

Lambert Coutts & Associates Dental Practice Partnership

Mydentist - Grange Road - Hartlepool

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 7 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

Mydentist - Grange Road – Hartlepool is situated in Hartlepool, Cleveland. It offers mainly NHS treatment to patients of all ages but also offers private dental treatments. The services include preventative advice and treatment, routine restorative dental care, orthodontics and domiciliary care.

The practice has three surgeries, a decontamination room, two waiting areas and a reception area. The reception area, one waiting area and one surgery are on the ground floor. The other two surgeries and the second waiting area are on the second floor.

There are seven dentists (including one locum dentist), a dental hygiene therapist, six dental nurses (including one trainee), three receptionists and a practice manager. They are also supported by an area development manager and a regional manager.

Summary of findings

The opening hours on the day of inspection were Monday 8-30am to 5-30pm, Tuesday from 9-00am to 5-30pm, Wednesday from 9-00am to 5-30pm, Thursday from 8-30am to 7-30pm, Friday from 8-30am to 5-00pm and Saturday from 8-00am to 1-00pm.

The practice manager is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

During the inspection we spoke with 16 patients who used the service and reviewed 18 completed CQC comment cards. The patients were generally positive about the care and treatment they received at the practice. Comments included that the staff were helpful, friendly and courteous. Patients also commented that the environment was clean and fresh.

Our key findings were:

- The practice was clean and hygienic.
- The practice had effective systems in place to assess and manage risks to patients and staff including infection prevention and control, health and safety and the management of medical emergencies.
- Staff were qualified and had received training appropriate to their roles.
- Dental care records were detailed and showed that treatment was planned in line with current best practice guidelines.
- Oral health advice and treatment were provided in-line with the 'Delivering Better Oral Health' toolkit.
- Patients were treated with care, respect and dignity.
- Patients were involved in making decisions about their treatment and were given clear explanations about their proposed treatment including costs, benefits and risks.
- Patients were able to make routine and emergency appointments when needed.
- There were clearly defined leadership roles within the practice and staff told us that they felt supported, appreciated and comfortable to raise concerns or make suggestions.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

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

Staff had received training in safeguarding patients and knew the signs of abuse and who to report them to.

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

Patients' medical histories were obtained before any treatment took place. The dentists were aware of any health or medication issues which could affect the planning of treatment.

Staff were trained to deal with medical emergencies. All emergency equipment and medicines were in date and in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines.

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

Are services effective?

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

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

The practice followed best practice guidelines when delivering dental care. These included Faculty of General Dental Practice (FGDP), National Institute for Health and Care Excellence (NICE) and guidance from the British Society of Periodontology (BSP). The practice focused strongly on prevention and treatment was provided in line with the 'Delivering Better Oral Health' toolkit (DBOH) with regards to fluoride application and oral hygiene advice.

Staff were supported to deliver effective care through training and supervisions. The clinical staff were up to date with their continuing their professional development (CPD) and they were supported to meet the requirements of their professional registration.

Are services caring?

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

We reviewed spoke with 16 patients who used the service and reviewed 18 completed CQC comment cards. The patients were generally positive about the care and treatment they received at the practice. Comments included that the staff were helpful, friendly and courteous. Patients also commented that they were involved in treatment options and full explanations of treatment was given. It was also noted that reception staff provided a warm welcome and were friendly, helpful and considerate.

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

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

Summary of findings

Are services responsive to people's needs?

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

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

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

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

The practice had made reasonable adjustments to enable patients with a disability or limited mobility to access dental treatment. However, the practice should review its procedure for patients who have difficulty using the stairs.

Are services well-led?

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

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

The practice regularly audited clinical and non-clinical areas as part of a system of continuous improvement and learning. They undertook a rolling text message satisfaction survey and were also undertaking the NHS Family and Friends Test.

There were good arrangements in place to share information with staff by means of monthly practice meetings and weekly bulletins which were displayed for staff to reference.

Mydentist - Grange Road - Hartlepool

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

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

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

During the inspection we spoke with 16 patients who used the service and reviewed 18 completed CQC comment

cards. We also spoke with two dentists, one dental nurse, two receptionists and the practice manager. To assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had clear guidance for staff about how to report incidents and accidents. Staff were familiar with the process for accident and incident reporting and also understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). We reviewed the accident book and found that any accidents were documented, investigated and reflected upon by the dental practice. A copy of the accident form was also sent to the head office for analysis and follow up in necessary. The practice manager would put a summary of the incident and any changes which need to happen on a weekly bulletin which was displayed for all staff to see.

