Streetly Smiles Dental Care

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Inspection Report

316 Chester Road
Streetly
Sutton Coldfield
West Midlands
B74 3ED
Tel: 01213531244
Website: www.streetlysmiles.co.uk

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Overall summary

We carried out an announced comprehensive inspection on 20 December 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

Streetly Smiles Dental Care is a dental practice providing general dental services on a private basis. The service is provided by one dentist and a dental hygienist. They are supported by three dental nurses and a receptionist. All of the dental nurses also carry out reception duties.

The practice is located on a main road near local amenities and bus routes. There is wheelchair access to the practice and car parking facilities. The premises consist of a reception area, a separate waiting room, two treatment rooms, a decontamination room, two storage rooms and toilet facilities on the ground floor. The first floor was for staff access only and comprised of two staff rooms, further storage and toilet facilities. The practice opened at 8:30am on Monday, Tuesday, Thursday, Friday, and at 10am on Wednesdays. Closing times varied between 12:30pm and 7pm. The practice also opened on one Saturday per month between 9am and 1pm.

The principal dentist and one other dentist (who does not work at this practice) are registered with the Care Quality Commission (CQC) as a partnership. The principal dentist is also the registered manager. 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.

Twelve patients provided feedback about the practice. We looked at comment cards patients had completed

Summary of findings

prior to the inspection and we also spoke with patients. The information from patients was very complimentary. Patients were positive about their experience and they commented that staff were friendly and welcoming.

Our key findings were:

- The practice was organised and appeared clean and tidy on the day of our visit.
- Patients told us they found the staff welcoming and friendly. Patients were able to make routine and emergency appointments when needed.
- An infection prevention and control policy was in place. We saw the decontamination procedures followed recommended guidance.
- The practice had systems to assess and manage risks to patients, including health and safety, safeguarding, safe staff recruitment and the management of medical emergencies. We identified some necessary improvements.
- Dental professionals provided treatment in accordance with current professional guidelines.
- 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.
- Practice meetings were used for shared learning.
- The practice demonstrated that they had recently completed audits in infection control, radiography and dental care record keeping. However, some of these audits had historically been overlooked.

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

- Review the flooring in one treatment room and consider replacing it with a smooth impervious covering with coving as part of their future refurbishment programme.
- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued by the relevant agencies. Staff should also review the system for the recording, investigating and reviewing incidents or significant events with a view to preventing further occurrences and ensuring that improvements are made as a result.
- Review their recruitment policy and ensure they consistently follow it for all staff members.
- Review the availability of an interpreter service for patients who do not speak English as their first language.
- Review stocks of medicines and equipment and the system for identifying and disposing of expired stock. They should also ensure they carry out regular checks of the equipment as frequently as defined by current 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 systems to assess and manage risks to patients. These included whistleblowing, complaints, safeguarding and the management of medical emergencies. It also had a recruitment process to help ensure the safe recruitment of staff. We identified some necessary improvements in some of these areas.

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 procedures were mostly 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'. We identified some necessary improvements on the day of our visit which centred on future refurbishment plans to update the flooring in one treatment room.

Staff told us they felt confident about reporting accidents but not incidents. Staff were aware of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Are services effective?

No action

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. 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?

No action

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. Patients described staff as friendly and welcoming. Patients commented they felt involved in their treatment and it was fully explained to them. Nervous patients said they felt at ease here and the staff were pleasant and caring.

Summary of findings

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 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. Arrangements were in place for patients requiring emergency dental care when the practice was closed.

The practice had an effective complaints process.

The practice offered access for patients with limited mobility.

Are services well-led?

No action

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.

The practice used several methods to successfully gain feedback from patients. Staff meetings took place on a regular basis.

The practice carried out audits such as radiography, dental care record keeping and infection control at regular intervals to help improve the quality of service. All audits had documented learning points with action plans. However, some audits had been previously overlooked and had not been carried out at regular intervals in line with current guidance.

Streetly Smiles Dental Care

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 Streetly Smiles Dental Care on 20 December 2016. The inspection was carried out by a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Prior to the inspection we reviewed information we held about the provider from various sources. 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 principal dentist, two dental nurses and the receptionist. We also reviewed CQC comment cards which patients had completed and spoke with patients. 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 systems in place for staff to report accidents but not incidents. The last accident was recorded in December 2015. We saw records of accidents and these were completed with sufficient details about what happened and any actions subsequently taken.

