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Birchfield Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 24 May 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

Birchfield Dental Practice is a mixed dental practice providing NHS (predominantly) and private dental treatment for both adults and children. The service is provided by seven dentists. They are supported by a practice manager (who works part-time at this practice), one general administrator, two dental hygienists, one receptionist and eight dental nurses (three of whom are trainees). The dental nurses also carry out reception duties.

The practice is located in a busy shopping area and is all on the ground floor so can accommodate patients with restricted mobility. The premises consist of a reception area, waiting room, toilet facilities, six treatment rooms, a decontamination room, an office, a staff room and a stock room. There is free parking and a dedicated parking bay for patients with disabilities. Opening hours are from 9am to 5pm on Monday to Friday. The practice is also open on alternate Saturdays from 9am to 1pm.

The provider is registered with the Care Quality Commission (CQC) as an individual. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run. The provider does not carry out dental treatment at this practice.

Thirty-nine patients provided feedback about the practice. We looked at comment cards patients had completed prior to the inspection and we also spoke with patients on the day of the inspection. Overall the

Summary of findings

information from patients was complimentary. Patients were positive about their experience and they commented that staff were caring, friendly and professional.

Our key findings were:

- The practice had systems to assess and manage risks to patients, including infection prevention and control, health and safety, safeguarding and the management of medical emergencies.
- The practice appeared clean and tidy on the day of our visit and many patients also made similar comments.
- Patients told us they found the staff helpful and friendly. Patients were able to make routine and emergency appointments when needed.
- 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.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- The practice had an effective complaints system in place and there was an openness and transparency in how these were dealt with.
- Staff told us they felt well supported and comfortable to raise concerns or make suggestions.
- The practice demonstrated that they regularly undertook audits in infection control, radiography and dental care record keeping.

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

- Review practice protocols for reporting any defects in the upholstery in clinical areas so that these can be repaired in a timely manner.

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). Accidents and incidents in the previous 12 months prior to our inspection had been documented.

The practice had systems to assess and manage risks to patients, whistleblowing, complaints, safeguarding, health and safety and the management of medical emergencies. It had a recruitment policy to help ensure the safe recruitment of staff.

Patients' medical histories were obtained before any treatment took place. The dentist was aware of any health or medicines issues which could affect the planning of treatment. Staff were trained to deal with medical emergencies. Emergency equipment and medicines were in date and in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines.

The practice was carrying out infection control procedures as described in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary dental practices'.

Are services effective?

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

The practice monitored any changes to the patients' oral health and made referrals for specialist treatment or investigations where indicated. Explanations were given to patients in a way they understood and risks, benefits and options were explained. Record keeping was in line with guidance issued by the Faculty of General Dental Practice (FGDP).

The dentists followed national guidelines when delivering dental care. These included FGDP and National Institute for Health and Care Excellence (NICE). We found that preventative advice was given to patients in line with the guidance issued in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Are services caring?

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

On the day of the inspection we observed privacy and confidentiality were maintained for patients using the service. Patient feedback was positive about the care they received from the practice. They commented they were treated with kindness and respect while they received treatment. Patients commented they felt involved in their treatment and it was fully explained to them.

Are services responsive to people's needs?

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

There was an effective procedure in place for acknowledging, recording, investigating and responding to complaints made by patients. We saw examples of many processes undertaken by the practice which led to improvements made

Summary of findings

as a result of concerns raised by patients. Examples included the introduction of various information leaflets for patients, customer service training for staff and subsequent questionnaires for staff to demonstrate learning. We think this is notable practice as it demonstrates a commitment to improving the quality of care by directly involving patients and staff.

The practice had an efficient appointment system in place to respond to patients' needs. They were usually able to see patients requiring urgent treatment within 24 hours. There were clear instructions for patients requiring urgent care when the practice was closed.

The practice offered access for patients with disabilities and this included accessible toilet facilities.

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 staff we spoke with felt supported in their own particular roles.

There were several systems in place to monitor the quality of the service including various audits. The practice used various methods to successfully gain feedback from patients. Staff meetings took place on a regular basis and the practice used several methods to obtain feedback from its patients and staff.

Birchfield Dental Practice

Detailed findings

Background to this inspection

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

We inspected Birchfield Dental Practice on 24 May 2016. The inspection team consisted of one CQC inspector, a dental specialist advisor and the deputy chief inspector for the primary medical services.

