Oasis Dental Care (Central) Limited

Oasis Dental Care Central - Northampton 2

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 4 October 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

Oasis Dental Care Central - Northampton 2 is a large dental practice in the centre of Northampton. It offers three distinct services to adults and children.

Firstly a general dental service which provides treatment either funded by the NHS or privately. This service sees patients for their ongoing oral needs and registers patients in this regard.

Secondly the practice offers and emergency NHS service from 8 am to 8 pm seven days a week, every day of the year. This is not a drop in service but can be accessed by calling the NHS 111 emergency telephone number. Patients are seen only as an emergency and would return to see their own dentist afterwards.

Thirdly the practice accepts referrals for minor oral surgery (MOS). Patients are referred for tooth extractions and other minor oral surgical procedures under local anaesthetic (with the patient awake).

The practice offers treatment under conscious sedation (these are techniques in which the use of a drug or drugs

Summary of findings

produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation) for nervous patients. The practice also offers dental implants, where a metal post or posts are placed surgically into the jaw bone and are used to support a single tooth, or multiple teeth.

The practice is staffed by seven dentists, an oral surgeon and two dental hygienists, supported by a head dental nurse, eight qualified dental nurses, three minor oral surgery nurses and four trainee dental nurses. Administration staff are a practice manager, a minor oral surgery manager, a practice co-ordinator, two administrators and three receptionists.

The practice is wheelchair accessible via the rear entrance of the building from the car park.

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

Feedback about the service was obtained by speaking to patients that visited the practice on the day of our visit, and by comment cards that were left on the premises for the two weeks preceding our visit. Three patients provided feedback.

Our key findings were:

- The practice was visibly clean and clutter free.
- The practice met the national guidance in infection control standards.
- Patients reported that staff explained options to them, and dental care records detailed these discussions.
- Clinicians used nationally recognised guidance in the care and treatment of patients.
- There was appropriate equipment for staff to undertake their duties and equipment was well maintained.
- The practice carried medicines and equipment for use in a medical emergency in line with national guidance.

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

- Review the practice's 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 the practice's recruitment policy and procedures to ensure character references for new staff are requested and recorded suitably.
- Review the labelling of medicines that are dispensed giving due regard to schedule 26 of the Human Medicines Regulations 2012.
- Review the use of rectangular collimators on X-ray machines to further reduce the radiation dose to patients.
- Review the practice's audit protocols of various aspects of the service, such as infection control to ensure they are completed at the appropriate intervals to help improve the quality of service. Practice should also check all audits have documented learning points and the resulting improvements can be demonstrated.

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.

The practice had emergency medicines and equipment in line with national guidance. These were checked regularly to ensure they were available and in date in the event of a medical emergency.

Infection control standards met those outlined in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' published by the Department of Health.

Radiation safety was reviewed, and equipment was found to be serviced and tested in accordance with legislation, however rectangular collimators, which would further reduce the effective dose of radiation to the patient were not always used.

No action

Are services effective?

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

Clinicians kept accurate detailed and contemporaneous records of patient care. They used national guidance in the care and treatment of patients.

Staff were appropriately registered and trained for their roles within the practice, including in the provision of conscious sedation.

Staff demonstrated a good understanding of the Mental Capacity Act 2005 (MCA) and it's relevance in obtaining consent for patients who may lack capacity to consent for themselves.

No action

Are services caring?

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

Staff described how patients' confidential information was kept private. This included paper records being locked away and computers being password protected.

Comments received from patients were positive about their experiences at the practice and we witnessed staff being polite and friendly to patients.

No action

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 ample means to see emergency patients, but in the event that they found it difficult to see patients they worked closely with the other urgent care providers in the county who might have better availability.

The practice afforded wheelchair access, and staff described various ways in which the individual needs of patients were met by the practice.

No action

Summary of findings

New patients to the practice could expect to secure an NHS appointment within three to four weeks. The practice endeavoured to see all patients in pain within 24 hours, and patients referred for minor oral surgery would be offered an appointment within two weeks.

Are services well-led?

No action 

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

The practice had policies and protocols in place to assist in the smooth running of the service.