There was no incident form or policy within the practice and staff we spoke with had a limited understanding of what might constitute a significant event. Discussing and sharing incidents is an excellent opportunity for staff to learn from the strengths and weakness in the services they offer. The principal dentist told us they would introduce an incident reporting book and discuss this with all staff.

Staff we spoke with understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). No RIDDOR reportable incidents had taken place at the practice in the last 12 months.

There was no system in place for staff to respond to national patient safety and medicines alerts that affected the dental profession. The practice had not registered with the Medicines and Healthcare products Regulatory Agency (MHRA). Staff were unaware of recent alerts affecting dental practice and there was no evidence to show that appropriate action had been taken in response to them. The principal dentist was not aware of the practice's arrangements for staff to report any adverse drug reactions.

Not all staff we spoke with were aware of the Duty of Candour regulation. 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. The principal dentist told us they would update all of the team at the next staff meeting in January.

Reliable safety systems and processes (including safeguarding)

The practice had child protection and protection of vulnerable adult policies and procedures in place. These policies were readily available and provided staff with information about identifying, reporting and dealing with suspected abuse. Staff had access to contact details for local safeguarding teams. The principal dentist was the safeguarding lead in the practice. Staff members we spoke with were all knowledgeable about safeguarding. There had not been any safeguarding referrals to the local safeguarding team; however staff members were confident about when to refer concerns. Training records showed staff had received safeguarding training in 2016.

The British Endodontic Society recommends the use of rubber dams for endodontic (root canal) treatment. We saw rubber dam kits at the practice and were told that the dentist used them when carrying out root canal treatment. A rubber dam is a thin 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. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured.

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

The practice had processes in place for the safe use of needles and other sharp instruments.

Medical emergencies

Within the practice, the arrangements for dealing with medical emergencies in the practice were mostly in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). However, some necessary improvements were required.

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 and delivers 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. All equipment and medicines were stored in a secure but accessible area.

Are services safe?

Staff undertook checks of the equipment and emergency medicines to ensure they were safe to use. However, they were not carrying out the checks in line with current guidance. The emergency oxygen was checked every three months but should be at least weekly. They documented weekly checks of the AED and monthly checks of the emergency medicines.

The emergency medicines were all in date and stored securely. Glucagon was stored in the fridge and the temperature was monitored and documented on a daily basis. A glucagon injection kit is used to treat episodes of severe hypoglycaemia which is defined as having low blood glucose levels. However, we found some expired defibrillator pads (part of the AED kit) that had not been discarded. There were additional pads which were within their expiry.

All staff we spoke with were aware of the location of this equipment and equipment and medicines were stored in purposely designed storage containers.

Staff recruitment

We looked at the recruitment records for three members of the practice team. The records we saw contained evidence of employment contracts and induction plans. Where relevant, the files contained copies of staff's dental indemnity and General Dental Council (GDC) registration certificates. Some of the records contained staff identity verification and written references. The principal dentist told us they always requested two written references but this had been overlooked on one occasion. They had recently realised this and were awaiting the receipt of these references.

There were also Disclosure and Barring Service (DBS) checks present for the staff members. 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 principal dentist applied for updated DBS checks for all staff during the recruitment process.

The practice had a system in place to monitor the professional registration and dental indemnity of its clinical staff members.

The practice had a recruitment policy for the safe recruitment of staff; however, this did not have specific information about DBS checks required for each potential post. The principal dentist informed us that they will amend the policy to make it more specific.

Monitoring health & safety and responding to risks

We saw evidence of a 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 was specific to the practice and had all relevant contact details in the event of an emergency.

The practice had arrangements in place to monitor health and safety. There was a general risk assessment for the practice to help identify potential hazards We reviewed several risk management policies. Staff had completed online training in fire safety awareness and the principal dentist had completed fire warden training. An external contractor completed a fire risk assessment in November 2015 and any outstanding actions had been completed. We saw evidence that the fire extinguishers had been serviced in September 2016 and they were visually checked and documented every week by staff at the practice. Fire drills took place every six months to ensure staff were rehearsed in evacuation procedures. Staff carried out and recorded weekly fire alarm tests and regularly checked the fire doors and emergency lighting.

Information on COSHH (Control of Substances Hazardous to Health 2002) 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.

Infection control

There was an infection control policy and procedures to keep patients and staff safe. The policy was reviewed annually and was dedicated to the practice. 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 practice had a nominated infection control lead that was responsible for ensuring infection prevention and control measures were followed.

Are services safe?

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. At the time of our visit, the principal dentist told us they would request further information from one staff member's occupational health physician to ensure that they had adequately responded to the immunisation.

