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112 Bridge Road Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 9 March 2017 to ask the practice the following key questions;

Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?
We found 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
Bridge Road Dental Practice is a dental practice providing private treatment for both adults and children. The practice is based in a former domestic dwelling in Locks Heath a town in South Hampshire.

The practice has two dental treatment rooms one of which is based on the ground floor and a separate decontamination area used for cleaning, sterilising and packing dental instruments. The ground floor is accessible to wheelchair users, prams and patients with limited mobility.

The practice employs one dentist, two hygienists and three nurses who also cover reception.

The practice's opening hours are between 8am and 5.30pm on Monday and Tuesday, 8am and 1pm on Wednesday and Friday and 10am and 7.30pm on Thursday.

Summary of findings

There are arrangements in place to ensure patients receive urgent medical assistance when the practice is closed.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual and is legally responsible for making sure that the practice meets the requirements relating to safety and quality of care, as specified in the regulations associated with the Health and Social Care Act 2008.

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 received feedback from 48 patients. These provided a positive view of the services the practice provides. Patients commented on the high quality of care, the caring nature of all staff, the cleanliness of the practice and the overall high quality of customer care.

We obtained the views of 12 patients on the day of our inspection.

Our key findings were:

- We found that the practice ethos was to provide patient centred dental care in a relaxed and friendly environment.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment were readily available in accordance with current guidelines.
- The practice appeared clean and well maintained.
- There was appropriate equipment for staff to undertake their duties, and equipment was generally properly maintained.
- Infection control procedures were and the practice generally followed published guidance.
- The practice had a safeguarding lead with processes in place for safeguarding adults and children living in vulnerable circumstances. We noted that a formal written policy for safeguarding adults needed to be introduced.
- There was a process in place for the reporting and shared learning when untoward incidents occurred in the practice. We noted that a system for receiving national safety alerts needed to be introduced.
- The dentist provided dental care in accordance with current professional and National Institute for Care Excellence (NICE) guidelines.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Patients could access treatment and urgent and emergency care when required.
- Staff received training appropriate to their roles and were supported in their continued professional development (CPD) by the principal dentist.
- Staff we spoke with felt well supported by the principal dentist and were committed to providing a quality service to their patients.
- Patient feedback before and during our inspection gave us a positive picture of a friendly, caring, professional and high quality service.
- The practice had clinical governance and risk management structures in place, but we observed several shortfalls in systems and processes. Areas for improvement have been detailed in the summary section of the report below.

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

- Review the security of the decontamination room which contained substances subject to COSHH regulations to prevent unauthorised access by the public.
- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as, Public Health England (PHE).
- Review the use of audits, such as those checking the quality of infection prevention and control measures, to help monitor and improve the quality of service. The practice should also check that where appropriate, audits have documented learning points and the resulting improvements can be demonstrated.
- Review the systems that are in place to meet health and safety regulations with respect to fire risk; including reviewing the fire safety risk assessment and fire safety training.
- Review practice's safeguarding policies and staff training and ensure all staff are aware of their responsibilities.

Summary of findings

- Review the current staffing arrangements to ensure all dental care professionals are adequately supported by a trained member of the dental team when treating patients in a dental setting.
- Review the practice's testing protocols for equipment used for cleaning used dental instruments taking into account guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

The practice had arrangements in place for essential areas such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found that most equipment used in the dental practice was well maintained. There were several gaps including electrical wiring and the maintenance of air conditioning equipment. We have since been provided evidence to confirm this shortfall is being addressed.

The practice took its responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents.

Although most staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults, there were some staff that required update training.

Are services effective?

No action

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

The dental care provided was evidence based and focused on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice.

We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals. The staff received professional training and development appropriate to their roles and learning needs.

Are services caring?

No action

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

We obtained the views of 12 patients on the day of our visit. These provided a positive view of the service the practice provided.

All of the patients commented that the quality of care was very good. Patients commented on friendliness and helpfulness of the staff and dentists were good at explaining the treatment that was proposed.

