Twickel Dental Limited

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Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 17 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.

Twickel Dental Limited provide NHS and private dental treatment and the majority of patients at the practice are NHS. The practice is situated in a rural area of Shropshire, Much Wenlock. The majority of the population (44.6%) who receive a service from Twickel Dental Limited are aged 55 years or older, with 35.4% of the practice patients being of working age and 20% were children. Twickel Dental Limited has a principal dentist who works between four and five days per week and a dental associate who works five days per week. The practice team includes a dental hygienist who works on a Friday each week and four dental nurses. One of the dental nurses primarily works in a receptionist/practice manager role.

Twickel Dental Limited practice premises had been subject to recent refurbishment. The treatment room surgeries are fully equipped and the reception area is now separated from the waiting room to enable further patient privacy. The reception area and waiting room are on the ground floor. The main entrance to reception has a couple of steps that patients with restricted mobility are aware of. The practice has a separate side door entrance which patients with restricted mobility can use to access the service. The practice has two dental treatment rooms. These rooms contain spacious areas for the decontamination and cleaning, sterilising and packing of dental instruments.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to use to tell us about their experience of the practice. We collected 14 completed cards and spoke with two patients. These

Summary of findings

provided a positive view of the service the practice provides. Patients told us the practice was welcoming and that the dentist was understanding, thorough and helpful. Several patients specifically commented that the dentist put them at ease. We spoke with four staff members all were particularly good at understanding the needs of people living with dementia illnesses and those with learning disabilities. They understood their responsibilities under the Mental Capacity Act (2005).

The practice is part of the British Dental Association Good Practice scheme. The business is operated by a private limited company which has one director who is also the registered manager with CQC. 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.

Our key findings were:

- The practice had systems for dealing with significant events and accidents and staff understood their responsibilities for providing a safe service.
- The practice was visibly clean and had processes to help staff manage infection prevention and control effectively.
- The practice had systems, medicines and equipment for the management of medical emergencies and staff were trained to know how to deal with these.
- The practice had safeguarding processes and staff understood their responsibilities for safeguarding adults and children.
- Clinical records included the essential information expected about patients' care and treatment including treatment plans and consent to care and treatment.
- The practice was committed to staff education and development. Staff received training appropriate to their roles and were encouraged and supported in their continued professional development (CPD).
- The practice had received one complaint in eight years and had a clear system for handling and responding to complaints.
- Patients who completed Care Quality Commission comment cards were pleased with the care and treatment they or their family member received and were complimentary about the whole practice team.
- The practice had well organised governance and leadership arrangements and an open door policy which made staff feel valued and listened to with few exceptions. The exception were for example, a lack of management oversight on staff training to be assured that all staff were up to date with their training needs and a lone working policy.
- The practice had open and supportive leadership and staff were happy in their roles, professional and enthusiastic.

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

- Ensure necessary employment checks are in place for all staff and records held of the required specified information in respect of persons employed by the practice in line with Schedule 3 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Consider further detail on the health promotion advice given and verbal consents within the patient records.
- Further improve the security of prescription pads in line with NHS Protect guidelines.
- Formalise the practice induction training and ensure staff receive appropriate training in Health and Safety and ensure regular fire awareness training for staff employed at the practice.
- Ensure documentation and risk assessments are in place when informed by suppliers that a particular medicine for emergencies in no longer available.
- Consider a lone working policy.

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 safe systems for dealing with medical emergencies, carrying out X-rays and for reducing the risk of infection. People who completed comments cards told that they felt the environment was clean and hygienic. Staff were aware of the management of adverse incidents process within the practice and all were clear and consistent about what would happen should an incident occur. Health and safety risks were known and understood by staff and staff took appropriate action when risks were identified. In general appropriate checks were carried out before the appointment of new staff and there were arrangements in place to ensure newly appointed staff were supported during an induction period. Exception examples were that some of the staff files we looked at showed that gaps in employment history had been explored, one staff member had satisfactory references held on file, but another did not and one staff member had not had a repeat DBS check completed prior to their appointment. The provider assured the Care Quality Commission that a repeat DBS check would be completed.

Are services effective?

