Bedale Dental Practice Limited

Bedale Dental Practice Limited

Inspection Report

18 Sussex Street
Bedale
Leyburn
North Yorkshire
DL8 2AL
Tel: 01677 422865
Website: www.bedaledentalpractice.co.uk

Date of inspection visit: 26 April 2016
Date of publication: 17/05/2016

Overall summary

We carried out an announced comprehensive inspection on 26 April 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

Bedale Dental Practice Limited is situated in Bedale, North Yorkshire. It offers NHS treatment for children and treatment for adults is provided either through a private dental plan or on a private basis. The services include preventative advice and treatment, routine restorative dental care, orthodontics and dental implants.

The practice has four surgeries, a decontamination suite, a waiting area and a reception area. All facilities are on the ground floor of the premises. There were accessible toilet facilities available.

There are four dentists (three partners and an associate), two dental hygienists, a clinical lead, eight dental nurses (one of which is a trainee), a reception manager, a receptionist and a practice manager. The practice also employs an external cleaner.

Summary of findings

The opening hours are Monday from 9-00am to 6-00pm, Tuesday from 8-30am to 5-00pm, Wednesday from 9-00am to 5-00pm, Thursday from 8-30am to 6-00pm, Friday from 8-00am to 1-00pm and Saturdays (by appointment only) from 9-00am to 12-00pm.

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

On the day of inspection we received 18 CQC comment cards providing feedback and spoke with five patients. The patients who provided feedback were positive about the care and treatment they received at the practice. They told us they were involved in all aspects of their care and were very pleased with the service. They found the staff to be caring, respectful, helpful and relaxing and they were treated with dignity and respect in a clean and tidy environment.

Our key findings were:

- The practice had systems in place to assess and manage risks to patients and staff including infection prevention, control and health and safety and the management of medical emergencies.
- Staff were qualified and had received training appropriate to their roles.
- Dental care records were detailed and showed that treatment was planned in line with current best practice guidelines.
- Oral health advice and treatment were provided in-line with the 'Delivering Better Oral Health' toolkit (DBOH).
- We observed that patients were treated with kindness and respect by staff. Staff ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood.
- Patients were involved in making decisions about their treatment and were given clear explanations about their proposed treatment including costs, benefits and risks.
- Patients were able to make routine and emergency appointments when needed.

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

- Review staff awareness of what a significant event is.
- Review the practice's procedure for the checking of the Automated External Defibrillator (AED) on a weekly basis.
- Review the practice's safeguarding policy ensuring the relevant contact details are clear.
- Review the practice's procedure for the storage of local anaesthetics.
- Review the practice's complaints policy to ensure it contains the time scales of when a complaint will be acknowledged and a formal response will be made.

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 had an awareness of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) and the notifications which need to be made to the CQC. Staff were not totally familiar with what a significant event was.

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

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

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

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

Are services effective?

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

Patients' dental care records provided comprehensive information about their current dental needs and past treatment. The practice monitored any changes to the patient's oral health and provided treatment when appropriate.

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

Staff were encouraged to complete training relevant to their roles and this was monitored by the practice manager. The clinical staff were up to date with their continuing their professional development (CPD).

Referrals were made to secondary care services if the treatment required was not provided by the practice.

Are services caring?

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

During the inspection we received 18 CQC comment cards providing feedback and spoke with five patients. The patients who provided feedback were positive about the care and treatment they received at the practice. They told us they were involved in all aspects of their care and were very pleased with the service. They found the staff to be caring, respectful, helpful and relaxing and they were treated with dignity and respect

We observed the staff to be welcoming and caring towards the patients.

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

Summary of findings

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

Are services responsive to people's needs?

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

The practice had an efficient appointment system in place to respond to patients' needs. There were vacant appointments slots for urgent or emergency appointments each day. There were clear instructions for patients requiring urgent care when the practice was closed.

There was a procedure in place for responding to patients' complaints. This involved acknowledging, investigating and responding to individual complaints or concerns. The complaints procedure did not have any time scales in it of when a complaint will be acknowledged and a formal response will be made.

The practice had made reasonable adjustments to enable patients in a wheelchair or with limited mobility to access treatment. These included a ramp to access the premises and an accessible toilet on the ground floor.