Are services responsive to people's needs?

No action

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

The service was aware of the needs of the local population and took these into account in how the practice was run, although there were some areas that could be improved including making available a hearing loop for patients who were hard of hearing and translation services for those patients whose first language was not English.

Summary of findings

Patients could access treatment and urgent and emergency care when required.

The practice had one ground floor treatment room and level access into the building for patients with mobility difficulties and families with prams and pushchairs.

Are services well-led?

No action 

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

Although the dentist provided effective clinical care leading to good patient outcomes, there were shortfalls in the clinical governance systems and processes underpinning the clinical care. Areas for improvement have been detailed in the summary section and the main body of the report.

Staff had an open approach to their work and shared a commitment to continually improving the service they provided.

There was a no blame culture in the practice. The practice had robust clinical governance and risk management structures in place.

We saw evidence of systems to identify staff learning needs which were underpinned by an appraisal system. Staff working at the practice were generally supported to maintain their continuing professional development as required by the General Dental Council.

Staff told us that they felt well supported and could raise any concerns with the principal dentist. All the staff we met said that they were happy in their work and the practice was a good place to work.

112 Bridge Road Dental Practice

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 9 March 2017. Our inspection was carried out by a lead inspector and a dental specialist adviser.

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.

Prior to the inspection, we asked the practice to send us some information that we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, and the details of their staff members including proof of registration with their professional bodies.

During our inspection visit, we reviewed policy documents and staff training and recruitment records. We obtained the views of four members of staff.

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 the systems that supported the patient dental care records. We obtained the views of 12 patients on the day of our inspection.

Patients gave 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

The practice had in place systems to support RIDDOR 2013 (reporting of injuries, diseases and dangerous occurrences regulations). The practice had an incident reporting system in place when something went wrong; this system also included the reporting of minor injuries to patients and staff.

We were told that no accidents occurred during 2015-16 and were managed in accordance with the practice's accident reporting policy.

We discussed with the principal dentist the action they would take if a significant incident occurred, they detailed a process that involved a discussion and feedback with any patient that might be involved. This indicated an understanding of their duty of candour. Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.

We found that the practice needed to introduce a system for collating national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA). The principal dentist assured us that this would be addressed as soon as practically possible.

Reliable safety systems and processes (including safeguarding)

We spoke to a dental nurse about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current EU directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne diseases. The practice used a system whereby needles were not manually re-sheathed using the hands following administration of a local anaesthetic to a patient. The practice used a special safety syringe for the administration of dental local anaesthetics to prevent needle stick injuries from occurring. The dentist was responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur. Although it was displayed in the treatment room it was not displayed in the decontamination room which is good practice to do so. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps.

We asked the staff how they treated the use of instruments used during root canal treatment. They explained that these instruments were single patient use only. The practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam. They explained that root canal treatment was carried out where practically possible using a rubber dam. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided.

The practice had a safeguarding lead who was the point of referral should members of staff encounter a child or adult safeguarding issue. A policy and protocol was in place for staff to refer to in relation to children who may be the victim of abuse or neglect. We noted that a policy needed to be introduced for adults. Training records showed that most staff had received appropriate safeguarding training for both vulnerable adults and children although several staff needed to undergo further update training.

The principal dentist assured us that these points would be addressed as soon as practically possible.

Information was available in the practice that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had 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. Staff had received training in how to use this equipment.

The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had access to medical oxygen along with other

related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines and oxygen we saw were all in date and stored in a central location known to all staff. We noted that a system needed to be introduced to monitor if the AED was working correctly. The principal dentist assured us that this would be addressed as soon as practically possible.

Although the practice previously held training sessions each year for the whole team so that they could maintain their competence in dealing with medical emergencies, the last training session was in 2015. The principal dentist assured us that this would be addressed as soon as practically possible. We have since been provided with evidence to confirm that training has been booked to take place on 25 April 2017.