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

Patients' individual needs and personal risks were being assessed. Care and treatment was being delivered in a way that ensured patient safety and welfare. Where specialist dental care needs were identified referrals had been made and were followed up to ensure continuity of care.

Patients told us that they felt fully informed about their dental care and were subsequently able to make informed decisions about their proposed treatment. Staff working at the practice were clear about their individual roles and responsibilities and had undertaken appropriate training to support them in their roles and enable them to meet the needs of patients. However, not all training was documented for example the staff induction.

Are services caring?

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

We found that staff were sensitive to the needs of their patients and aware of the need to ensure patient confidentiality. The patients who completed comment cards spoke highly of the care they received and told us the team was customer focused and treated them with respect.

Staff told us how they ensured patients were kept informed about their oral health at each visit and how they supported them to make decisions about their care. Patients told us that they felt involved in their treatment and that it was explained fully to them. Results from the NHS

Friends and Family Test and the practice's own surveys echoed these positive views.

Are services responsive to people's needs?

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

We found the practice was aware of patients' needs and in particular those who may have high levels of anxiety or specialist needs. Patients told us that they were able to get appointments when they needed to and that they could get appointments in an emergency. There were arrangements for dealing with any complaints and concerns raised by patients or their carers. We saw that when this had happened the complaint had been investigated and responded to appropriately.

Summary of findings

Are services well-led?

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

The principal dentist provided day to day support for the staff team as well as the receptionist whose role had extended to include some practice management. It was evident from discussions with staff that these arrangements worked well. Staff told us they felt supported and were encouraged to extend their learning. We saw that feedback from patients was encouraged and there were systems to capture feedback from patients as they visited the practice and to use the information to improve the service provided.

Twickel Dental 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 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 17 September 2015 by a CQC inspector and a dentist specialist advisor. Before the inspection we reviewed information we held about the provider and information that we asked them to send us in advance of the inspection. During our inspection visit, we reviewed a range of policies and procedures and other documents including dental care records. We spoke with four members of staff, including the management team. We looked around the premises including the treatment rooms. We looked at the storage arrangements for emergency medicines and equipment. We observed the dental nurse carrying out decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area.

We reviewed 14 Care Quality Commission (CQC) comment cards completed by patients and reviews posted on the NHS Choices website. Patients gave positive views about the care and experience of the practice. 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 procedures in place to investigate, respond to and learn from significant events and complaints. Staff were aware of the reporting procedures in place and followed them. We saw records which included accidents and incidents which were well maintained. We saw records that demonstrated that when a significant event had occurred it was fully investigated, appropriate advice taken and the learning was shared with all staff at the monthly practice meetings. Records showed the patient was fully informed in a timely manner and the practice policy was followed.

We saw that where incidents occurred such as sharp instruments or needle stick injuries that these were discussed, recorded and the outcome shared as learning for improvement. The practice responded to national patient safety and medicines alerts that were relevant to the dental profession. These were received and actioned by the principal dentist. Any relevant notices were displayed on staff noticeboards for their attention. Where policies had been updated systems were in place to confirm that staff read these updates. The dentists and staff spoken with had a clear understanding of their responsibilities in Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR) and had access to the appropriate recording forms.

Reliable safety systems and processes (including safeguarding)

We discussed child and adult safeguarding with staff at the practice. They were aware of how to recognise potential concerns about the safety and well-being of children, young people and vulnerable adults including older patients living with dementia. The practice had a safeguarding policy for staff to refer to and contact details for the relevant safeguarding professionals. This information was kept on the practice computer system together with staff access to a paper copy with a flow chart which staff could easily refer to. We saw documentary evidence that all staff had undertaken safeguarding training. Staff knew who to report concerns to outside of the practice and had access to the contact details for external agencies.

Rubber dams were used in root canal treatment. 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 and protect the airway.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. The practice had the emergency medicines set out in the British National Formulary guidance. Oxygen and other related items such as face masks were available in line with the Resuscitation Council UK guidelines. All of the emergency medicines were in date and stored securely with the exception of one. There was no risk assessment in place in respect of the lack of this medicine used in the treatment of anaphylaxis (shock). The practice told us and evidenced that their medicines supplier had informed them that there was a national shortage of this medicine. Staff at the practice had attempted to source this medicine elsewhere but had been unable to do so. Following the inspection the practices confirmed that they had managed to source and obtain a supply of a similar medicine.

