs for private treatment were discussed with patients before any treatment was agreed. The practice's website also included information for patients about private dental plans and their costs.

We discussed appointment times and scheduling of appointments. We looked at the appointment schedules for patients and found that patients were given adequate time slots for appointments of varying complexity of treatment. We saw that time slots were left free in the day for use by patients who required to be seen in an emergency. Staff confirmed that patients who telephoned for an emergency appointment were seen the day that they called the practice. One patient told us that they had called with dental pain and been told to come straight to the practice to be seen.

Staff told us that patients who had a double appointment (an appointment with the dentist and the hygienist) were telephoned to remind them of their appointment. This helped to reduce the number of patients who did not attend their appointment. We were told that patients were usually able to get a routine appointment within a day or two of their phone request.

The practice manager had completed a waiting time audit and found that 67% of patients were seen by the dentist with five minutes of their appointment time and a further 22% within five to ten minutes. Patients we spoke with told us that they were generally seen within a few minutes of their appointment time and confirmed that they found it easy to get an appointment at the practice.

Tackling inequity and promoting equality

The practice was located on the first and second floor of a converted building on a busy street, there was no car park and patients used the nearby pay and display car park if required. There were two toilets for patients use, one on each floor; the toilet on the first floor had been adapted to meet the needs of patients with disabilities. Entrance to the dental practice was up a flight of stairs. Staff said that they helped patients with mobility difficulties up and down the stairs if required. When patients enquired about registering with the practice, staff explained the access arrangements. They helped patients who could not access their building to find another practice that provided suitable access.

We were told that the majority of patients registered at the practice could speak English and that there had not been the need for use of a translation service in the past. A hearing loop was available at the reception desk.

Access to the service

The practice was open from 8.15am to 5.30pm on Monday to Thursday (closed between 1pm to 2pm) and from 8.15am to 1pm on Friday. When the practice was closed patients were directed to call NHS 111.

Patients we spoke with were aware of how to access appointments both during opening hours and

outside of opening hours. Patients told us that they could get an appointment at a time to suit them and said that they did not have difficulty getting through to the practice on the telephone. We were told that dentists gave sufficient time during the appointment for explanations and discussions about care and treatment. Patients told us that appointments generally ran on time and confirmed that they rarely waited past their appointment time. Staff said that if they were aware that the dentist was running late they would inform patients in the waiting room.

Concerns & complaints

Information for patients about how to complain was on display in the waiting area. This gave the contact details of other organisations patients could contact if they were unhappy with the practice's response to a complaint. For example the General Dental Council, NHS England and the Parliamentary and Health Service Ombudsman. We saw that complaints were recorded and copies of any correspondence with the complainant were kept. Details of any action taken were recorded. Complaints guidance for staff from the British Dental Association (BDA) was available as well as a flow chart for receipt of complaints. The practice manager was the lead for complaints and staff spoken with were aware of who to speak with if they received a complaint.

There was no complaint leaflet to guide patients on how to make a complaint. However, staff told us that they would

Are services responsive to people's needs?

(for example, to feedback?)

give patients a copy of the complaint policy if they requested information on how to make a complaint. None of the patient feedback we received raised any issues or concerns about this dental practice. Patients we spoke with confirmed that they had no concerns or complaints about the practice and had never felt the need to complain.

The practice had received two complaints within the last 12 months. We were told that there had been no audit or monitoring to identify trends as the practice had received such a small number of complaints. We looked at five sets of practice meeting minutes but could not see any evidence of discussions regarding complaints received. We were told that complaints were discussed at informal meetings as and when they were received. There were no minutes of these meetings and no evidence of lessons learnt. The practice manager confirmed that in future minutes would be taken of these meetings and lessons learnt documented.

Are services well-led?

Our findings

Governance arrangements

The practice is owned by a partnership of two principal dentists who are in charge of the day to day running of this practice. Support is provided by three associate dentists, a practice manager, dental nurses, hygienists and a receptionist. The practice had some governance arrangements in place to ensure risks were identified, understood and managed appropriately. For example, risk management processes were in place to ensure the safety of patients and staff members. We saw risk assessments relating to fire safety, sharps and infection control. A control of substances hazardous to health (COSHH) file was also available, this contained data sheets for all chemical products used at the practice.

The practice had policies and procedures in place to support the management of the service, and these were available in a policy folder. We saw policies in respect of infection control, health and safety, complaints handling, safeguarding children and vulnerable adults and whistleblowing.

There was a management structure in place to ensure that responsibilities of staff were clear. Staff told us that they felt supported and were clear about their roles and responsibilities. Staff told us that they would speak with one of the principal dentists about any issues or concerns within the practice.

Leadership, openness and transparency

The practice had developed a duty of candour statement stating that staff should be open and transparent and recording the practice's duty to inform patients when they are affected by something that goes wrong.

Staff spoken with told us that there was a culture of openness and honesty at the practice. We were told that staff chatted through the day's events during informal lunchtime meetings which all staff attended. Informal meetings were also held on a weekly basis for dental nurses. All staff we spoke with said that they were able to discuss any issues or concerns with one of the partners or practice manager. Formal practice meetings were held on a monthly basis. We were told that minutes of the meetings were on display in the reception area. However, not all staff we spoke with were aware of this and those staff who did not attend practice meetings were therefore not all aware of discussions held. The practice manager confirmed that the minutes of future practice meetings would be sent to all staff by email for them to review.

The practice had in place a whistleblowing policy that directed staff on how to take action against a co-worker whose actions or behaviours were of concern.

Learning and improvement

Staff maintained their continuous professional development as required by the General Dental Council. Training undertaken included annual updates regarding basic life support. Extended duty dental nurses had undertaken training to enable them to take X-rays and impressions. Staff said that they were encouraged to undertake training.

The practice undertook regular clinical audit to ensure the effectiveness of the service, and highlight any areas for improvement. Audits on infection control and quality of X-rays taken were available. However we saw that the last clinical record audit was completed in 2013 and was due for re-audit.

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

We spoke with the practice manager about the methods used to obtain feedback from patients and from staff who worked at the practice. We were shown the results of the last satisfaction survey completed in March 2015. Results seen were positive. We were told that a satisfaction survey of 100 patients was completed on an annual basis.

The Friends and Family Test (FFT) had also been introduced. The friends and family test is a national programme to allow patients to provide feedback on the services provided. We looked at the results of the FFT for October to December 2015, we saw that patients had recorded positive comments and all were extremely likely to recommend the dental practice.

There was a suggestions/comments box in the waiting room which was also used to gather patient feedback and patient testimonials were recorded on the practice website. Patients spoken with said that staff were friendly and approachable.

Are services well-led?

We spoke with staff about how they are kept informed about the results of any satisfaction survey. Staff said that these were discussed at practice meetings. However, we could not see any evidence of this in the minutes of practice meetings seen.

We discussed the systems in place to feedback or receive feedback from staff. We were told that staff were able to speak out during practice meetings or were able to speak with the practice manager or principal dentist at any time if they had any concerns.