Staff recruitment

The dentist, dental hygienist and dental nurses had current registration with the General Dental Council, the dental professionals' regulatory body.The practice had a recruitment policy that detailed the checks required to be undertaken before a person started work.For example, proof of identity, a full employment history, evidence of relevant qualifications, adequate medical indemnity cover, immunisation status and references.

We looked at one staff recruitment files and records confirmed this person had been recruited in accordance with the practice's recruitment policy.

The systems and processes we saw were in line with the information required by regulations. Staff recruitment records were stored securely to protect the confidentiality of staff personal information.

We saw that all staff had received appropriate checks from the Disclosure and Baring Service (DBS). These are checks to 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

The practice had arrangements in place to monitor health and safety. The practice maintained a system of policies and risk assessments which included radiation, fire safety, general health and safety and those pertaining to all the equipment used in the practice. We noted that not all staff had received fire safety training in the last 12 months and that the fire risk assessment required up dating.

The principal dentist assured us that this would be addressed as soon as practically possible.

The practice had in place a well-maintained Control of Substances Hazardous to Health (COSHH) file. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The practice had in place an infection control policy that was regularly reviewed. It was demonstrated through direct observation of the cleaning process and a review of practice protocols that HTM 01 05 (national guidance for infection prevention and control in dental practices) Essential Quality Requirements for infection control was being met. It was observed that audit of infection control processes carried out in February 2017 confirmed compliance with HTM 01 05 guidelines. We noted that the practice did not retain on record previous audit results of infection control procedure. The principal dentist assured us that this would be addressed as soon as practically possible.

We found the practice did not produce an annual statement in relation to infection prevention control required under The Health and Social Care Act 2008: Code of Practice about the prevention and control of infections and related guidance.

We saw that the two dental treatment rooms, waiting area, reception and toilet were visibly clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available including liquid soap and paper towel dispensers in each of the treatment rooms. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

The drawers of one treatment room were inspected and these were clean, ordered and free from clutter. Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

Are services safe?

A dental nurse we spoke with described to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. They demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

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); they described the method they used which was in line with current HTM 01 05 guidelines. We saw that a Legionella risk assessment had been carried out at the practice by a competent person in September 2015. The recommended procedures contained in the report were carried out and logged appropriately.

The practice had a separate decontamination room for instrument cleaning, sterilisation and the packaging of processed instruments. We found this room to be insecure. The dental nurse we spoke with demonstrated the process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a combination of an ultra-sonic cleaning bath and manual scrubbing for the initial cleaning process, following inspection with an illuminated magnifier; the instruments were placed in an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilised, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines.

We were shown the systems in place to ensure that the autoclave used in the decontamination process were working effectively. It was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were complete and up to date. We noted in relation to validation of the ultrasonic cleaning bath a system for residual protein testing was not in place and the results of the foil test were not retained. The principal dentist assured us that this would be addressed as soon as practically possible.

The segregation and storage of clinical 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 in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. This was stored in a locked room prior to collection by the waste contractor. Waste consignment notices were available for inspection.

We saw that general environmental cleaning was carried out according to a cleaning plan developed by the practice. We noted that cleaning materials that were subject to COSSH storage arrangements were not stored securely. The principal dentist assured us that this would be addressed as soon as practically possible.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclave had been serviced and calibrated in August 2016. The practice's X-ray machines had been serviced and calibrated as specified under current national regulations in April 2014 and were due to be tested again in April 2017.

Portable appliance testing (PAT) had been carried out in April 2015. We noted that the practice air conditioning machines had not been previously serviced. The principal dentist assured us that this would be addressed as soon as practically possible.

The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored securely.

The practice also dispensed their own medicines as part of a patients' dental treatment for certain oral surgery procedures. These medicines were a range of antibiotics, the dispensing procedures were in accordance with current secondary dispensing guidelines and medicines were stored according to manufacturer's instructions.

We observed that the practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid and mercury spillage.

Radiography (X-rays)

We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). This file contained the names of the Radiation

Are services safe?

Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the three yearly maintenance logs and a copy of the local rules. The local rules must contain the name of the appointed Radiation Protection Advisor, the identification and description of each controlled area and a summary of the arrangements for restriction access. Additionally, they must summarise the working instructions, any contingency arrangements and the dose investigation level.

We were shown that a radiological audit had been carried out in 2016. Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured. These findings showed that the practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. We saw training records that showed staff where appropriate had received training for core radiological knowledge under IRMER 2000 Regulations.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentist carried out consultations, assessments and treatment in line with recognised general professional guidelines. The dentist described to us how they carried out their assessment of patients for routine care.

The assessment began with the patient completing a medical history questionnaire disclosing 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 then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment, the diagnosis was then discussed with the patient and treatment options explained in detail.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products. The patient 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 the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Dental care records that were shown to us by the dentist demonstrated 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 using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums. These were carried out where appropriate during a dental health assessment.

Health promotion & prevention

The practice was focused on the prevention of dental disease and the maintenance of good oral health. To facilitate this aim the practice appointed a dental hygienist to work alongside of the dentist in delivering preventative dental care.

The dentist explained that children at high risk of tooth decay were identified and were offered fluoride varnish applications to keep their teeth in a healthy condition. They also placed fissure sealants (special plastic coatings on the biting surfaces of permanent back teeth in children who were particularly vulnerable to dental decay).

They also described the advice that they gave which included tooth brushing techniques explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'.

Dental care records we observed demonstrated that the dentist had given oral health advice to patients. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area.

Staffing

We observed a friendly atmosphere at the practice. All clinical staff had current registration with their professional body, the General Dental Council.

We noted that the external name plate which detailed names of the dentist and hygienists working at the practice did not include their General Dental Council (GDC) registration number in accordance with GDC guidance from March 2012.

All of the patients we asked told us they felt there was enough staff working at the practice. Staff told us there were enough staff. Staff we spoke with told us they felt supported by the principal dentist. They told us they felt they had acquired the necessary skills to carry out their role and were encouraged to progress.

The practice employed one dentist, two hygienists and three nurses who also cover reception.

There was a structured induction programme in place for new members of staff.

Are services effective?

(for example, treatment is effective)

The dental hygienist did not work with chair side support. We pointed this out to the practice manager and referred them to the guidance set out in the General Dental Council's guide 'Standards for the Dental Team', specifically standard 6.2.2 working with other members of the dental team.

Working with other services

The dentist explained how they worked with other services such as specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as special care dentistry and orthodontic providers.

Consent to care and treatment

The dentist we spoke with explained how they implemented the principles of informed consent; they had a very clear understanding of consent issues. The dentist explained how 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.

The dentist went on to explain how they would obtain consent from a patient who suffered with any mental impairment that may mean that they might be unable to fully understand the implications of their treatment. If there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed. They added they would involve relatives and carers if appropriate to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005. Staff were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting areas and we saw that doors were closed at all times when patients were with dentist.

Conversations between patients and dentist could not be heard from outside the treatment rooms which protected patients' privacy. Patients' clinical records were stored in a manual format, with paper records stored in an area of the practice not accessible to unauthorised members of the general public.

Staff were aware of the importance of providing patients with privacy and maintaining confidentiality.

We obtained the views of 48 patients prior to the day of our visit and 12 patients on the day of our visit. These provided a positive view of the service the practice provided. All of the patients commented that the dentist was good at treating them with care and concern.

Patients commented that treatment was explained clearly and the staff were caring and put them at ease. They also said that the reception staff were helpful and efficient. During the inspection, we observed staff in the reception area, they were polite and helpful towards patients and the general atmosphere was welcoming and friendly.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. A poster detailing fees was displayed in the waiting area.

The dentist paid particular attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the dentist recorded the information they had provided to patients about their treatment and the options open to them.

All the patients we asked told us the dentist was good at explaining treatment and involved them in decisions about their care and treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we looked at examples of information available to patients. We saw that the practice waiting area displayed a variety of information. These explained opening hours, emergency 'out of hours' contact details and arrangements and how to make a complaint. We observed that the appointment diaries were not overbooked and that this provided capacity each day for patients with dental pain to be fitted into urgent slots.