The practice also received fortnightly bulletins from the head office about significant events which had occurred at other Mydentist branches. If these were applicable to the practice then any learning from the significant event could be implemented into their own practice to ensure that the significant event did not occur again.

The practice responded to national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) that affected the dental profession. Any MHRA alerts were discussed with staff at practice meetings.

Reliable safety systems and processes (including safeguarding)

The practice had child and vulnerable adult safeguarding policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff. Staff had access to contact details for both child protection and adult safeguarding teams. Staff were knowledgeable about the different kinds of abuse which can occur including dental neglect. The practice manager was the safeguarding lead in the practice and all staff had undertaken level three safeguarding training in the last 12 months. All other staff had completed level two safeguarding training. The practice manager described to us an example where they had concerns about a patient and described the action which was taken. This was in line with the practice's policy.

The practice had 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), using a safe needle system and a protocol to prevent nurses from receiving needle stick injuries.

Rubber dams (this is a square sheet of latex used by dentists for effective isolation of the root canal and operating field and airway) were used in root canal treatment in line with guidance from the British Endodontic Society.

We saw that patients' clinical records were computerised, and password protected to keep people safe and protect them from abuse. Any paper documentation relating to dental care records including X-rays were kept secure in locked cabinets.

Medical emergencies

The practice had procedures in place which provided staff with clear guidance about how to deal with medical emergencies. This was in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). Staff were knowledgeable about what to do in a medical emergency and had received annual training in emergency resuscitation and basic life support as a team within the last 12 months. The practice manager also conducted quarterly medical emergency scenarios to re-fresh staff knowledge of what to do in the case of a medical emergency.

The emergency resuscitation kits, oxygen and emergency medicines were stored in a "red bag" in the reception area. There was also an additional oxygen cylinder on the first floor in a "green bag". Staff knew where the emergency kits were kept. The practice had an Automated External Defibrillator (AED) to support staff in a medical emergency. An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.

Records showed weekly checks were carried out to ensure the equipment and emergency medicines were safe to use. These including checking that the oxygen cylinder was full, the AED was fully charged and the emergency medicines had not been opened.

Are services safe?

We were told that when a domiciliary visit was carried out that a spare “red bag” was taken on the visit. This “red bag” was shared with other neighbouring practices.

Staff recruitment

The practice had a policy and a set of procedures for the safe recruitment of staff which included seeking references, proof of identity, checking relevant qualifications and professional registration.

The practice used an IT system to help with the different stages of staff recruitment. This began with the practice manager requesting a new member of staff (e.g. dentist or dental nurse). This was then submitted to the head office to advertise for the position. Subsequent stages included obtaining an application form from the applicant, an initial telephone interview, a formal interview and then issuing a letter of offer or rejection. This enabled the practice to keep an audit trail of all recruitment procedures.

We reviewed the information held in recruitment files and found the recruitment procedure had been followed. The practice manager told us the practice carried out Disclosure and Barring Service (DBS) checks for all newly employed staff. These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. We reviewed records of staff recruitment and these showed that all checks were in place.

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

Monitoring health & safety and responding to risks

A health and safety policy and risk assessment was in place at the practice. This identified the risks to patients and staff who attended the practice. The risks had been identified and control measures put in place to reduce them. We were told that the practice manager conducted a daily tour of the premises to ensure that there were no new hazards. If anything had been identified then the Mydentist facilities team would be notified and appropriate action would be undertaken.

The practice had access to the Mydentist online library of risk assessments for individual pieces of equipment. This

enabled them to ensure the risk assessments were practice specific. For example, we saw risk assessments for the use of the abrasive wheel (a piece of equipment used to polish dentures) and the use of a lignoject injection system (a specific piece of equipment used for numbing teeth and gums).

There were policies and procedures in place to manage risks at the practice. These included infection prevention and control, fire evacuation procedures and risks associated with Hepatitis B.

The practice maintained a file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including substances such as disinfectants, blood and saliva. The practice identified how they managed hazardous substances in its health and safety and infection control policies and in specific guidelines for staff, for example in its blood spillage and waste disposal procedures. The practice manager chose three substances in the COSHH folder to put on the practice bulletin so that staff were aware of any risks associated with the substance. The practice manager felt that this helped keep the staff aware of any risks and ensure that the folder was up to date.