The practice sought feedback from patients by way of patient satisfaction surveys and the NHS friends and family test.

Clinical audit was used as a tool to highlight areas of concern and improve performance, although required audits were not always carried out at the appropriate intervals.

Oasis Dental Care Central - Northampton 2

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 carried out an announced, comprehensive inspection on 4 October 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Before the inspection we asked the provider for information to be sent this included the complaints the practice had received in the last 12 months; their latest statement of purpose; the details of the staff members, their qualifications and proof of registration with their professional bodies. We spoke with members of staff and patients during the inspection.

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 to report, investigate and learn from significant incidents, although the systems in place varied. We found that different templates had been used to report significant incidents; some had prompted staff to identify any leaning from the incident, where others had not.

The practice had an accident book, where accidents such as sharps injuries were documented. Although these contained some detail they lacked sufficient detail in the outcome of the accident, and were not logged as a significant incident.

We discussed this with the practice manager who agreed that a consistent approach would be implemented and a log started to contain details of every accident or incident in one place so that any trends could be identified.

A duty of candour was evident and encouraged through the significant incident reporting process. Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

The practice had a policy regarding duty of candour that indicated the practices expectations of honestly and candour in all matters. This had been signed by al the staff to indicate they understood this requirement.

The practice received communication from the Medicines and Healthcare products Regulatory Agency (MHRA). These were e-mailed to the practice and the practice manager took responsibility to action and cascade the information through the staff.

The practice were aware of their responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). RIDDOR is managed by the Health and Safety Executive (HSE), although since 2015 any RIDDORs related to healthcare have been passed to the Care Quality Commission (CQC). Forms to make a report and guidance on how and when to do so was available for staff to reference.

Reliable safety systems and processes (including safeguarding)

The practice had a policy in place regarding safeguarding vulnerable adults and child protection. This was due for review in May 2017 and had been signed by all staff. The practice manager was the designated lead in safeguarding and records had been made of a safeguarding concern being raised.

Staff we spoke with were able to describe the types of abuse that they may be witness to, and the actions they would take to safeguard the individual.

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 31 March 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

We discussed the use of rubber dam with the dentists in the practice. A rubber dam is a thin, rectangular sheet, usually of latex rubber. It is used in dentistry to isolate a tooth from the rest of the mouth during root canal treatment and prevents the patient from inhaling or swallowing debris or small instruments. The British Endodontic Society recommends the use of rubber dam for root canal treatment. A rubber dam was used almost universally by clinicians, and its use was audited by the management team to ensure that it was used wherever possible.

The practice had a protocol in place for dealing with sharps. Dentists were solely responsible for disposing of sharps, and a system of safety needles was in use which allows a plastic tube to be drawn up over the needle and locked into place after use. The syringe and needle can then be safely disposed of without fear of injury. These measures were in line with the guidance Health and Safety (Sharp Instruments in Healthcare) 2013.

Flowcharts indicating the action to take if staff had an injury form a contaminated sharp were displayed in every treatment room, and a robust protocol was in place indicating that advice always be sought from occupational health, or accident and emergency. However reporting of sharps injuries had lacked certain details regarding outcomes in this area.

Medical emergencies

Are services safe?

The dental practice had medicines and equipment in place to manage medical emergencies. These were stored together and two separate kits were available on the premises. Kits were stored in areas protected by a key code, but not all staff we spoke with were aware of the code to access the equipment. Following the inspection the practice held a staff meeting to address this concern and put measure sin place to ensure all staff could access the emergency medicines and equipment when necessary.

Emergency medicines were available in line with the recommendations of the British National Formulary.

Equipment for use in a medical emergency was in line with the recommendations of the Resuscitation Council UK this included an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.

All medicines and equipment were checked regularly to ensure they were ready for use should an emergency arise.

Staff had all undertaken medical emergencies training, and staff we spoke with were able to detail which emergency medicine would be required for certain medical emergencies.

Scenario training was carried out occasionally for the general practice staff, but more frequently for staff carrying out conscious sedation (these are techniques in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation).

