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# Manor Park Dental Practice

## Inspection Report

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Date of inspection visit: 10 September 2015
Date of publication: 22/10/2015

## Overall summary

We carried out an announced comprehensive inspection on 10 September 2015 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**

The Manor Park Dental practice is located in the London Borough of Bromley. The premises are laid out over two floors with seven treatment rooms, two dedicated decontamination rooms, waiting rooms with reception area, staff room, storage room and two toilets.

The practice provides private dental services and treats both adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers, crowns and bridges, implants, orthodontics and oral hygiene.

The staff structure of the practice is comprised of a principal dentist (who is also the owner), eight associate dentists, two hygienists, nine dental nurses and three receptionists. One of the dental nurses also works as the practice manager. There is an orthodontist who works at the practice one day a week. One of the associate dentists was also qualified as a vocational trainer and was currently supervising one trainee dentist at the practice.

The practice opening hours are from Monday to Friday from 8.30am to 6.00pm.

This is an established practice which changed ownership and registration with the Care Quality Commission (CQC) in January 2015. It has not been inspected since this change in ownership. The principal dentist was the registered manager at the time of the inspection. A registered manager is a person who is registered with the CQC to manage the service. Like registered providers,

# Summary of findings

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.

The inspection took place over one day and was carried out by a CQC inspector and dentist specialist advisor.

Forty people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

**Our key findings were:**

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were effective systems in place to reduce and minimise the risk and spread of infection.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- The practice manager had a clear vision for the practice and staff told us they were well supported by the management team.
- Governance arrangements and audits were effective in improving the quality and safety of the services.

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

- Review the practice's sharps procedures giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Review processes for learning from incidents and accidents to ensure that opportunities for improving the quality of the service are maximised.

# 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 systems in place to minimise the risks associated with providing dental services. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse. The practice had policies and protocols, which staff were following, for the management of infection control, medical emergencies and dental radiography. There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. We found the equipment used in the practice was well maintained and checked for effectiveness.

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

The practice provided evidence-based care in accordance with relevant, published guidance, for example, from the General Dental Council (GDC). The practice monitored patients' oral health and gave appropriate health promotion advice. Staff explained treatment options to ensure that patients could make informed decisions about any treatment. The practice worked well with other providers and followed up on the outcomes of referrals made to other providers. Staff engaged in continuous professional development (CPD) and were meeting the training requirements of the GDC.

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

We received positive feedback from patients through comment cards. Patients felt that the staff were kind and caring; they told us that they were treated with dignity and respect at all times. We found that dental care records were stored securely and patient confidentiality was well maintained.

**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 access to telephone interpreting services to support people who did not have English as their first language. The needs of people with disabilities had been considered and there was level access to the waiting area and treatment rooms. Patients were invited to provide feedback via a satisfaction survey.

There was a clear policy in place which was used to handle complaints as they arose. Only two complaints had been received by the practice in the past year. We saw that these had been dealt with promptly and that the complaints handling procedure had been disseminated to staff during a meeting.

Patients generally had good access to appointments, including emergency appointments, which were available on the same day. There was some feedback which indicated that there were occasionally long waits for appointments. The principal dentist had taken action to address this issue through the re-organisation of the emergency appointments system, new agreements with staff around holiday cover, and the development of a longer-term plan for the provision of weekend opening hours.

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

# Summary of findings

The practice had good clinical governance and risk management structures in place. These were well maintained and disseminated effectively to all members of staff. A system of audits was used to monitor and improve performance.

A new provider had taken over the running of the practice in January 2015. They had been effectively supported by the previous owner during a transition period to ensure the smooth and safe running of the practice.

Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the principal dentist. They were confident in the abilities of the management team to address any issues as they arose.

# Manor Park Dental Practice

**Detailed findings**

## Background to this inspection

We carried out an announced, comprehensive inspection on 10 September 2015. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a dental specialist advisor.

We reviewed information received from the provider prior to the inspection. We also informed the local Healthwatch and NHS England area team that we were inspecting the practice; however we did not receive any information of concern from them.