Prior to the inspection we reviewed information we held about the provider from various sources. We informed NHS England that we were inspecting the practice and we did not receive any information of concern from them. We also requested details from the provider in advance of the inspection. This included their latest statement of purpose describing their values and objectives and a record of patient complaints received in the last 12 months.

During the inspection we toured the premises, spoke with the practice manager, the provider, five dentists, two dental nurses and three receptionists. We spoke with patients and reviewed CQC comment cards which patients had completed. We reviewed a range of practice policies and practice 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 arrangements for staff to report incidents and accidents. We saw evidence that these were discussed in staff meetings and learning was shared. We reviewed incidents and accidents and found that they had been documented appropriately. We were told that all incidents were logged so that staff could learn from the strengths and weaknesses in the services they offered.

Staff members we spoke with all understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any RIDDOR reportable incidents in the last 12 months.

The practice responded to national patient safety and medicines alerts that affected the dental profession. We were told that the practice had registered with the MHRA (Medicines and Healthcare products Regulatory Agency). There was a folder in place with all relevant alerts and these were discussed with staff at staff meetings for shared learning. The practice also had arrangements in place for staff to report any adverse drug reactions.

Reliable safety systems and processes (including safeguarding)

The practice had child protection and vulnerable adult 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 – this information was also displayed in the patients' waiting room area. One of the dentists was the safeguarding lead in the practice. Staff members we spoke with were knowledgeable about safeguarding and had completed safeguarding training. We saw details documented about safeguarding incidents – we saw that the practice responded appropriately and contacted external organisations in a timely manner.

The British Endodontic Society recommends the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a rectangular sheet of latex used by dentists for effective isolation of the root canal, operating field and airway. Rubber dam kits were available at the practice. We spoke with staff and they told us that not all dentists used them when carrying out root canal treatment. If they did not use the rubber dam, the dentist(s) used alternative measures to protect the airway. The practice manager spoke with the relevant dentists after our visit and emailed us within three days with evidence that these dentists were due to attend training on the placement of rubber dam in November 2016.

The practice had a policy for raising concerns and the provider was the whistleblowing lead. All staff members we spoke with were aware of the whistleblowing process within the practice. All dental professionals have a professional responsibility to speak up if they witness treatment or behaviour which poses a risk to patients or colleagues.

Never events are serious incidents that are wholly preventable. Staff members we spoke with were aware of never events and had processes to follow to prevent these happening. For example, they had a process to make sure they did not extract the wrong tooth.

Internal training took place in November 2015 on the duty of candour regulation. The intention of this regulation is to ensure that staff members are open and transparent with patients in relation to care and treatment.

Medical emergencies

Within the practice, the arrangements for dealing with medical emergencies were in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). The practice had access to emergency resuscitation kits, oxygen and emergency medicines. There was an Automated External defibrillator (AED) present. 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.

Staff received annual training in the management of medical emergencies. The practice took responsibility for ensuring that all of their staff received annual training in this area. Three staff members had also received training in emergency first aid.

Staff undertook regular checks of the equipment and emergency medicines to ensure they were safe to use. They documented daily checks of the emergency oxygen and AED and weekly checks of the emergency medicines. The

Are services safe?

emergency medicines were all in date and stored securely. Glucagon (one type of emergency medicine) was stored in the fridge and the temperature was monitored and documented on a daily basis.

Staff recruitment

The practice had a policy for the safe recruitment of staff. We looked at the recruitment records for four members of the practice team and these were all comprehensive. The records we saw contained evidence of immunisation status, staff identity verification, curricula vitae, employment contracts and induction plans. Evidence of dental indemnity and copies of their GDC registration certificates were also present (where relevant). There were references present for all staff files we reviewed (apart from the practice cleaner).

There were Disclosure and Barring Service (DBS) checks present for all of the staff files we viewed. The DBS carries out 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 vulnerable adults. The DBS checks were repeated every three years and annual risk assessments were also carried out.

The practice had a system in place to monitor professional registration of its clinical staff members. We reviewed a selection of staff files and found that certificates were present and had been updated to reflect the current year's membership.

Monitoring health & safety and responding to risks

We saw evidence of a comprehensive business continuity plan which described situations which might interfere with the day to day running of the practice. This included extreme situations such as loss of the premises due to fire. We reviewed the plan and found that it had all relevant contact details in the event of an emergency.