The dentist decided how long a patient's appointment needed to be and took into account any special circumstances such as whether a patient was very nervous, had an impairment and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to help prevent inequity for patients that experienced limited mobility or other barriers that may hamper them from accessing services.

There were some areas that could be improved including making available a hearing loop for the hard of hearing and translation services for those patients whose first language was not English.

To improve access for patients who found steps a barrier one treatment room was based on the ground floor.

Access to the service

The practice's opening hours were between 8am and 5.30pm on Monday and Tuesday, 8am and 1pm on Wednesday and Friday and 10am and 7.30pm on Thursday.

We asked 12 patients if they were satisfied with the hours the surgery was open; all but one patient said yes.

There were arrangements in place to ensure patients received urgent dental assistance when the practice was closed. This was provided by the dentist who had an on call rota arrangement with a number of nearby practices.

Concerns & complaints

There was a complaints policy which provided staff with information about handling formal complaints from patients. Staff told us the practice team viewed complaints as a learning opportunity and discussed those received in order to improve the quality of service provided.

Information for patients about how to make a complaint was available in the practice's waiting room. This included contact details of other agencies to contact if a patient was not satisfied with the outcome of the practice investigation into their complaint. We asked 12 patients if they knew how to make a complaint if they had an issue and all but one said yes.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was an effective system in place which ensured a timely response.

For example, a complaint would be acknowledged within two working days and the complaint would be investigated within 10 days. We were told there had not been any complaints in the previous 12 months.

We noted the practice leaflet did not include details of how patients could provide feedback and how to make a complaint.

Are services well-led?

Our findings

Governance arrangements

Although the dentist provided effective clinical care leading to good patient outcomes, there were shortfalls in the clinical governance systems and processes underpinning the clinical care. Areas for improvement have been detailed in the summary section of the report.

The governance arrangements for this location consisted of the principal dentist who was responsible for the day to day running of the practice.

All of the staff we spoke with were aware of the policies and how to access them. We noted management policies and procedures were generally kept under review by the principal dentist on a regular basis.

Leadership, openness and transparency

The practice ethos focused on providing patient centred dental care in a relaxed and friendly environment. The comment cards we saw reflected this approach.

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said they felt comfortable about raising concerns with the practice owner. There was a no blame culture within the practice. They felt they were listened to and responded to when they did raise a concern. We found staff to be hard working, caring and committed to the work they did.

All of the staff we spoke with demonstrated an understanding of the principles of clinical governance in dentistry and were happy with the practice facilities. Staff reported that the principal dentist was proactive and aimed to resolve problems very quickly. As a result, staff were motivated and enjoyed working at the practice and were proud of the service they provided to patients.

Learning and improvement

We saw evidence of systems to identify staff learning needs which were underpinned by an appraisal system and a programme of clinical audit. For example, we observed that all staff received an annual appraisal.

We found there were some clinical audits taking place at the practice. These included infection control and X-ray quality.

Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. Staff told us that the practice ethos was that all staff should receive appropriate training and development.

The principal dentist encouraged staff to carry out professional development wherever possible. Most staff had undergone the recommended update training as specified by the General Dental Council there were a number of gaps. These have been detailed in the main body of the report.

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

The practice gathered feedback from patients through surveys, compliments and complaints. We saw that there was a robust complaints procedure in place, with details available for patients in the waiting area.

Results of the most recent practice survey carried out indicated that 100% of patients, who responded, said they had trust in the dentist. We noted the survey was dated 2015. The principal dentist told us the survey was carried out on a three yearly basis by a dental insurance provider.

Staff told us that the dentists were very approachable and they felt they could give their views about how things were done at the practice. Staff told us that they had frequent meetings and described the meetings as good with the opportunity to discuss successes, changes and improvements. For example, changes included the introduction of a dental water line treatment.