During our inspection visit we reviewed policy documents and spoke with seven members of staff, including the principal dentist. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We asked one of the dental nurses to demonstrate how they carried out decontamination procedures of dental instruments.

Forty people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

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**

There was an effective system in place for reporting and learning from incidents. Four incidents had been recorded in the past year. There was a policy for staff to follow for the reporting of these events and we saw that this had been followed in these cases.

Incidents had been appropriately recorded and investigated. Actions taken at the time and any lessons that could be learned to prevent a recurrence were noted and discussed with staff; where necessary a staff meeting had also been convened to discuss learning points which would improve the quality of care. For example, a meeting had been held in August 2015 to discuss access to emergency appointments following an incident where a patient, who was experiencing some dental pain, had become upset regarding the availability of urgent appointments. This had led to a change in scheduling to ensure that emergency appointments were available throughout the day.

We noted that it was the practice policy to offer an apology when things went wrong. We saw examples of written apologies that had been offered following a complaints and incidents. There was also a Duty of Candour policy which directed staff to operate in an open and transparent manner in the event that something went wrong.

Staff understood the process for accident and incident reporting including the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). There was a book for the recording of any accidents. We noted that one of the accidents which had occurred in July 2015 related to a sharps injury. Appropriate actions had been taken at the time in line with the sharps injury protocol. However, the accident had not been formally reviewed as an incident to understand why it occurred on this occasion, what might have been done to prevent it, and what actions staff could take to prevent a recurrence. The practice did not have a written sharps protocol or risk assessment for the handling of sharps at the time of our inspection. However, our discussions with staff demonstrated that all staff were following the same protocol, for example, where the re-sheathing and disposal of needles was the responsibility of the dentist.

**Reliable safety systems and processes (including safeguarding)**

One of the principal dentists was the named practice lead for child and adult safeguarding. The safeguarding lead was able to describe the types of behaviour a child might display that would alert them to possible signs of abuse or neglect. They also had a good awareness of the issues around vulnerable elderly patients who presented with dementia.

The practice had a well-designed safeguarding policy which referred to national guidance, held evidence of staff training and local authority telephone numbers for escalating concerns that might need to be investigated. This information was displayed in the waiting areas and treatment rooms.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, there was a risk assessment and associated protocols in relation to fire safety. Staff received training in fire safety and there were named fire marshals on site each day. Emergency exit routes were shown on the back of each surgery door and appropriate assembly point outside had been established following advice from the fire service.

The practice followed national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments in line with guidance supplied by the British Endodontic Society. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth.

**Medical emergencies**

The practice had arrangements in place to deal with medical emergencies. The practice had an automated external defibrillator (AED). (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). The practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. Oxygen and other related items, such as manual breathing aids and portable suction, were available in line with the Resuscitation Council UK guidelines. The emergency medicines were all in date and stored securely with emergency oxygen in a central

# Are services safe?

location known to all staff. Staff received annual training in using the emergency equipment. The staff we spoke with were all aware of the locations of the emergency equipment on both floors of the premises.

**Staff recruitment**

The practice staffing consisted of a principal dentist (who was also the owner), eight associates, one trainee dentist, two hygienists, nine dental nurses and three receptionists. One of the dental nurses also worked as the practice manager. There was an orthodontist who worked at the practice one day a week.

There was a recruitment policy in place and we reviewed the recruitment files for four staff members. We saw that relevant checks to ensure that the person being recruited was suitable and competent for the role had been carried out. This included the use of an application form, interview notes, review of employment history, evidence of relevant qualifications, the checking of references and a check of registration with the General Dental Council. We noted that it was the practice's policy to carry out DBS checks for all members of staff and details related to these checks were kept.

**Monitoring health & safety and responding to risks**

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety policy in place. The practice had been assessed for risk of fire and there were documents showing that fire extinguishers had been recently serviced.

There were effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. Actions were described to minimise these risks. COSHH products were securely stored. Staff were aware of the COSHH file and of the strategies in place to minimise the risks associated with these products.