The practice had arrangements in place to monitor health and safety. We reviewed several risk management policies. We saw evidence that a fire risk assessment had taken place in May 2016 and fire extinguishers had been serviced in July 2015. The fire extinguishers and fire escape routes were checked weekly and this was documented. We saw evidence that designated staff members had received fire safety marshal training. Fire alarms were tested weekly and this was documented. Fire drills took place annually (at least) and there was clear guidance on what to do in the event of fire.

Information on the Control of Substances Hazardous to Health 2002 (COSHH) regulations was available for all staff to access. We looked at the COSHH file and found this to be comprehensive where risks associated with substances hazardous to health had been identified and actions taken to minimise them. This was reviewed annually.

Infection control

There was an infection control policy and procedures to keep patients and staff safe. The practice followed the guidance about decontamination and infection control issued by the Department of Health, namely the 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05)'. The practice had a nominated infection control lead that was responsible for ensuring infection prevention and control measures were followed. We saw evidence that staff had carried out training in infection control.

We reviewed a selection of staff files and saw evidence that clinical staff were immunised against Hepatitis B to ensure the safety of patients and staff.

We observed the treatment rooms and the decontamination room to be visibly clean. Several patients commented that the practice was clean and tidy. Work surfaces and drawers were free from clutter. Patient dental care records were computerised and the keyboards in the treatment rooms were all water-proof, sealed and wipeable in line with HTM 01-05.

The floors were adequately sealed in all clinical areas. In three treatment rooms, there were tears in the dental chairs which would make effective cleaning difficult. One of these had been temporarily covered to assist with cleaning. The practice manager was aware of only one of the chairs that required repair. Within three days, we received an email from the practice with details about the supplier (with quotations) that was due to re-upholster the damaged chairs.

There were handwashing facilities in the treatment rooms and staff had access to supplies of personal protective equipment (PPE) for themselves and for patients.

Are services safe?

Decontamination procedures were carried out in a dedicated decontamination room. In accordance with HTM 01-05 guidance an instrument transportation system was in place to ensure the safe movement of instruments between the treatment rooms and the decontamination room.

Sharps bins were appropriately located and out of the reach of children. They were dated and wall-mounted. We observed waste was separated into safe and lockable containers for regular disposal by a registered waste carrier and appropriate documentation retained. Clinical waste storage was in an area where members of the public could not access it. The correct containers and bags were used for specific types of waste as recommended in HTM 01-05.

We spoke with clinical staff about the procedures involved in cleaning, rinsing, inspecting and sterilising dirty instruments. Clean instruments were packaged, date stamped and stored in accordance with current HTM 01-05 guidelines. There appeared to be sufficient instruments available and staff confirmed this with us. Staff we spoke with were aware of disposable items that were intended for single use only.

Staff used an ultrasonic cleaning bath to clean the used instruments; they were subsequently examined visually with an illuminated magnifying glass and then sterilised in an autoclave. An ultrasonic cleaning bath is a device that uses high frequency sound waves to clean instruments. The decontamination room had clearly defined clean and dirty zones to reduce the risk of cross contamination. Staff wore appropriate personal protective equipment during the process and these included disposable gloves, aprons and protective eye wear. Heavy duty gloves are recommended during the manual cleaning process and they were replaced on a weekly basis in line with HTM 01-05 guidance.

The practice had systems in place for quality testing the decontamination equipment daily, weekly and quarterly. We saw records which confirmed these had taken place.

The practice had a protocol which provided assistance for staff in the event they injured themselves with a contaminated sharp instrument. This was clearly displayed in the treatment rooms and it had contact details. Staff we spoke with were familiar with the Sharps Regulations 2013 and were following guidance. These set out recommendations to reduce the risk of injuries to staff from contaminated sharp instruments. These regulations were displayed in the decontamination room.

The practice manager informed us that environmental cleaning of all clinical and non-clinical areas were carried out daily by an external cleaner.

The Department of Health's guidance on decontamination (HTM 01-05) recommends self-assessment audits of infection control procedures every six months. It is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. We saw evidence that the practice carried these out every three months. Action plans were documented subsequent to the analysis of the results. By following the action plan, the practice could subsequently assure themselves that they had made improvements as a direct result of the audit findings.

Staff members were following the guidelines on managing the water lines in the treatment rooms to prevent Legionella. Legionella is a term for particular bacteria which can contaminate water systems in buildings. We saw evidence that a Legionella risk assessment was carried out by an external contractor in November 2015. We saw evidence that the practice recorded water temperature on a monthly basis to check that the temperature remained within the recommended range.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as X-ray equipment, pressure vessels and autoclaves.