Staff recruitment

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all recruitment files. This includes: proof of identity; checking the prospective staff members' skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed). DBS checks identify whether a person had a criminal record or was 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 the staff recruitment files for six members of staff and found that DBS checks had been sought for all staff, and when a check had been sought for a new member of staff a risk assessment was put into place indicating that the person would not work unsupervised until the DBS check was returned. The practice aimed to repeat DBS checks for all staff every three years.

The practice did not always record that references had be sought and obtained from all members of staff. The practice manager indicated that they would be held at head office, but these were not shown to us following the inspection.

Monitoring health & safety and responding to risks

The practice had systems in place to monitor and manage risks to patients, staff and visitors to the practice. A health and safety policy (which was due for review in May 2017) was available for staff to reference. This had been signed by all staff and included details on clinical waste, fore and sedation.

Practice risk assessments had been completed in January 2016 and covered multiple areas of risk including the use of autoclaves, blood and saliva, manual handling, slips, trips and falls, and electrical safety.

A fire risk assessment had been completed in September 2016. This did not identify any immediate hazards, although two low priority risks and one medium priority risk were being addressed by the practice manager.

The practice conducted regular fire walks to ensure that evacuation routes were kept clear and fire training was given in a staff meeting on 27 September 2016.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a file of information pertaining to the hazardous substances used in the practice and actions described to minimise their risk to patients, staff and visitors. Two files of information were regularly updated and substances grouped according to their type to make finding the information easier.

Are services safe?

A risk assessment of the use of sharps had been completed in January 2016. Sharps bins were appropriately sited, signed and dated.

Infection control

The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for cleaning, sterilising and storing dental instruments and reviewed their policies and procedures.

The practice had an infection control policy which was due for review in May 2017 and had been signed by all staff. This included hand hygiene, single use items and personal protective equipment.

The practice had a dedicated decontamination facility with separate dirty and clean rooms linked by a hatch. Washer disinfectors were used to clean the instruments. A washer disinfector is a piece of equipment not dissimilar to a dishwasher that is designed specifically to clean dental instruments. Instruments were inspected after cleaning and sterilised in one of five autoclaves.

All instruments were pouched, signed and dated with a use by date, and store in central storage areas. This meant that instruments were kept away from clinical areas until they were required.

We observed the decontamination procedure in the practice and found that it met current national guidance, and checks performed on the process were in line with the requirements of HTM 01-05.

All clinical staff had documented immunity against Hepatitis B. Although one staff member had not had the blood test to confirm that their vaccinations had been effective. Staff who are likely to come into contact with blood products, or are at increased risk of needle stick injuries should receive these vaccinations to minimise the risk of contracting blood borne infections. Following the inspection we were advised that the staff member had been for testing to ensure they had immunity to Hepatitis B.

The practice employed a company to undertake the environmental cleaning of the practice. The practice followed the national colour coding scheme for cleaning materials and equipment in dental premises. This ensured that equipment used for cleaning was specific to the area that was being cleaned. For example, equipment used to clean clinical areas was different to equipment used to clean the kitchen.

We saw evidence of cleaning schedules for daily and weekly cleans. Cleaning equipment was stored appropriately.

The practice had contracts in place for the disposal of contaminated waste and waste consignment notes were seen to confirm this. Clinical waste was stored in a locked room on the premises prior to its removal.

The practice had a risk assessment regarding Legionella. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The assessment had been carried out by an external company on 26 September 2016. The practice was monitoring water temperatures monthly, however due to some confusion the fact that the hot water was below the recommended temperature had not been raised.

Once this was recognised the water temperature was addressed and training was undertaken by the practice manager to ensure a similar situation would not occur again, however the incident was not raised as a significant event.

The practice was carrying out quarterly dip slides. These are designed to measure and monitor microbial activity in the water, and these had not raised any concern.

Equipment and medicines

The practice had a full range of equipment to carry out the services they offered and in adequate number to meet the needs of the practice.

Portable appliance testing had been carried out in April 2015, and the following equipment had been serviced and validated within the year preceding our inspection: both compressors, all five autoclaves, all three washer disinfectors, fire extinguishers, fire alarm and emergency lighting and the X-ray developing machine.