The practice responded promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. MHRA alerts, and alerts from other agencies, were received by the principal dentist and disseminated by them to the staff, where appropriate. For example, we noted that an alert regarding the safety of some dental equipment had been received in January 2015. It was evident that this information had been reviewed and the principal dentist had written on the alert to indicate that no further action was needed.

There was a business continuity plan in place. This had been kept up to date with key contacts in the local area. There was also an arrangement in place to use the premises of a second practice owned by the principal dentist for emergency appointments in the event that the practice's own premises became unfit for use.

**Infection control**

There were systems in place to reduce the risk and spread of infection. There was an infection control policy which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. One of the dental nurses was the infection control lead. Staff files showed that staff regularly attended training courses in infection control. Clinical staff were also required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients.

There were good supplies of protective equipment for patients and staff members including gloves, masks, eye protection and aprons. There were hand washing facilities in the treatment rooms and the toilets.

The practice had followed the guidance on 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)'. 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 area which ensured the risk of infection spread was minimised.

We examined the facilities for cleaning and decontaminating dental instruments. There were two decontamination rooms; one on each floor of the premises. The rooms were well organised with a clear flow from 'dirty' to 'clean'. One of the dental nurses demonstrated how they used the room on the first floor and showed a good understanding of the correct processes. The nurse wore appropriate protective equipment, such as heavy duty gloves and eye protection. The practice used a system of

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ultra-sonic cleaning bath, and a washer disinfector as part of the initial cleaning process. Following inspection of cleaned items, they were placed in an autoclave (steriliser). When instruments had been sterilized they were pouched and stored appropriately until required. All pouches were dated with an expiry date in accordance with current guidelines.

The dental nurse showed us that systems were in place to ensure that the autoclaves, ultra-sonic bath and washer disinfector were working effectively. These included the automatic control test and steam penetration tests for the autoclave, foil tests for the ultrasonic cleaning bath, and protein residue test for the washer disinfector. It was observed that the data sheets used to record the essential daily validation were always complete and up to date.

The practice employed domestic staff to carry out more general cleaning of the premises. There was a cleaning schedule to follow and the infection control lead reviewed their work to ensure schedules were being effectively followed.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. For example, we observed that sharps containers, clinical waste bags and municipal waste were properly maintained and stored. The practice used a contractor to remove dental waste from the practice. Waste consignment notices were available for inspection.

The practice had carried out practice-wide infection control audits every six months, as well as monthly audits of waste disposal processes and decontamination of treatment rooms. Actions were taken where issues were identified as a result of the auditing process. For example, a recent audit from June 2015 had led to a discussion with the clinical staff about sterilising matrix bands and the appropriate disposal of face masks as clinical waste.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). The method described was in line with current HTM 01-05 guidelines. A Legionella risk assessment had also been carried out by an appropriate contractor in July 2015. The contractor had been engaged to carry out continuous and regular monitoring of the water systems.

**Equipment and medicines**

We found that the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor, fire equipment and X-ray equipment had all been inspected and serviced in 2015. Portable appliance testing (PAT) had been completed in accordance with good practice guidance in July 2015. PAT is the name of a process during which electrical appliances are routinely checked for safety.

Prescription pads were kept to the minimum necessary for the effective running of the practice. They were individually numbered and stored securely.

The expiry dates of medicines, oxygen and equipment were monitored using a daily and monthly check sheet which enabled the staff to replace out-of-date drugs and equipment promptly.

**Radiography (X-rays)**

The practice had in place a Radiation Protection Adviser and a Radiation Protection Supervisor in accordance with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). A radiation protection file, in line with these regulations, was present. This file was well maintained and complete. Included in the file were the critical examination pack for the X-ray set, the three-yearly maintenance log, a copy of the local rules and appropriate notification to the Health and Safety Executive. The maintenance log was within the current recommended interval of three years with the next service due in 2018. We saw evidence that staff had completed radiation training.

A copy of the most recent radiological audit was available for inspection. This demonstrated that a high percentage of radiographs were of grade one (the highest) standard. We checked a sample of individual dental care records to confirm the findings. These records showed that dental X-rays were justified, reported on and quality assured every time.