Employers must ensure that their electrical equipment is maintained in order to prevent danger. Regular portable appliance tests (PAT) confirms that portable electric items used at the practice are safe to use. The practice previously had PAT carried out in December 2015.

The practice kept a log of prescriptions given so they could ensure that all prescriptions were tracked and safely given. Prescriptions were stored securely.

There was a separate fridge for the storage of medicines and dental materials. The temperature was monitored and recorded daily.

Are services safe?

We were told that the batch numbers and expiry dates for local anaesthetics were always recorded in patients' dental care records – we corroborated this when reviewing records. Stock rotation of all dental materials was carried out on a regular basis and all materials we viewed were within their expiry date. This was also documented.

Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. The practice used a digital X-ray system.

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. Local rules were available in the practice for all staff to reference if needed.

We saw evidence of notification to the Health and Safety Executive (HSE). Employers planning to carry out work with ionising radiation are required to notify HSE and retain documentation of this.

We saw evidence that all dentists were up to date with required training in radiography as detailed by the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

We saw evidence that the practice carried out X-ray audits for all dentists and this was a continuous process. Audits are central to effective quality assurance, ensuring that best practice is being followed and highlighting improvements needed to address shortfalls in the delivery of care. We saw that the results were analysed and reported on with subsequent action plans. The practice had recently introduced a system whereby dentists grade their colleague's X-rays - this would be a fairer procedure as it would reduce the likelihood of bias.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept up to date, detailed electronic dental care records. They contained information about the patient's current dental needs and past treatment. The dentists carried out assessments in line with recognised guidance from the Faculty of General Dental Practice (FGDP).

We spoke with five dentists about the oral health assessments, treatment and advice given to patients and corroborated what they told us by looking at patient dental care records. Dental care records included details of the condition of the teeth, soft tissues lining the mouth, gums and any signs of mouth cancer. Medical history checks were not documented in all of the records we viewed. This should be updated and recorded for each patient every time they attend.

The Basic Periodontal Examination (BPE) is a screening tool which is used to quickly obtain an overall picture of the gum condition and treatment needs of an individual. We saw that the practice was recording the BPE for all adults and children aged 7 and above (as per guidelines). Patients with gum disease had the option of being referred to a hygienist at the practice.

The practice kept up to date with other current guidelines and research in order to develop and improve their system of clinical risk management. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to lower wisdom teeth removal and in deciding when to recall patients for examination and review. Following clinical assessment, the dentist told us they 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 was recorded and reports on the X-ray findings were available in the dental care records.

Staff told us that treatment options and costs (where applicable) were discussed with the patient and this was corroborated when we spoke with patients.

Health promotion & prevention

The medical history form patients completed included questions about smoking and alcohol consumption. The dentists we spoke with told us that patients were given advice appropriate to their individual needs such as smoking cessation, alcohol consumption or dietary advice. There were posters and oral health promotion leaflets available in the practice to support patients look after their health. Examples included information on safeguarding, healthy eating and children's teeth. Many of these were available in different languages.

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'. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. For example, the practice recalled patients, as appropriate, to receive fluoride applications to their teeth. Where required, toothpastes containing high fluoride were prescribed.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. This covered areas such practice policies and the Mental Capacity Act.

Staff told us they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, orthodontic therapists, clinical dental technicians and dental technicians. All clinical staff members were registered with the GDC (apart from the trainee dental nurses as only qualified staff can register).

The practice manager monitored staffing levels and planned for staff absences to ensure the service was uninterrupted. We were told that dental nurses were transferred from the provider's other practice when they were short-staffed. The practice also utilised a locum agency for dental nurses. The practice manager showed us evidence from the locum agency to show that the agency is responsible for carrying out safety checks of the local dental nurses. These included evidence of their GDC registration, DBS checks and proof of immunisation to Hepatitis B. The practice held an induction checklist for agency workers. The practice was in the process of recruiting two new dental nurses (one of whom was a trainee).

Are services effective?

(for example, treatment is effective)

Dental nurses were supervised by the dentists and supported on a day to day basis by the practice manager. Staff told us the practice manager was readily available to speak to at all times for support and advice.

We were told that the dental nurses were encouraged to carry out further training and two of them were currently enrolled on a course which would enable them to take dental impressions.