We observed the treatment rooms and the decontamination room to be visually clean. Many patients commented that the practice was clean and tidy. Work surfaces and drawers were free from clutter. In one treatment room, the flooring was not sealed and this could compromise effective cleaning.

Dental chairs were covered in non-porous material which aided effective cleaning. 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.

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

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. 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 decontaminating 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 manual processes to clean the used instruments; they were subsequently examined visually with an illuminated magnifying glass and then sterilised in an autoclave. 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 included all the necessary information and was easily accessible. 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.

Staff told us that checks of all clinical areas such as the decontamination room and treatment rooms were carried out daily by the dental nurses. All clinical and non-clinical areas were cleaned daily by staff. The practice had a dedicated area for the storage of their cleaning equipment.

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 reviewed the audit from December 2016 and the provider told us this was the first audit they had completed since they took over the practice. They were aware of the recommended guidance but told us they had inadvertently overlooked audits. They told us they would introduce a more robust process to ensure this did not reoccur.

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 reviewed the Legionella risk assessment and this was carried out by an external contractor in December 2013.

Are services safe?

The principal dentist reviewed this annually. 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 pressure vessels, X-ray sets and autoclaves.

Employers must ensure that their electrical equipment is maintained in order to prevent danger. Regular portable appliance tests (PAT) confirm that portable electric items used at the practice are safe to use. We saw evidence of regular tests and the current PAT was valid until May 2017.

The practice dispensed antibiotics and these were stored securely. The practice maintained a log of all medicines that had been dispensed.

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

Stock rotation of all dental materials was carried out on a regular basis by the dental nurse and all materials we viewed were within their expiry date. A system was also in place for ensuring that all processed packaged instruments were within their expiry date.

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 traditional X-rays.

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.

The X-ray equipment in the treatment room was fitted with a part called a rectangular collimator which is good practice as it reduces the radiation dose to the patient.

We saw evidence that the dentist was 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 an X-ray audit in June 2016. 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 evidence that the results were analysed and reported on.

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 the principal dentist about the oral health assessments, treatment and advice given to patients and they showed us a selection of patient dental care records to corroborate this. 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 documented in 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 12 and above, however, the guidance states that this should be completed for all children aged 7 and above. We saw evidence that patients diagnosed with gum disease were appropriately treated.

The practice kept up to date with other current guidelines and research in order to develop and improve their system of clinical risk management. Following clinical assessment, the dentists 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 were discussed with the patient and this was corroborated when we spoke with patients.

Health promotion & prevention

The principal dentist told us that patients were given advice appropriate to their individual needs such as smoking cessation, alcohol consumption or dietary advice. There were oral health promotion leaflets available in the practice to support patients in looking after their health. Examples included information on stopping smoking, gum disease and the effects of medical conditions on oral health.

The practice was aware of the provision of 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 oral hygiene advice. 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 included areas such as confidentiality and child protection.

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

The principal dentist monitored staffing levels and planned for staff absences to ensure the service was uninterrupted. We were told that some of the employed dental nurses were part-time and had the flexibility to work additional hours, if required. Occasionally, the practice utilised a locum dental nurse agency.

Dental nurses were supervised by the dentists and supported on a day to day basis by the principal dentist. Staff told us that the dentist was readily available to speak with at all times for support and advice. A dental nurse always worked with the dentist and hygienist and an additional nurse was usually available each day to help with decontamination procedures.

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 specialist dental services for complex oral surgery. We viewed one

Are services effective?

(for example, treatment is effective)

referral letter and noted that it was comprehensive to ensure the specialist services had all the relevant information required. Patients were given the option of receiving a copy of their referral letter.

Staff understood the procedure for urgent referrals, for example, patients with suspected oral cancer.

Consent to care and treatment

Patients were given appropriate information to support them to make decisions about the treatment they received. Staff ensured patients gave their consent before treatment began and this was recorded in the dental care records.

Staff members we spoke with 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. The principal dentist had recently completed training in the MCA.

Staff members we spoke with 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 members confirmed individual treatment options, risks, benefits and costs were discussed with each patient. Staff and patients told us that written treatment plans were provided. Patients were given time to consider and make informed decisions about which option they preferred.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Twelve patients provided feedback about the practice. We looked at CQC comment cards patients had completed prior to the inspection and spoke with patients during our visit. Patient feedback was positive about the care they received from the practice. They described staff as friendly and welcoming. Patients commented they felt involved in their treatment and the dentist took the time to fully explain it to them. Nervous patients said they felt at ease here and some praised the staff for their relaxing manner.