The practice kept a stock of medicines to dispense to patients. These were stored appropriately, however the labels did not contain the practices details (name and address) which is a requirement of schedule 26 of the Human Medicines Regulations 2012.

Are services safe?

Glucagon is an emergency medicine used to treat diabetics. It is temperature sensitive, and although it can be stored at room temperature its shelf life would be reduced. We found that the practice was storing the glucagon appropriately at room temperature they had not amended the expiry date on one of the two available to reflect the fact that it was not refrigerated. This was immediately amended following the inspection.

Conscious sedation was carried out on the premises (these are techniques in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation). The practice kept full logs of the medicines used in sedation, and all equipment was in place. We saw detailed records pertaining to the assessment, completion and recovery of the patient.

The practice was meeting the standards set out in the guidelines published by the Standing Dental Advisory Committee: conscious sedation in the provision of dental care. Report of an expert group on sedation for dentistry, Department of Health 2003 and were aware of the updated guidance issued in 2015.

Radiography (X-rays)

The practice demonstrated compliance with the Ionising Radiation Regulations (IRR) 1999, and the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.

The practice had six intra-oral X-ray machines that were able to take an X-ray of one or a few teeth at time, and one dental panoramic tomograph (DPT) machine that takes a panoramic image of all the teeth and jaws.

Rectangular collimation limits the beam size to that of the size of the X-ray film. In doing so it reduces the actual and effective dose of radiation to patients. We saw that rectangular collimators were available for use by clinicians, but were not used universally.

Local rules were available for each X-ray unit. These are a safety requirement to have a record of those persons responsible for the X-ray machines. In addition they are required to list those persons that are trained to operate the equipment, details of the controlled zone for each machine, and contingency plans in the event of the machine malfunctioning.

The machines had been tested and serviced in accordance with regulation.

Justification for taking an X-ray was documented in the patients dental care record, as well as a report of the findings of the radiograph and a grade of the quality of the X-ray.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

During the course of our inspection patient care was discussed with the dentists and we saw patient care records to illustrate our discussions.

A comprehensive medical history form was completed by patients annually, and updated verbally at each attendance. This ensured that the dentist was kept informed of any changes to the patient's general health which may have impacted on treatment.

Dental care records showed that the dentists regularly checked gum health by use of the basic periodontal examination (BPE). This is a simple screening tool that indicates the level of treatment need in regard to gum health. Scores over a certain amount would trigger further, more detailed testing and treatment.

Screening of the soft tissues inside the mouth, as well as the lips, face and neck was carried out to look for any signs that could indicate serious pathology. Patients were assessed regarding their risk of gum disease, decay and cancer.

The dentists used current National Institute for Health and Care Excellence (NICE) guidelines to assess each patient's risks and needs and to determine how frequently to recall them. They also used NICE guidance to aid their practice regarding antibiotic prophylaxis for patients at risk of infective endocarditis (a serious complication that may arise after invasive dental treatments in patients who are susceptible to it), and removal of lower third molar (wisdom) teeth.

The decision to take X-rays was guided by clinical need, and in line with the Faculty of General Dental Practitioners directive.

Health promotion & prevention

Dental care records we saw indicated that an assessment was made of patient's oral health and risk factors. Medical history forms that patients were asked to fill in included information on nicotine use; this was used by dentists to introduce a discussion on oral health and prevention of disease.

We found a good application of guidance issued in the DH publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is a toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Clinicians we spoke with were aware of the local services available regarding stopping smoking and directed patients toward them. Dental care records indicated that oral hygiene discussions took place as well as discussions on diet and smoking.

Staffing

The practice had seven dentists, an oral surgeon and two dental hygienists, supported by a head dental nurse, eight qualified dental nurses, three minor oral surgery nurses and four trainee dental nurses. Administration staff consisted of a practice manager, a minor oral surgery manager, a practice co-ordinator, two administrators and three receptionists.

Prior to our inspection we checked that all appropriate clinical staff were registered with the General Dental Council and did not have any conditions on their registration.

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 GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians, dental technicians, and orthodontic therapists.