Working with other services

The practice worked with other professionals in the care of their patients where 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. We viewed three referral letters and noted that all were comprehensive to ensure the specialist services had all the relevant information required.

The practice understood the procedure for urgent referrals, for example, patients with suspected oral cancer. These referrals were logged and followed up to ensure they were received.

The practice carried out an audit into their own referral protocols. The results of the audit highlighted that all patients should be given a copy of their referral letter.

Consent to care and treatment

Patients were given appropriate verbal and written information to support them to make decisions about the treatment they received. Staff ensured patients gave their consent before treatment began.

Staff members were knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent (in accordance with the Mental Capacity Act 2005). The 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. Staff members we spoke with had an understanding of the MCA and information was also displayed about this in the waiting room for patients.

Staff members we spoke with were clear about involving children in decision making and ensuring their wishes were respected regarding treatment. They were familiar with the concept of Gillick competence regarding the care and treatment of children under 16. Gillick competence principles help clinicians to identify children aged under 16 who have the legal capacity to consent to examination and treatment.

Staff confirmed individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. Patients were given time to consider and make informed decisions about which option they preferred. We saw evidence of customised treatment plans when reviewing dental care records. One patient we spoke with told us that they do not recall being given a written treatment plan.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Thirty-nine patients provided feedback about the practice. We looked at comment cards patients had completed prior to the inspection and we also spoke with patients on the day of the inspection. Overall the information from patients was complimentary. Patients were positive about their experience and they commented that staff treated them with dignity and were caring. Patients described it as an excellent service and said the dentists explained what they were doing. Patients were satisfied with the standard of care and found the staff were kind and professional. Patients commented they would recommend this practice to their relatives and friends. One patient highlighted that sometimes things were explained too quickly.

We observed privacy and confidentiality were maintained for patients who used the service on the day of the inspection. For example, the doors to the treatment rooms were closed during appointments and confidential patient details were not visible to other patients. We observed staff members were helpful, discreet and respectful to patients. Staff members we spoke with were aware of the importance of providing patients with privacy and we saw this was covered during induction. The reception area was not left unattended. There was a room available for patients to have private discussions with staff. Confidential patient information was stored in a secure area.

We were told that the practice appropriately supported anxious patients using various methods. For children (especially anxious patients), the dentists used child appropriate language and the tell-show-do technique. The tell-show-do technique is an effective way of establishing rapport as it is very much an **interactive** and communicative approach. They also had the choice of seeing different dentists, including male or female dentists.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients commented they felt involved in their treatment and it was fully explained to them. Patients were also informed of the range of treatments available. Patients commented that the cost of treatment (where applicable) was discussed with them and this information was also provided to them in the form of a customised written treatment plan. One patient commented they do not recall receiving a written treatment plan.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We conducted a tour of the practice and we found the premises and facilities were appropriate for the services that were planned and delivered. Patients with mobility difficulties were able to access the practice as the practice was located on the ground floor. There was wheelchair access to the toilet and treatment rooms. CCTV was present in the waiting room and there were leaflets available for patients about this.

The practice had an appointment system in place to respond to patients' needs. Patients we spoke with told us that they were not always seen on time but they felt the wait was not too long. We were told it was easy to make an appointment.

We were told that patients with mental health conditions and physical and learning disabilities were given longer appointments so that sufficient time was allocated to meet their dental needs.

Staff told us the majority of patients who requested an urgent appointment would be seen within 24 hours. The practice used dedicated emergency slots to accommodate patients requiring urgent dental treatment.

All patients received courtesy text message reminders 24 hours before their appointment to confirm the time and date. There were practice leaflets for patients as well as quarterly newsletters.

Tackling inequity and promoting equality

The practice had an equality and diversity policy to support staff in understanding and meeting the needs of patients. The practice recognised the needs of different groups in the planning of its services. The practice had an audio loop system for patients who might have hearing impairments.

The practice had access to an interpreting service for patients that were unable to speak fluent English. Most staff members (dentists and dental nurses) spoke different languages relevant to patients – these included Urdu, Punjabi and Somalian. The newsletter contained information about this service. Many information leaflets in the waiting room were provided in several different languages which were relevant to the local population. Examples included information in Polish, Portuguese, Punjabi and French.

Access to the service

Patients could access care and treatment in a timely way and the appointment system met their needs.