Infection control

There was an infection control policy and procedures to keep patients safe. These included hand hygiene, health and safety, safe handling of instruments, managing waste products and decontamination guidance. The practice followed the guidance about decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 -Decontamination in primary care dental practices (HTM 01-05)'. The lead dental nurse was the nominated infection control lead who was responsible for ensuring infection prevention and control measures were followed.

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

We observed the treatment rooms and the decontamination room to be clean and hygienic. Work surfaces were free from clutter. Staff told us they cleaned the treatment areas and surfaces between each patient and at the end of the morning and afternoon sessions to help maintain infection control standards. There was a

Are services safe?

cleaning schedule which identified and monitored areas to be cleaned. There were hand washing facilities in each treatment room and staff had access to supplies of personal protective equipment (PPE) for patients and staff members. Patients confirmed that staff used PPE during treatment. Posters promoting good hand hygiene and the decontamination procedures were clearly displayed to support staff in following practice procedures. Sharps bins were appropriately located, signed and dated and not overfilled. We observed waste was separated into safe containers (hard and soft waste) for disposal by a registered waste carrier and appropriate documentation retained.

Decontamination procedures were carried out in a dedicated decontamination room 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 minimised the risk of the spread of infection.

The infection control lead showed us the procedures involved in disinfecting, inspecting and sterilising dirty instruments; packaging and storing clean instruments. The practice routinely used a washer disinfectant to clean the used instruments, examined them visually with an illuminated magnifying glass, and then sterilised them in an autoclave. The decontamination room had clearly defined dirty and clean zones in operation to reduce the risk of cross contamination. Staff wore appropriate PPE during the process and these included disposable gloves, aprons and protective eye wear.

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

The practice had carried out the self- assessment audit in December 2015 relating to the Department of Health's guidance on decontamination in dental services (HTM01-05). This is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. The audit showed the practice was meeting the essential standards required by HTM 01-05.

Records showed a risk assessment process for the control of Legionella had been carried out in March 2015

(Legionella is a bacteria which can contaminate water systems in buildings). The practice undertook processes to reduce the likelihood of legionella developing which included running the water lines in the treatment rooms at the beginning of each session and between patients, monitoring cold and hot water temperatures each month and the use of a dental unit water line cleansing solution.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as X-ray sets, autoclaves, the washer disinfectant and the compressor. We saw evidence of regular servicing of the autoclave and X-ray machines. Portable appliance testing (PAT) was completed in June 2015 (PAT confirms that portable electrical appliances are routinely checked for safety).

Prescriptions were stamped only at the point of issue to maintain their safe use. The practice kept a log of all prescriptions given to patients to keep a track of their safe use. The practice audited the provision of prescriptions to ensure they were being provided safely. Prescription pads were kept locked in a safe at night to ensure they were secure.

Radiography (X-rays)

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

The practice used an automated X-ray developer. We were told that the chemicals involved in developing X-rays was regularly changed to ensure that the developing process was effective. This was checked by taking and processing daily test X-rays. This procedure prevented the need to re-take X-rays due to developer issues.

Are services safe?

X-ray audits were carried out every six months. This included assessing the quality of the X-rays which had been taken. The results of the most recent audit undertaken confirmed they were compliant with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

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

During the course of our inspection we discussed patient care with the dentists and checked dental care records to confirm the findings. Clinical records were comprehensive and included details of the condition of the teeth, soft tissue lining the mouth, gums and any signs of mouth cancer.

Records showed patients were made aware of the condition of their oral health and whether it had changed since the last appointment. Medical history checks were updated by each patient every time they attended for treatment and entered in to their electronic dental care record. This included an update on their health conditions, current medicines being taken and whether they had any allergies. The practice used markers on the dental care records to highlight if a patient had a medical condition or was taking a medicine which could affect treatment.

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

Health promotion & prevention

The practice had a strong focus on preventative care and supporting patients to ensure better oral health in line with the 'Delivering Better Oral Health' toolkit (DBOH). DBOH published Public Health England is an evidence based toolkit used by dental teams to improve oral health in a

primary and secondary care setting. For example, the practice recalled children at high risk of tooth decay to receive fluoride applications and fissure sealants to their teeth. We were told that as the region had fluoridated water the incidence of dental decay in children was particularly low.

The practice had a selection of dental products on sale in the reception area to assist patients with their oral health. Patients were given advice regarding maintaining good oral health. When required, high fluoride toothpastes were prescribed.