Clinical staff were up to date with their recommended CPD as detailed by the GDC including medical emergencies, infection control and safeguarding training.

The practice had reviewed staff training requirements in conscious sedation as set out in The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015. All four dental nurses that assisted with sedation had completed courses in sedation, and had completed immediate life support courses in accordance with the new guidance.

Minor oral surgery sessions always involved two dental nurses as well at the clinician. One dental nurse would scrub up and assist, leaving the other to fetch anything needed without compromising the sterile field.

Are services effective?

(for example, treatment is effective)

Three dental nurses had completed the course in radiography and were competent to take X-rays. We saw evidence of their up to date training in this area.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the treatment themselves.

Routine referrals were tracked by the service to ensure they were actioned in a timely manner. Urgent referrals for suspicious pathology were faxed to the hospital, and then followed up with an immediate phone call to ensure that the fax had been received. In addition the clinician contacted the patient two weeks later to ensure that they had heard from the hospital.

The practice provided dental implants. If cone beam computered tomography (CBCT) imaging was deemed necessary the practice would arrange this through a sister practice with this facility. Alternatively, if the patient was not able to travel this could be arranged locally.

Consent to care and treatment

The clinicians described the process of gaining full, educated and valid consent to treat. This involved detailed discussions with the patients of the options available and the positives and negatives of each option. Models, drawing and leaflets were used to further ensue that the patients understood the treatment options available to them. We saw that details of these discussions were documented in the patient care records.

We noted particularly robust processes in place for the consent of dental implants and conscious sedation.

Consent for the minor oral surgery was obtained verbally prior to administration of the local anaesthetic, and then the patient was asked to read and sign a consent form. We discussed this with the minor oral surgery manager who assured us they would re-visit their process in this matter.

The Mental Capacity Act 2005 (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 demonstrated an understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment. The practice had access to an external organisation that could act as an independent advocate for a patient who lacked capacity.

Similarly staff demonstrated an understanding of the situation in which a child under the age of 16 could legally consent for themselves. This is termed Gillick competence. Clinicians also spoke about involving children in discussions regarding their treatment, even if they cannot consent for themselves.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Comments we received from patients indicated that they were very happy with the level of care they received from the practice, with some commenting that they were skilled at dealing with children. We witnessed staff treating patients in a kind and friendly manner.

Reception staff we spoke with commented that patients who had undergone oral surgery could sometimes need a few minutes before driving home, and that they would encourage patients to take a seat following their treatment until they felt fully well enough to leave.

Staff we spoke with explained how they ensured information about patients using the service was kept confidential. The computer was password protected and positioned below the level of the counter so that it could not be overlooked by a patients stood at the counter.

Staff described how they would take patients into a private room to discuss and sensitive matters so as not to be overheard. These measures were underpinned by the practices policies on confidentiality, data protection and information security.

Involvement in decisions about care and treatment

Dental care records shown to us gave a detailed description of discussions held between the clinician and patients regarding the treatments options available to them, and their risks and benefits. We received comments from patients that confirmed that options for treatment had been discussed with them.

A patient information folder available in the treatment area had treatment leaflets on many treatments so that patients could understand the options available to them.

Price lists for NHS and private treatment were displayed for patients.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

As part of our inspection we conducted a tour of the practice and found the premises and facilities were appropriate for the services delivered.

Regarding the emergency service, they practice described working as a team with the other urgent dental care providers around the county, so that if they were busy an appointment may be able to be secured quicker at another centre.

The practice had a baby changing station and an emergency call bell in the toilet to assist patients attending the practice.

The practice had a bariatric dental chair in one of the downstairs treatment rooms. This was used primarily for minor oral surgery but clinicians could move treatment rooms to accommodate larger patients in greater comfort and safety.

The practice sent out text message reminders of appointments, which patients commented that they found very helpful.

We discussed appointments scheduling with the minor oral surgery team. Consideration was given to the patient's medical history when arranging appointments. For example: Patients whose medical conditions require them to eat regularly would be offered appointments at the beginning of the morning or afternoon to ensure that treatment would be finished and any numbness worn off before they had to eat again. Patients on blood thinning medication would also be scheduled earlier to allow for any extra time involved in ensuring bleeding had stopped.