The practice had a system in place for patients requiring urgent dental care when the practice was closed. Patients were signposted to the NHS 111 service for advice on obtaining emergency dental treatment. There was also information in the waiting room for patients about this service.

Opening hours were from 9am to 5pm on Monday to Friday. The practice was also open on alternate Saturdays from 9am to 1pm.

Concerns & complaints

We saw evidence that verbal and written complaints received by the practice had been recorded, analysed and investigated. We found that complainants had been responded to in a timely manner. The practice tried to resolve all complaints on the same day. We saw that that any learning identified was cascaded to team members. We saw examples of changes and improvements that were made as a result of concerns raised by patients. Examples included the introduction of information leaflets for patients with details of waiting times and customer service training for staff. The practice manager had also developed a quiz for staff and they were requested to complete this after the customer service training.

The practice had a complaints process which provided staff with clear guidance about how to handle a complaint. Any formal or informal comments or concerns were passed on to the practice manager to ensure responses were made in a timely manner. This information would then be discussed in staff meetings. Information for patients about how to make a complaint was displayed clearly at the practice. This had details of external organisations in the event that patients were dissatisfied with the practice's response.

The learning from complaints was very evident from the handling of the complaints that we reviewed. This included the staff meetings and subsequent changes to the practice protocols as well as training in customer relations for all staff. The practice manager told us that complaints were

Are services responsive to people's needs?

(for example, to feedback?)

used to help them improve the services they offered. They welcomed complaints in an open and transparent manner. We think this is notable practice as it demonstrates a commitment to improving the quality of care by directly involving patients and staff.

Patients had made comments on the NHS Choices website. The practice had responded to the positive and negative entries on the website in a timely manner.

Are services well-led?

Our findings

Governance arrangements

The practice manager was in charge of the day to day running of the service. The practice manager worked at the practice one or two days per week. We were told that they were available on the telephone on all other days. We saw they had systems in place to monitor the quality of the service. These were used to make improvements to the service. The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately. One example was their risk assessment of injuries from sharp instruments. We were told that the dentists always re-sheathed and dismantled needles so that fewer members of the dental team were handling used sharp instruments. This reduced the risk of injury to other staff members posed by used sharp instruments.

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. All staff we spoke with were aware of whom to raise any issue with and told us the senior staff were approachable, would listen to their concerns and act appropriately. There were designated staff members who acted as dedicated leads for different areas, such as an infection control lead.

Learning and improvement

The practice manager monitored staff training to ensure essential staff training was completed each year. This was free for all staff members and included emergency resuscitation and basic life support. The practice manager also kept a log of staff members' CPD records to ensure they were meeting GDC requirements.

Staff audited areas of their practice regularly as part of a system of continuous improvement and learning. These included audits of radiography (X-rays), dental care record keeping and infection control. Several other audits also took place and we were told about changes made to practice processes as a direct result of these audits.

Staff meetings took place on a monthly basis. The minutes of the meetings were comprehensive and made available for all staff. This meant that any staff members who were not present also had the information and all staff could update themselves at a later date. Suggestions for staff meetings were requested from staff and displayed on the staff notice board. This was then used to generate the monthly staff agenda. Staff were requested to complete evaluation and reflective learning forms after each staff meeting. Topics such as audits, complaints and safeguarding had been discussed in the last three months.

Peer review meetings took place at least annually (but usually more frequently). We saw minutes from July 2015 and January 2016 and these showed that topics such as infection control and record keeping were discussed.

Staff appraisals were carried out annually and these were present in all of the staff files that we reviewed. Regular appraisals present an opportunity where learning needs, concerns and aspirations can be discussed.

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

Patients and staff we spoke with told us that they felt engaged and involved at the practice.

The practice had systems in place to involve, seek and act upon feedback from people using the service. Examples included providing a clock and moving the position of the television in the waiting room. Views and suggestions were cascaded to all members of the practice team in staff meetings. There was a suggestions box and a comments book in the waiting room for patients. The practice undertook the NHS Family and Friends Test (FFT). The FFT captures feedback from patients undergoing NHS dental care. The results were collated monthly and displayed in the reception area so that patients were kept informed.

Staff we spoke with told us their views were sought and listened to and there were dedicated staff satisfaction questionnaires. Staff felt supported by the practice manager and told us there was an open door policy. The practice had a scheme whereby they nominated a colleague to receive the Employee of the Month award. The scheme was described in a positive way and staff received a recognition certificate, flowers and chocolates. More than one colleague could receive it each month.