The medical history form patients completed included questions about smoking and alcohol consumption. We saw evidence in dental care records that patients were given advice appropriate to their individual needs such as smoking cessation or dietary advice. There were health promotion leaflets available in the waiting room and surgery to support patients.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. The induction process included making the new member of staff aware of the infection control procedures, showing the new staff member the location of emergency medicines and arrangements for fire evacuation procedures. We saw evidence of completed induction checklists. Dentists who were new to the Mydentist company also attended a three day induction course at the Mydentist academy which covered areas such as cardiopulmonary resuscitation and the patient journey.

We were told and saw evidence that before a new member of staff started at the practice they were sent copies of the practice's policies, procedures and risk assessments to read prior to starting work. We were told that this saved time during the induction period.

Staff told us they had good access to on-going training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). Staff were able to access online training courses via the company's intranet. The practice manager kept a log of what training staff had completed and when it was due to be repeated. This ensured that staff were up to date with their training requirements.

Are services effective?

(for example, treatment is effective)

Records showed professional registration with the GDC was up to date for all clinical staff and we saw evidence of on-going CPD. Mandatory training included immediate life support, infection control and health, safety and fire awareness.

Working with other services

The practice worked with other professionals in the care of their patients when this was in the best interest of the patient. For example, referrals were made to hospitals and specialist dental services for further investigations or specialist treatment. The practice completed detailed proformas or referral letters to ensure the specialist service had all the relevant information required. A log of all referrals made was kept in each surgery. A copy of the referral letter was kept in the patient's dental care records. Letters received back relating to the referral were first seen by the referring dentist to see if any action was required and then stored in the patient's dental care records.

The practice manager had conducted an audit of the practice's referrals. This checked whether the referrals had been sent within a reasonable time frame.

Consent to care and treatment

Patients were given appropriate verbal and written information to support them to make decisions about the

treatment they received. For example, we were told that the dentists would draw diagrams explain what was involved in different treatments to assist with their understanding.

Staff were knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent. Staff described to us how valid consent was obtained for all care and treatment and the role family members and carers might have in supporting the patient to understand and make decisions.

Staff had completed training and understood the Mental Capacity Act (MCA) 2005 and how it was relevant to ensuring patients had the capacity to consent to their dental treatment.

Staff ensured patients gave their consent before treatment began and this was signed by the patient. This consent was in the form of a signed document outlining the costs involved with the treatment. Where verbal consent was given, for example, for an examination this was documented in the dental care records. Patients were given time to consider and make informed decisions about which option they preferred. Staff were aware that consent could be removed at any time.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

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

We observed privacy and confidentiality were maintained for patients who used the service on the day of inspection. Dental care records were not visible to the public on the reception desk. We observed staff were helpful, discreet and respectful to patients. Staff said that if a patient wished to speak in private an empty room would be found to speak with them.

Patients' electronic care records were password protected and regularly backed up to secure storage. The paper parts of the care records were locked in cabinets when the practice was closed.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Feedback from patients indicated they were involved in their treatment and it was fully explained to them. Staff described to us how they involved patients' relatives or carers when required and ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood. We were told that the dentists would often draw pictures to illustrate what was involved in different treatment. For example, they would draw pictures describing what was involved in root canal treatment or the provision of a crown.

There were also information leaflets available on the reception desk to inform patients about treatments which were available. There was also a great deal of information with regards to different treatment options on the practice's website.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We found the practice had an efficient appointment system in place to respond to patients' needs. Staff told us that patients who requested an urgent appointment would be seen within 24 hours if not the same day. We saw evidence in the appointment book that there were dedicated emergency slots available each day for each dentist. If the emergency slots had already been taken for the day then the patient was offered to sit and wait for an appointment if they wished. Staff also told us that another option would be to contact a local sister practice to see emergency patients if they were unable to do so. However, this happened very infrequently.

Tackling inequity and promoting equality

The practice had equality and diversity, and disability policies to support staff in understanding and meeting the needs of patients. Reasonable adjustments had been made to the premises to accommodate disabled patients. These included a ramp to access the building and a hearing loop. The ground floor surgery was large enough to accommodate a wheelchair or pram. However, there were no accessible ground floor toilet facilities. We were told that if this was ever an issue a domiciliary visit would be organised.

We asked patients if they were ever asked by staff of their ability to cope with the stairs. Several patients had not been asked this. We discussed this with the practice manager and we were told that this would be discussed with staff at the next practice meeting in order to implement a process of finding out whether a patient could cope with the stairs. We were told that the dentists each had sessions in the ground floor surgery and had staggered lunch hours in order to accommodate their own patients who could not cope with the stairs.