# Are services effective?

(for example, treatment is effective)

## Our findings

**Monitoring and improving outcomes for patients**

The practice carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. A dentist we spoke with described how they carried out patient assessments using a typical patient journey scenario. The practice used a pathway approach to the assessment of the patient which was supported and prompted by the use of computer software. The assessment began with a review of the patient's medical history and patients were also asked to complete a social history (for example, exploring current diet and alcohol intake). This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were made aware of the condition of their oral health and whether it had changed since the last appointment.

Following the clinical assessment, the diagnosis was discussed with the patient and treatment options explained in detail. The dental care record was updated with the proposed treatment after discussing options with the patient. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

A check of a random sample of dental care records showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw notes containing details about the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums.) These were carried out at each dental health assessment. Details of the treatments carried out were also documented; local anaesthetic details including type, site of administration, batch number and expiry date were recorded.

**Health promotion & prevention**

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. Staff told us they discussed oral health with their patients, for example, effective tooth brushing or dietary advice. The dentist was aware of the need to discuss a general preventive agenda with their patients. This included discussions around smoking cessation, sensible alcohol use and weight management. The dentist also carried out examinations to check for the early signs of oral cancer.

We observed that there were a range of health promotion materials displayed in the waiting area. These could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition. There was also advice on smoking cessation. A range of toothpastes, toothbrushes and oral hygiene aids were available for purchase.

**Staffing**

Staff told us they received appropriate professional development and training. We reviewed staff files and saw that this was the case. The training covered all of the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, safeguarding and X-ray training.

There was an induction programme for new staff to follow to ensure that they understood the protocols and systems in place at the practice. To ensure that new dentists were able to integrate into the practice and to ensure consistency of approach by existing dentists, a practice manual was available in each treatment room. We saw that this manual contained relevant safety information and copies of policies, for example in relation to safeguarding and the Mental Capacity Act (2005).

The practice held yearly appraisals meetings with each member of staff. This provided staff with an opportunity to discuss their current performance as well as their career aspirations. Notes from these meetings were kept in each staff member's file. We also noted that a new system of peer review had recently been implemented to provide staff with an opportunity to feedback on each other's performance, share best practice and implement actions to drive quality improvement.

**Working with other services**

The principal dentist explained how they worked with other services, when required. Dentists were able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. A referral letter was prepared and sent to the hospital with full details of the dentists findings and a copy was stored on the practices' records system. When the patient had

# Are services effective?

## (for example, treatment is effective)

received their treatment they were discharged back to the practice. Their treatment was then monitored after being referred back to the practice to ensure patients had received a satisfactory outcome and all necessary post procedure care. A copy of the referral letter was always available to the patient if they wanted this for their records. We noted there were no patient complaints relating to referrals to specialised services. The dentists were also able to refer their patients to other dentists internally, depending on their specialisms and level of experience. For example, the practice employed an orthodontist one day a week and other dentists at the practice referred their patients for assessment and treatment to them.

**Consent to care and treatment**

The practice ensured valid consent was obtained for all care and treatment. Staff discussed treatment options, including risks and benefits, as well as costs, with each patient. Notes of these discussions were recorded in the clinical records. Patients were asked to sign to indicate they had understood their treatment plans and formal written consent forms were completed for specific treatments such as tooth extraction.

Staff were aware of the Mental Capacity Act (2005). They could accurately explain the meaning of the term mental capacity and described to us their responsibilities to act in patients' best interests, if patients lacked some decision-making abilities. 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.

# Are services caring?

## Our findings

**Respect, dignity, compassion & empathy**

We collected feedback from 40 patients. They described a positive view of the service. Patients commented that the team were courteous, friendly and kind. Patients were happy with the quality of treatment provided. During the inspection we observed staff in the reception area. They were polite and helpful towards patients and the general atmosphere was welcoming and friendly.