Are services well-led?

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

There was a management structure in place and all staff felt supported and appreciated in their own particular roles. The practice manager and clinical lead were responsible for the day to day running of the practice.

Effective arrangements were in place to share information with staff by means of monthly practice meetings which were well minuted for those staff unable to attend.

The practice regularly audited clinical and non-clinical areas as part of a system of continuous improvement and learning.

They conducted patient satisfaction surveys, were currently undertaking the NHS Friends and Family Test (FFT) and there was a comments box in the waiting room for patients to make suggestions to the practice.

Bedale Dental Practice Limited

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 registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection was led by a CQC inspector who had access to remote advice from a specialist advisor.

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

During the inspection we received 18 CQC comment cards providing feedback and spoke with five patients. We also spoke with three dentists, two dental nurses, the reception manager, the clinical lead and the practice manager. To assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had guidance for staff about how to report incidents and accidents. We noted staff were not totally aware of what constituted a significant event. For example, staff described to us an event which occurred which had not been recorded as a significant event. We discussed that any event which could potentially cause harm should be considered as a significant event and documented, investigated and reflected upon by the dental practice to reduce the chance of it re-occurring. We were told that this would be discussed at the next practice meeting to ensure that these events were identified and reported appropriately.

Staff understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR) and provided guidance to staff within the practice's health and safety policy. Staff were also aware of when and how to notify the CQC of incidents in accordance with the Care Quality Commission (Registration) Regulations 2009.

The practice received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) that affected the dental profession. Any alerts which were relevant to dentistry were printed off and stored for future reference. Any alerts which included materials or equipment at the practice would be actioned immediately.

Reliable safety systems and processes (including safeguarding)

The practice had child and vulnerable adult safeguarding policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff. We noted that it was not particularly clear in the policy of the contact details for the relevant authorities to contact in the event of a safeguarding alert. This was highlighted and we were told that the telephone numbers for the relevant organisations would be made more apparent.

One of the principal dentists was the safeguarding lead for the practice and all staff had undertaken level two safeguarding training.

The practice had systems in place to help ensure the safety of staff and patients. These included the use of a safe sharps system, needle re-sheathing devices and guidelines about responding to a sharps injury (needles and sharp instruments). The sharps injury procedure was displayed in all surgeries and the decontamination suite.

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

We saw that patients' clinical records were computerised and password protected to keep people safe and protect them from abuse. If staff had to leave a computer unattended then the computer would be locked to ensure that members of the public could not access confidential details. Any paper documentation relating to the dental care records were locked away in secure cabinets when the practice was closed.

Medical emergencies

The practice had procedures in place which provided staff with clear guidance about how to deal with medical emergencies. This was in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). The procedure for resuscitation was displayed in several areas of the practice to assist staff in the event of a cardiac event. Staff were knowledgeable about what to do in a medical emergency and had completed training in emergency resuscitation and basic life support within the last 12 months.

The emergency resuscitation kits, oxygen and emergency medicines were stored in the decontamination suite. Staff knew where the emergency kits were kept. The practice had an Automated External Defibrillator (AED). An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.

Records showed weekly checks were carried out on the oxygen cylinder and monthly checks were carried out on the emergency drugs and the AED. These checks ensured that the oxygen cylinder was full, the emergency medicines were in date and the AED was fully charged. The

Are services safe?

Resuscitation Council UK guidelines state that the AED should also be checked on a weekly basis. This was highlighted and we were told that this would be added to the weekly checklist in the decontamination suite.

Staff recruitment

The practice had a policy and a set of procedures for the safe recruitment of staff which included an interview, seeking references, proof of identity, checking relevant qualifications and professional registration. We reviewed a sample of staff files and found the recruitment procedure had been followed. The practice manager told us they carried out Disclosure and Barring Service (DBS) checks for all newly employed staff. These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. We reviewed records of staff recruitment and these showed that all checks were in place.

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

Monitoring health & safety and responding to risks

A health and safety policy and risk assessment was in place at the practice. This identified the risks to patients and staff who attended the practice. The risks had been identified and control measures put in place to reduce them. We saw that the managers had recently started carrying out a monthly environmental and refurbishment check. This included checks for slips, trips and falls and the general condition of the premises. Any issues identified were either actioned immediately or put on a list of things to do taking into account the likelihood of the risk.