Emergency oxygen was in a central location known to all staff. The expiry dates of medicines and equipment were monitored using a monthly check sheet which enabled the staff to replace out of date drugs and equipment promptly. The practice held in-house training sessions for the whole team to maintain their competence in dealing with medical emergencies using an outside provider.

Staff recruitment

We looked at the staff files for four of the current employees and the practice's recruitment policy and procedure. We saw that in general the practice held the required information for each member of staff employed. This included photographic proof of identity. The recruitment policy reflected the requirements of Regulation 19(3) and Schedule 3 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. It contained clear information about the checks the practice would carry out when appointing new staff. Disclosure and Barring Service (DBS) carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children

Are services safe?

or adults who may be vulnerable. We saw that the practice had accepted a satisfactory DBS check from a previous employer for a clinical staff member appointed. The DBS check for the staff member was dated 2012. There was no signed declaration that there were no changes that would affect the content of this. The provider assured the Care Quality Commission that a repeat DBS check would be completed.

Monitoring health & safety and responding to risks

The practice had a health and safety policy which was due for review in April 2016.There were a number of health and safety related policies. These included manual handling, sharps, slips, trips and falls and fire safety. We saw that there were fire safety records showing that the practice had carried out regular checks of the fire alarm system and fire extinguishers and a fire risk assessment was in place. The records also showed that staff had taken part in fire drills during 2015.However we noted that the records of one fire drill did not contain the attendees names. The provider assured us that this would be rectified. Staff could not recall when they last attended fire safety awareness training but told us they had all had received training as part of their induction.

The practice had a treatment room situated on the ground floor of the building which patients who experienced limited mobility were invited to use by accessing the practice by the side entrance.

Infection control

The practice was visibly clean, tidy and uncluttered. An infection control policy was in place, which clearly described how cleaning was to be undertaken at the premises including the treatment rooms and the general areas of the practice. The types of cleaning and frequency were detailed and checklists were available for staff to follow. The dental nurses, dental hygienist, dental therapist and receptionists had their own responsibilities in the treatment rooms. The practice had systems in place for testing and auditing infection control procedures. We found that there were adequate supplies of liquid soaps and hand towels throughout the premises. Posters describing proper hand washing techniques were displayed in the dental surgeries. Sharps bins were properly located, signed, dated and not overfilled. A clinical waste contract was in place and waste was stored securely until collection.

We looked at the procedures in place for the decontamination of used dental instruments. The practice did not have a dedicated decontamination room. The decontamination areas within the treatment rooms had clearly defined dirty and clean zones in operation to reduce the risk of cross contamination. Staff wore appropriate personal protective equipment during the process. These included aprons, protective eye wear with a face visor and the practice of double gloving involved wearing disposable gloves with the additional protection of heavy duty gloves to minimise the risk of injury from sharp instruments was used.

We found that instruments were being cleaned and sterilised in line with the Department of Health's guidance, Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices published guidance. On the day of our inspection, a dental nurse demonstrated the decontamination process to us and used the correct procedures. The practice first cleaned the instruments which were scrubbed in a sink designated for this purpose. All instruments were then rinsed and examined visually with a magnifying glass before being sterilised in an autoclave. At the end of the sterilising procedure the instruments were correctly packaged, sealed, stored and dated with an expiry date. We looked at the sealed instruments in the surgeries and found that they all had an expiry date that met the recommendations from the Department of Health. The equipment used for cleaning and sterilising was checked, maintained and serviced in line with the manufacturer's instructions. Daily, weekly and monthly records were kept of decontamination cycles to ensure that equipment was functioning properly. Records showed that the equipment was in good working order and being effectively maintained.

We saw that staff were well presented and wore clean uniforms. We saw that appropriate personal protective equipment was worn by staff and provided for patients when undergoing treatment. Staff files reflected that staff had received inoculations against Hepatitis B and received regular blood tests to check the effectiveness of that inoculation. People 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 blood borne infections.

Are services safe?

The practice had contracted an external company to conduct their legionella risk assessment and test which took place in September 2015 and the report on any actions to be taken was awaited.