All the staff we spoke with were mindful about treating patients in a respectful and caring way. They were aware of the importance of protecting patients' privacy and dignity. There were systems in place to ensure that patients' confidential information was protected. Dental care records were stored electronically. Any paper correspondence was scanned and added to the electronic record prior to disposal. Electronic records were password protected and regularly backed up; paper records were stored securely and were locked up. Staff understood the importance of data protection and confidentiality and had received training in information governance. Reception staff told us that people could request to have confidential discussions in an empty treatment room, if necessary

The practice obtained regular feedback from patients via a satisfaction survey and through the use of the 'Friends and Family Test'. The practice manager was responsible for analysing the results of the survey on an annual basis. We noted from their report in 2014 that the majority of feedback about staff was positive and corroborated our own findings regarding staff's caring attitude. The practice had also received 44 completed 'Friends and Family' tests in the past two months. All of the people completing these tests stated they would be likely to recommend the practice to other people.

**Involvement in decisions about care and treatment**

The practice displayed information in the waiting area which gave details of the NHS and private dental charges and fees. There were a range of information leaflets in the waiting area which described the different types of dental treatments available. Patients were routinely given copies of their treatment plans which included useful information about the proposed treatments, any risks involved, and associated costs. We reviewed a sample of dental care records and saw examples where notes had been kept of discussions with patients around treatment options, as well as the risks and benefits of the proposed treatments.

We spoke with two of the associate dentists and two of the dental nurses on the day of our visit. All of the staff told us they worked towards providing clear explanations about treatment and prevention strategies. They emphasised that patients were given time to think about the treatment options presented to them and that it was up to the patient to decide whether and when they wanted the treatment to take place. The patient feedback we received via discussions and comments cards, together with the data gathered by the practice's own survey, confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting patients' needs**

The practice had a system in place to schedule enough time to assess and meet patients' needs. Each dentist could decide on the length of time needed for their patient's consultation and treatment. The dentists we spoke with told us they scheduled additional time for patients depending on their knowledge of the patient's needs, including scheduling additional time for patients who were known to be anxious or nervous. Staff told us they did not feel under pressure to complete procedures and always had enough time available to prepare for each patient.

**Tackling inequity and promoting equality**

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. The practice had to a telephone translation service, although they had not had to use this so far. There was written information for people who were hard of hearing as well as a hearing loop in the reception area. Large print documents for patients with some visual impairment were also available.

The practice had assessed disability access at the practice in 2004 and made some adjustments to the structure of the premises to ensure that it was entirely wheelchair accessible. For example, there was level access to the reception area, and a ramp at the entrance. The corridors were wide enough to allow for easy wheelchair access. However, there was no disabled toilet at the practice. The principal dentist discussed future plans for the redevelopment of part of the practice with us; these included plans for the installation of a disabled toilet.

**Access to the service**

The practice was open Monday to Friday from 8.00am to 6.00pm. The practice displayed its opening hours at their premises. New patients were also given a practice information leaflet which included the practice contact details and opening hours.

The principal dentist told us that all of the dentists had some gaps in their schedule on any given day to ensure that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, could be accommodated. We reviewed the electronic appointments system and saw that this was the case.

Staff told us they had enough time to treat patients and that patients could generally book an appointment in good time to see the dentist of their choice. Reception staff told us that there were generally appointments available within a reasonable time frame, but that some patients did end up waiting up to four weeks to be seen. They stressed that emergency appointments for those with urgent need were available every day and there were enough of these to meet demand. The feedback we received from patients confirmed that they could generally get an appointment within a reasonable time frame and that they had adequate time scheduled with the dentist to assess their needs and receive treatment. However some patients also commented that waiting time for appointments could be long.

The principal dentist was aware that there were some issues which needed to be addressed in terms of access to appointments. They had opened discussions with staff about extending opening hours to the evenings and weekends, as well as how to ensure adequate supply of appointments by co-ordinating when dentists took their annual leave. There was a plan in place for the coming year regarding offering additional opening hours which would start with the provision of some appointments on Saturday mornings.

**Concerns & complaints**

There was a complaints policy which described how the practice handled formal and informal complaints from patients. Information about how to make a complaint was displayed in the reception area.