There were policies and procedures in place to manage risks at the practice. These included infection prevention and control, fire evacuation procedures and risks associated with Hepatitis B. We saw that the practice conducted weekly smoke alarm tests and an annual fire drill. Fire extinguishers were serviced on an annual basis.

The practice maintained a file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including substances such as disinfectants, and dental materials in use in the practice. The practice identified how they managed hazardous substances in its health and safety and infection control policies and in specific guidelines for staff, for example in its blood spillage and waste disposal procedures.

Infection control

There was an infection control policy and procedures to keep patients safe. These included hand hygiene, safe handling of instruments, managing waste products and decontamination guidance. The practice followed the guidance about decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 -Decontamination in primary care dental practices (HTM 01-05)'. The clinical lead was the infection control lead for the practice. Each day there was a dedicated decontamination nurse who was responsible for the running the decontamination suite. This role changed from day to day.

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

We observed the treatment rooms and the decontamination suite to be clean and hygienic. Work surfaces were free from clutter. Staff told us they cleaned the treatment areas and surfaces between each patient and at the end of the morning and afternoon sessions to help maintain infection control standards. There was a cleaning schedule which identified and monitored areas to be cleaned and there was colour coded mops and buckets which were used to clean different areas of the practice. There were hand washing facilities in the treatment rooms and staff had access to supplies of personal protective equipment (PPE) for patients and staff members. We saw that there were daily, weekly and monthly checklists for the dental nurses to follow in each of the surgeries. Posters promoting good hand hygiene and the decontamination procedures were clearly displayed to support staff in following practice procedures. Sharps bins were appropriately located, signed and dated and not overfilled. We observed waste was separated into safe containers for disposal by a registered waste carrier and appropriate documentation retained.

Decontamination and sterilisation procedures were carried out in separate decontamination and sterilisation rooms in accordance with HTM 01-05 guidance. An instrument

transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which minimised the risk of the spread of infection.

One of the dental nurses showed us the procedures involved in disinfecting, inspecting and sterilising dirty instruments; packaging and storing clean instruments. The practice routinely used a washer disinfector to clean the used instruments, examined them visually with an illuminated magnifying glass, and then sterilised them in a validated autoclave. As there were separate decontamination and sterilisation rooms this greatly reduces the risk of cross contamination. Staff wore appropriate PPE during the process and these included disposable gloves, aprons and protective eye wear.

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

The practice had carried out an Infection Prevention Society (IPS) self- assessment audit in January 2016 relating to the Department of Health's guidance on decontamination in dental services (HTM01-05).This is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. The results of the audit showed that the practice had achieved 97% and there was an action plan in place which identified areas for improvement.

Records showed a risk assessment process for Legionella had been carried out (Legionella is a term for particular bacteria which can contaminate water systems in buildings). The practice undertook processes to reduce the likelihood of legionella developing which included running the water lines in the treatment rooms at the beginning and end of each session, monitoring cold and hot water temperatures each month and the use of reverse osmosis water with water conditioning tablets in the dental unit water lines.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as X-ray sets, the autoclaves and the compressor. The practice maintained a comprehensive list of all equipment including dates when maintenance contracts which required renewal. We saw evidence of validation of the autoclave and the compressor. Portable appliance testing (PAT) had been completed in April 2016 (PAT confirms that portable electrical appliances are routinely checked for safety).

During the inspection we noted that local anaesthetic cartridges were stored loose in the drawers. These cartridges should be kept in their blister packs until ready to use. This was highlighted to the clinical lead and this was addressed.

NHS prescriptions were stamped only at the point of issue and were kept locked away when not needed to ensure their safe use. The practice also dispensed antibiotics for their private patients. These were kept locked away in a cupboard in the waiting area. When these antibiotics were dispensed they were logged in the patient's dental care records including the batch number of the medicine, the strength and the quantity prescribed.