Access to the service

The practice displayed its opening hours in the premises and on the practice website. The opening hours on the day of inspection were Monday 8-30am to 5-30pm, Tuesday from 9-00am to 5-30pm, Wednesday from 9-00am to

5-30pm, Thursday from 8-30am to 7-30pm, Friday from 8-30am to 5-00pm and Saturday from 8-00am to 1-00pm. Patients could access care and treatment in a timely way and the appointment system met their needs.

Where treatment was urgent patients would be seen within 24 hours or sooner if possible. When the practice was closed patients who required emergency dental care were signposted to the NHS 111 service on the telephone answering machine. Details for patients of what to do if they have a dental emergency outside of the practice opening hours was also displayed outside of the practice. We asked patients if they knew how to access emergency care and several patients stated that they did not. We discussed this with the practice manager and we were told that a prominent sign would be put up in the waiting to inform patients of the NHS 111 service.

Concerns & complaints

The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. There were details of how patients could make a complaint displayed in the waiting room and on the website. The practice manager was responsible for dealing with complaints when they arose. Staff told us they raised any formal or informal comments or concerns with the practice manager to ensure responses were made in a timely manner. If the complaint related to clinical work then these were passed on to the individual dentist to deal with. If appropriate the dentist would use their indemnity organisation for advice on how to deal with complaints. Staff told us that they aimed to resolve complaints in-house initially. We reviewed the complaints which had been received in the past 12 months and found that they had been dealt with in line with the practices policy.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients. We found there was an effective system in place which helped ensure a timely response. This included acknowledging the complaint within three working days and providing a formal response within 20 working days. If the practice was unable to provide a response within 20 working days then the patient would be made aware of this.

Are services responsive to people's needs?

(for example, to feedback?)

The practice used an electronic database to log the progress of complaints. This including recording when letter or emails had been received or sent and when telephone calls had been received or made. This enabled the practice to keep and audit trail of any complaints.

Are services well-led?

Our findings

Governance arrangements

The practice manager was responsible for the day to day running of the service. There was a range of policies and procedures in use at the practice. We saw they had systems in place to monitor the quality of the service and to make improvements. The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately.

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

There was an effective management structure in place to ensure that responsibilities of staff were clear. Staff told us that they felt supported and were clear about their roles and responsibilities.

Leadership, openness and transparency

Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. These were discussed openly at staff meetings where relevant and it was evident that the practice worked as a team and dealt with any issue in a professional manner.

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

Learning and improvement

Quality assurance processes were used at the practice to encourage continuous improvement. Information about the quality of care and treatment was actively gathered from a range of sources, for example incidents and comments from patients. The practice audited areas of its practice as part of a system of continuous improvement and learning. This included clinical audits such as dental care records, X-rays, prescriptions, referrals and infection control. We looked at the audits and saw that the practice

was generally performing well. Where issues had been identified action plans were formulated to address the issues and re-audit date was set. The practice manager kept a log of when audits were due to be completed.

Staff told us they had access to training by means of the company's on-line training system and this was monitored by the practice manager to ensure essential training was completed; this included medical emergencies and basic life support. Staff working at the practice were supported to maintain their continuous professional development as required by the General Dental Council.

The practice held monthly staff meetings where significant events, patients' complaints, infection control reviews and practice performance were discussed and learning was disseminated. The practice manager also collated weekly bulletins which were displayed throughout the practice to inform staff of any current issues, for example, significant events which had occurred at other Mydentist practices, a summary of the fortnightly Mydentist practice manager bulletin and an update on COSHH.

The dentists had monthly one-to-one meetings with the practice manager. These meetings involved discussions about performance, patient feedback and general wellbeing. The practice manager used up to date information to help the dentists identify areas to make them more productive and offer help if needed.

All other staff had bimonthly meetings with the practice manager. These meetings involved discussions about performance, training needs, aspirations and general wellbeing. These meetings were used to help formulate a personal development plan.

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

The practice had systems in place to involve, seek and act upon feedback from people using the service including carrying out a monthly patient survey and a text message survey for patients who had finished a course of treatment. The patient survey included questions about the patients' overall satisfaction, whether staff were friendly, whether they were seen on time, whether the dentist made them feel at ease and if they understood the choices about treatment. The most recent patient survey showed a high level of satisfaction with the quality of the service provided.

Are services well-led?

We were told that staff were actively encouraged to seek feedback from patients and they aimed to get three satisfaction surveys completed each day. Feedback was regularly disseminated to staff at the monthly practice meetings.