Tackling inequity and promoting equality

Staff we spoke with expressed that they welcomed patients from all backgrounds and cultures, and all patients were treated according to their individual needs.

The practice was wheelchair accessible via the rear door to the premises from the car park. A buzzer was positioned so that reception staff could come to the door and assist patients. The practice had two downstairs treatment rooms that afforded wheelchair access, and a disabled toilet.

Interpreters could be arranged to assist those patients for whom English was not their first language, and a hearing loop was in place at reception to assist patients that used hearing aids.

These measures were underpinned by the practice's equality, diversity and disability policy which has been signed by all staff and detailed the practice's expectation that reasonable adjustments be made to accommodate all patients with individual needs.

Access to the service

The practice was open from 8 am to 8 pm 365 days of the year. Outside these hours any emergency dental patients would be directed to attend accident and emergency.

Emergency slots were set aside during each day, and after 6.30 pm every day was left solely for emergency patients, as were weekends and bank holidays.

A new patient wishing to register with the practice for general dental treatment would be able to access an NHS appointment within three to four weeks. Privately they could generally be seen sooner.

Any patient in pain accessing the emergency service wold be offered an appointment within 24 hours, and dependant on the triage from the NHS 111 service.

Patients referred for minor oral surgery would receive an appointment within two weeks of the referral being received and treatment may be carried out on the first visit.

Concerns & complaints

The practice had a complaints policy in place which was displayed in the waiting area. As well as directing patients on how to raise a complaint within the service it also gave contact details for external agencies that a complaint could be escalated to.

We saw records of recent complaints made to the service. These were investigated and fed back to the complainant, with apologies where necessary.

Are services well-led?

Our findings

Governance arrangements

The practice manager took responsibility for the day to day running of the practice. In addition other staff members had been assigned lead roles in areas of the practice. We noted clear lines of responsibility and accountability across the large practice team.

The practice had policies and procedures in place to support the management of the service, and these were available for staff to reference in hard copy form. Policies were noted in infection control, health and safety, complaints handling, safeguarding children and vulnerable adults, information governance and whistleblowing. All policies had been reviewed in the previous year.

Staff meeting were held monthly to discuss running of the practice and training. Dentists had a separate meeting, the most recent was in February 2016 and the minor oral surgery team had regular meetings where they discussed the results of clinical audit and patient satisfaction surveys. The most recent was September 2016.

Leadership, openness and transparency

Staff we spoke with reported an open and honest culture across the practice and they felt fully supported to raise concerns with the practice manager.

A whistleblowing policy was available and had been signed by all staff in June 2016. It directed staff to raise concerns about a colleague's poor performance either internally or to an external agency. Whistleblowing was discussed with all staff at a staff meeting in September 2016.

Learning and improvement

The practice sought to continuously improve standards by use of quality assurance tools, and continual staff training.

Clinical audits were used to identify areas of practice which could be improved. Infection control audits had been carried out in June 2016 and did not raise any areas of concern. Audits had not been carried out six monthly as per the guidance.

An audit of X-ray quality had been completed in January 2016. This was operator specific and gave a results analysis and actions for individual clinicians. The subsequent re-audit demonstrated improvements in the overall grades of the X-rays taken.

A general record keeping audit had been completed in May 2015.

The minor oral surgery team audited their service separately for records and radiography. The results of both being fed back to the team via team meetings.

Staff were supported in achieving the General Dental Council's requirements in continuing professional development (CPD). We saw evidence that most clinical staff were up to date with the recommended CPD requirements of the GDC.

The practice manager kept a log of staff CPD so that they kept an oversight of staff training requirements.

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

The practice obtained feedback from patients from several pathways. Patient satisfaction surveys were carried out, most recently in September 2016, and the results were displayed in the practice waiting area. In addition the practice took part in the NHS friends and family test.

The practice had made changes in response to patient feedback, notably in making more emergency appointments available to patients to facilitate this aspect of the service.

The practice management team welcomed feedback from staff both formally via the appraisal process, or informally at any time.