There had been two written complaints recorded in the past year. These complaints had been responded to in line with the practice policy. One of the dentists, who was the named complaints manager, had carried out investigations and discussed learning points with relevant members of staff. Patients had received a written response, including an apology, when anything had not been managed appropriately. There was evidence in notes from meetings with clinical staff to show that individual cases were reviewed to understand whether they could learn or change their practice following complaints made.

# Are services well-led?

## Our findings

**Governance arrangements**

The practice had good governance arrangements with an effective management structure. The practice had experienced a change in ownership in January 2015 with a view to securing the long-term future of the practice. The previous provider was still working at the practice and was during the transition period to provide clinical and managerial support to the new provider. The practice manager was a long-standing member of the dental nursing staff and had also given the new principal effective support during the transition period.

The principal dentist and practice manager had implemented suitable arrangements for identifying, recording and managing risks through the use of scheduled risk assessments and audits. There were relevant policies and procedures in place. These were all frequently reviewed and updated. Staff were aware of the policies and procedures and acted in line with them. Records, including those related to patient care and treatments, as well as staff employment, were kept accurately.

The principal dentist had organised staff meetings, where necessary, to discuss key governance issues and there were plans in place to establish these meetings on a monthly basis. For example, we saw minutes from a meeting in August 2015 where discussions around opening hours, cover for dentists during periods of annual leave, and the scheduling of emergency appointments had taken place.

**Leadership, openness and transparency**

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said that they felt comfortable about raising concerns with the principal dentist or practice manager. They felt they were listened to and responded to when they did so.

We spoke with the principal dentist about their ethos and future plans for the practice. They had developed a coherent development plan which covered changes to the premises and ways of working with a view to securing the financial stability of the practice and improving patients' experience of care. For example, the principal dentist planned to implement new computer software to enable the safe and effective recording and sharing of patient information between members of the team. This could also positively impact on the patient experience by providing an overall improvement to the administration system in terms of making appointments, obtaining test results and scheduling recalls.

We found staff to be hard working, caring and committed and overall there was a sense that staff worked together as a team. There was a system of yearly staff appraisals to support staff in carrying out their roles to a high standard. A recent peer review feedback session had also taken place to support the sharing of information and development of an open and learning culture at the practice.

**Learning and improvement**

The practice had a rolling programme of clinical audit in place. These included audits for infection control, clinical record keeping and X-ray quality. Audits were repeated at appropriate intervals to evaluate whether or not quality had been maintained or if improvements had been made. We looked at a sample of audits which generally revealed a high level of compliance against agreed standards. For example, the clinical record keeping audit ensured that dentists were recording essential clinical data such as medical history taking, condition of the gums and soft tissues of the mouth, and the dental recall interval. The practice had a programme of clinical audit and risk assessments in place. Risk assessments were being successfully used to minimise the identified risks. For example, we saw evidence of actions taken following a recent Legionella risk assessment.

Staff were also being supported to meet their professional standards and complete continuing professional development (CPD) standards set by the General Dental Council (GDC). We saw evidence that staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the GDC.

One of the associate dentists was also a vocational trainer and supervised one trainee dentist. They had made a long-standing commitment to contribute to the development of a new generation of skilled professionals. The principal dentist supported the development of all members of staff and, for example, knew which dental nurses were interested in pursuing further qualifications in

# Are services well-led?

oral health and radiology. There were also plans in place to improve patient care through the provision of a dental nurse with specialist oral health knowledge who could take the lead as a patient care co-ordinator.

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

The practice gathered feedback from patients through the use of a yearly patient satisfaction survey. The survey covered topics such as the quality of staff explanations, cleanliness of the premises, and general satisfaction with care. The majority of responses indicated a high level of satisfaction.

We noted that the practice acted on feedback from patients where they could. For example, issues around waiting times for appointments had begun to be addressed through the re-organisation of the emergency appointments system, new agreements with staff around holiday cover, and the longer-term plan for the provision of weekend opening hours.

Staff commented that the principal dentist was open to feedback regarding the quality of the care. The appraisal system and staff meetings also provided appropriate forums to give their feedback.