Radiography (X-rays)

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

X-ray audits were carried out every year by one of the principal dentists. This included assessing the quality of the X-rays which had been taken. The results of the most recent audit undertaken confirmed they were compliant with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). An action plan had been made up to continuously improve the quality of X-rays taken. As a result of the audit they had identified an X-ray plate which had become scratched and was due to be replaced.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

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

During the course of our inspection we discussed patient care with the dentists and checked dental care records to confirm the findings. Clinical records were comprehensive and included details of the condition of the teeth, soft tissue lining the mouth, gums and any signs of mouth cancer. If the patient had more advanced gum disease then a more detailed inspection of the gums was undertaken by one of the dental hygienists and the appropriate treatment was proposed to the patient.

One of the dentists had a special interest in orthodontics. They carried out an assessment in line with recognised guidance from the British Orthodontic Society (BOS). This included an assessment of the patient's oral hygiene, diet and an Index of Orthodontic Treatment Need score (IOTN). An IOTN score comprises of two sections, an aesthetic component and a dental health component. For patients to qualify for orthodontics on the NHS they must score above a certain level of IOTN. Patients were then referred to the local orthodontic department for a treatment plan to be formulated. Upon receiving the treatment plan back the dentist would undertake the treatment which had been prescribed. Patients were recalled at suitable intervals for reviews of the treatment. After finishing their orthodontic treatment patients were recalled at specific intervals to ensure that the patient was complying with the post-orthodontic care (wearing retainers). We saw that the dentist who carried out the orthodontics treatment had completed the Peer Assessment Rating (PAR) index for the cases which had been completed. The PAR index is a fast, simple and robust way of assessing the standard of orthodontic treatment that an individual provider is achieving. The results of the PAR index was 87%. The BOS states that a mean PAR score of greater than 70% represents a very high standard of treatment.

The practice also offer dental implants. They use the services of another dentist who places the dental implants. We checked dental care records in relation to the assessment prior to the implants being placed. These including an assessment of the periodontal health, the condition of the remaining teeth, the quality of bone (using X-rays), the type and quality of the gum where the implant is to be placed and any aesthetic considerations (especially if it was to replace a front tooth). We were told that as part of the whole implant process the clinical lead provided support to patients undertaking dental implant treatment. This involved calling the patient up the week after their initial consultation to discuss the treatment which had been proposed and answer any questions which they may have. The clinical lead was a point of contact within the practice for patients having dental implants in case they had any issues.

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

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

Health promotion & prevention

The practice had a strong focus on preventative care and supporting patients to ensure better oral health in line with the 'Delivering Better Oral Health' toolkit (DBOH). DBOH is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary

Are services effective?

(for example, treatment is effective)

care setting. For example, the dentist applied fluoride varnish to children who attended for an examination. Dietary advice was given to patients where appropriate. There were also patient information leaflets in the waiting room relating to "preventing tooth decay" and "keeping your gums healthy". High fluoride toothpastes were prescribed for patients at high risk of dental decay.

The practice had a selection of dental products on sale in the reception area to assist patients with their oral health.

The medical history form patients completed included questions about smoking and alcohol consumption. We were told by the dentist and saw in dental care records that smoking cessation advice was given to patients where appropriate. Patients were made aware of the link between smoking and gum health and oral cancer. We were told that smoking cessation advice leaflets were given to patients who were interested in stopping smoking.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. The induction process for dental nurses involved getting the new dental nurse aware of the location of emergency medicines, arrangements for fire evacuation procedures, going through the materials which are used and a detailed introduction to the decontamination process including how the equipment is used and the validation requirements. The clinical lead was responsible for these inductions and they told us that they would use the "Tell-Show-Do" method to inform the new dental nurse of the decontamination process. We saw evidence of completed induction checklists in the recruitment files.

Staff told us they had good access to on-going training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). The practice organised training for medical emergencies to help staff keep up to date with current guidance on treatment of medical emergencies in the dental environment. Records showed professional registration with the GDC was up to date for all clinical staff and we saw evidence of on-going CPD.

Staff had annual appraisals and training requirements were discussed at these. Other topics discussed at the appraisals were team work, professionalism, knowledge of job and efficiency.

We saw evidence of completed appraisal documents.

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 including oral surgery and sedation. Patients were offered a choice of where they could be referred. This included an option of being referred to an NHS or a private provider. They would be informed of the difference in waiting lists between the two providers.