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. Staff members we spoke with were aware of the importance of providing patients with privacy. The reception area was not left unattended and confidential patient information was stored in a secure area. There was a room available for patients to have private discussions with staff. We observed that staff members were helpful, discreet and respectful to patients on the day of our visit.

We were told that the practice appropriately supported children and anxious patients using various methods. The dentist and hygienist spent time discussing the treatment with patients and reassurance was given in a relaxing manner. Patients could also request a referral for dental treatment under sedation.

The practice offered complimentary services such as free Wi-Fi to their patients. A handbook for patients was available in the waiting room with information about the practice and staff.

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 was discussed with them and this information was also provided to them in the form of a customised written treatment plan.

Examination and treatment fees were displayed in the waiting room.

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 both treatment rooms were on the ground floor. Car parking was available near the entrance to the practice but there were no designated bays for patients with physical disabilities. However, staff told us they would move their own cars to allow space for patients requiring parking near the entrance. The practice had a portable ramp that was used for patients attending the practice in a wheelchair. Toilet facilities were available on the ground floor but these were not wheelchair-accessible.

The practice had an appointment system in place to respond to patients' needs. Patients we spoke with told us that they were usually seen on time and that it was easy to make an appointment. Staff told us they would inform patients if the dentist was running late – this gave patients the opportunity to rebook the appointment if preferred.

Staff told us the majority of patients who requested an urgent appointment would be seen within 24 hours. We reviewed the appointment system and saw that emergency slots were usually available on a daily basis to accommodate patients requiring urgent treatment. If these slots became unavailable, the practice was able to accommodate patients by opening beyond their usual working hours.

Patient feedback confirmed that the practice was providing a good service that met their needs. The practice sent appointment reminders to all patients that had consented.

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 did not have an audio loop system for patients who might have hearing impairments. However, the practice used various methods so that patients with hearing impairments could still access the services. These included lip-reading and providing written information for patients.

The practice did not have access to an interpreting service for patients that were unable to speak fluent English. Consequently they did not have access to sign language interpreters either. The principal dentist told us they would consider this in future in order to improve communication with the relevant patients.

Access to the service

Feedback from patients confirmed they 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 a local practice via their telephone answering machine.

The practice opened at 8:30am on Monday, Tuesday, Thursday, Friday, and at 10am on Wednesdays. Closing times varied between 12:30pm and 7pm. The practice also opened on one Saturday per month between 9am and 1pm.

Concerns & complaints

The practice had a complaints process which provided staff with clear guidance about how to handle a complaint. Staff members we spoke with were fully aware of this process. Information for patients about how to make a complaint was available at the practice and accessible to patients. This included details of external organisations in the event that patients were dissatisfied with the practice's response.

We saw evidence that complaints received by the practice had been recorded, analysed and investigated. There was a designated complaints lead and all verbal complaints were documented. We were given examples of changes and improvements that were made as a result of concerns raised by patients.

Are services well-led?

Our findings

Governance arrangements

The principal dentist was in charge of the day to day running of the service. 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 dentist 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. The practice also had risk assessments for areas such as the autoclaves, manual handling and electrical appliances.

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 a safeguarding lead and infection control lead.

The provider had systems in place to support communication about the quality and safety of services. The principal dentist told us they were aware of the need to be open, honest and apologetic to patients if mistakes in their care were made. This was in line with the Duty of Candour regulation.

Learning and improvement

The principal dentist monitored staff training to ensure essential staff training was completed each year. Some essential training was free for staff members and this included emergency resuscitation and basic life support. The GDC requires all registrants to undertake CPD to maintain their professional registration.

Staff audited areas of their practice as part of a system of continuous improvement and learning; however, some of the audits had not been completed as often as current guidance recommends. We reviewed audits of radiography (X-rays), dental care record keeping and infection control.

Staff meetings took place on a monthly basis. The minutes of the meetings were 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.

We reviewed three staff appraisals and found that staff received these every six months. Regular appraisals provide 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. An example of this included the recent modernisation of the two treatment rooms in response to suggestions made by patients. We were told that views and suggestions were cascaded to all members of the practice team in staff meetings. There was a suggestions box in the waiting room for patients although the response rate was low. Patients were invited to complete satisfaction surveys and this was an ongoing process.

Staff we spoke with told us their views were sought and listened to but there were not any dedicated staff satisfaction questionnaires.