The dentists completed detailed proformas or referral letters to ensure the specialist service had all the relevant information required. A copy of the referral letter was kept in the patient's dental care records. Letters received back relating to the referral were first seen by the referring dentist to see if any action was required and then stored in the patient's dental care records.

The practice had a procedure for the referral of a suspected malignancy. This contacting the hospital to put them on an urgent waiting list.

The practice kept a log of all referrals which had been sent. This included a list of when the letter had been sent, when any letters had been received back and the method of delivery.

Consent to care and treatment

Patients were given appropriate information to support them to make decisions about the treatment they received. Staff were knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent. Staff described to us how valid consent was obtained for all care and treatment and the role family members and carers might have in supporting the patient to understand and make decisions. Staff were clear about involving children in decision making and ensuring their wishes were respected regarding treatment. This included a good knowledge of Gillick competency.

The dentists would use X-rays and animations to describe what was wrong with a tooth. This helped the patient in understanding why a particular treatment was needed and therefore made the consent process more robust.

Are services effective?

(for example, treatment is effective)

Staff had received training and had an understanding of the principles of the Mental Capacity Act (MCA) 2005 and how it was relevant to ensuring patients had the capacity to consent to their dental treatment.

Staff ensured patients gave their consent before treatment began and a form was signed by the patient. We were told that individual treatment options, risks, benefits and costs were discussed with each patient. Staff were aware that consent could be removed at any time.

Patients undergoing dental implant treatment were given a detailed treatment plan which included details of the procedure involved, alternative treatments and long term maintenance.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

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

Many of the staff had been working at the practice for several years. Some had been working there for 20 years. It was clearly evident that there was a friendly atmosphere within the practice.

We were told by staff that if a dentist was ever running behind then the patient would be informed of this delay. They would be given an apology and offered either to re-book or wait to see the dentist. They would be offered a cup of tea or coffee whilst they were waiting.

We observed privacy and confidentiality were maintained for patients who used the service on the day of inspection. Dental care records were not visible to the public on the reception desk. We observed the receptionist to be helpful, discreet and respectful to patients. She was aware that no personal details should be discussed at the reception desk to ensure the dignity of patients. She also told us that if a patient wished to speak in private, an empty room would be found to speak with them. We noted that there was background music playing in the reception and waiting room area which provided an element of auditory privacy.

Patients' electronic care records were password protected and regularly backed up to secure storage. We saw that if staff ever left a computer unattended then it would be locked. Any paper documentation relating to dental care records were securely stored in locked cabinets.

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. Staff described to us how they involved patients' relatives or carers when required and ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood. Information leaflets with regards to orthodontic treatment were provided to any children who were about to undertake orthodontic treatment.

One of the dentists told us they used computerised graphics and models of teeth to assist in describing different treatments to patients (including implants, crowns and bridges). They felt that this enabled patients to more fully understand the proposed treatment. The animations were also available on a television in the waiting area and on the practice website for patients to reference when they got home. The website included detailed information about orthodontics treatments (including the different types of braces used), root canal treatment, crowns and dental implants. The dentists told us that they would prompt patients to use the practice website as a useful source of information with regards to treatments provided at the practice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We found the practice had an efficient appointment system in place to respond to patients' needs. Staff told us that patients who requested an urgent appointment would be seen the same day. We saw evidence in the appointment book that there were dedicated emergency slots available in both the morning and afternoon with each day for each dentist. If the emergency slots had already been taken for the day then the patient was offered to sit and wait for an appointment if they wished.

Patients commented they had sufficient time during their appointment and they were not rushed. Staff told us that they ensured that enough time was allocated for each appointment so that time could be spent with the patient to make sure each patient received the correct level of attention. We were also told that patients got a text message reminder three days before their appointment to remind them of it. We observed the clinics ran smoothly on the day of the inspection and patients were not kept waiting.

Tackling inequity and promoting equality

The practice had equality and diversity, and disability policies to support staff in understanding and meeting the needs of patients. Reasonable adjustments had been made to the premises to accommodate patients with mobility difficulties. These included step free access to the premises and a ground floor accessible toilet. All the facilities were located on the ground floor of the premises. All of the surgeries were large enough to accommodate a wheelchair or a pram.

Access to the service

The practice displayed its opening hours in the premises, in the practice information leaflet and on the practice website. The opening hours are Monday from 9-00am to 6-00pm, Tuesday from 8-30am to 5-00pm, Wednesday from 9-00am to 5-00pm, Thursday from 8-30am to 6-00pm, Friday from 8-00am to 1-00pm and Saturdays (by appointment only) from 9-00am to 12-00pm.

Patients told us that they were rarely kept waiting for their appointment. Patients could access care and treatment in a timely way and the appointment system met their needs. We saw that patients could get an appointment for a filling within two to three weeks.

Where treatment was urgent patients would be seen the same day. The practice had a system in place for patients requiring urgent dental care when the practice was closed. Patients were signposted to the 111 service on the telephone answering machine. Information about the out of hours emergency dental service was also in the practice information leaflet and on the practice website.

Concerns & complaints

The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. There were details of how patients could make a complaint displayed in the waiting room, in the practice information leaflet and on the practice website. The practice manager was responsible for dealing with complaints when they arose. Staff told us they raised any formal or informal comments or concerns with the practice manager to ensure responses were made in a timely manner. Staff told us that they aimed to resolve complaints in-house initially. We reviewed a complaint which had been received in the past 12 months and found that they had been dealt with well and to the patient's satisfaction.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients. We found that there were no time scales of when the practice aimed to acknowledge the complaint or aim to provide a formal response. This was highlighted to the practice manager and we were told that the complaints policy would be amended accordingly.

The practice kept a log of complaints which had been received. This included details of any correspondence and the outcome of the complaint. This log did not include when an acknowledgment of the complaint had been made. This was highlighted to the practice manager and we were told that this acknowledgment would be included in the complaint log from now on.

Are services well-led?

Our findings

Governance arrangements

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

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

There was a management structure in place to ensure that responsibilities of staff were clear. The practice manager was responsible for finance arrangements and complaints, the clinical lead was responsible for infection control and managing the dental nurses and the reception manager was responsible for overseeing that the appointment book was monitored effectively. Staff told us that they felt supported and were clear about their roles and responsibilities.

Leadership, openness and transparency

The culture of the practice encouraged candour, openness and honesty to promote the delivery of high quality care and to challenge poor practice. Staff told us there was an open culture within the practice and they were confident to raise any issues at any time. These would be discussed openly at staff meetings where relevant and it was evident that the practice worked as a team and dealt with any issue in a professional manner.

The practice held monthly staff meetings. These meetings were minuted for those who were unable to attend. During these staff meetings topics such as infection control, training requirements, the appointment booking system and staff rotas were discussed. We were also told that the nurses had their own meetings where topics relating to their job roles were discussed. These included setting up the surgery, infection control and the laboratory work logging system.

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

Learning and improvement

Quality assurance processes were used at the practice to encourage continuous improvement. The practice audited areas of their practice as part of a system of continuous improvement and learning. This included clinical audits such as dental care records, X-rays and infection control. We looked at the audits and saw that the practice was performing well. However, where improvements could be made these were identified and followed up as appropriate. For example, a new X-ray plate had been ordered and maintenance to the upholstery of one of the dental chairs had been added to the refurbishment plan.

Staff told us they had access to training and this was monitored to ensure essential training was completed each year; this included medical emergencies, basic life support and infection control. Staff working at the practice were supported to maintain their continuous professional development as required by the General Dental Council.

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

The practice had systems in place to involve, seek and act upon feedback from people using the service including carrying out patient satisfaction surveys, new patient surveys and a comment box in the waiting room. The satisfaction survey included questions about whether staff were helpful, the comfort and cleanliness of the surroundings, the amount of information which was provided and the quality of care provided. We were told that as a result of patient feedback that the practice now had daily newspapers in the waiting room and they had painted lines in the car park to make the parking easier for patients.

They also had a form for patients leaving the practice. This included the reason for leaving the practice and any specific feedback. This could then be looked at and any improvements could be made as appropriate.

The practice also undertook the NHS Friends and Family Test (FFT). The FFT is a feedback tool that supports the

Are services well-led?

fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. The latest results showed that 100% of patients asked said that they would recommend the practice to friends and family.