Equipment and medicines

The building was well maintained. The dentist had recently refurbished the practice and had plans in place to consider extending the practice to include two further treatment rooms with a potential decontamination room.

We looked at the maintenance schedules for the equipment used in the practice. This showed that equipment was maintained in accordance with the manufacturers' instructions using appropriate dental engineers. This included the equipment used to sterilise instruments, X-ray equipment and equipment for dealing with medical emergencies to ensure they were in working order and easily accessible. Portable electrical appliances had been tested by an electrical contractor in May 2015. The practice had a system in place to monitor medicines in use at the practice. Staff checked the medicines regularly and kept records of this. We saw from a sample of clinical records that the dentist recorded the name of the medicines they prescribed together with the dose and timing. The batch numbers, area given and expiry dates for local anaesthetics were recorded in the clinical notes we saw. There was sufficient sterilised equipment available for patients' treatment and these were rotated regularly to ensure they remained in date for use.

Prescription storage was within a lockable room within a drawer. We discussed the document produced by NHS Protect Security of prescription forms guidance (Updated August 2013). The provider assured us that appropriate prescription storage and monitoring measures would be taken in line with this guidance.

Radiography (X-rays)

We were shown records relating to the Ionising Radiation Regulations 1999 (IRR99) and Ionising Radiation Medical Exposure Regulations 2000 (IRMER).The records included the local rules and the names of the Radiation Protection Advisor and the Radiation Protection Supervisor along with the necessary documentation relating to the maintenance of the X-ray equipment. The maintenance logs were within the current recommended interval of 3 years.

We looked at the dentist's continuous professional development (CPD) training records in relation to IRMER requirements; these were within the recommended five year renewal period. We saw a copy of the most recent radiological audit completed in 2015. We looked at a sample of dental care records where X-rays had been taken on the day of our visit. These showed that the dentist had recorded their justification for taking these X-rays. These findings showed that practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

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. The dentist told us they asked patients to complete a medical history questionnaire to provide the practice with details of health conditions, medicines being taken and any allergies suffered. The dentist described a typical examination which covered the condition of a patient's teeth, gums and soft tissues and detecting the signs of mouth cancer. They explained that they made patients aware of the condition of their oral health and whether it had changed since the last appointment. They gave each patient a treatment plan which included the cost involved where applicable.

We looked at a sample of dental treatment records for patients who attended the practice. These confirmed that the findings of the dentist's assessment and details of the treatment carried out were recorded although the notes were brief and on occasion lacked verbal consent documentation. We saw details of the condition of patients' gums were recorded using the basic periodontal examination (BPE) scores 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. The records also confirmed that the dentist had checked the soft tissues lining the mouth which can help to detect early signs of cancer. The records confirmed that each of the dental X-rays taken were justified, reported on and quality assured and contained treatment plans and details of any associated costs. When the patient's treatment was complete, the dentist incorporated a risk based approach to determining the dental recall interval based on the National Institute for Health and Care Excellence (NICE) dental recall guidelines.

Health promotion & prevention

The waiting room contained literature in leaflet form that explained the services offered at the practice. The dentists and dental therapist advised adults and children of steps to take to maintain healthy teeth. They explained tooth brushing techniques and gave advice on diet, smoking, and alcohol consumption. Patients we spoke with specifically mentioned that the dentist gave guidance about oral health care and the dental hygienist also provided nutritional information as they had received specific training in this role. Staff had attended various courses to improve their health promotion and prevention knowledge and skills. For example one dental nurse had received training in provide further information on the application of fluoride to help keep children's teeth in a healthy condition, as well as on smoking cessation and oral health.

Staffing

The practice team consisted of the principal dentist, an associate dentist, a dental hygienist, and four dental nurses. One of the dental nurses worked predominately as a receptionist and supported the principal dentist in an administrative/ practice manager role.

Staff we spoke with said they had received an induction on commencement of employment at the practice, that this included familiarising themselves with the practices policies and procedures. We saw that staff completed a checklist which was signed and dated once they had read the policies and procedures and/or any changes in policies and procedures. This included a wide range of important and appropriate topics such as emergency medicines arrangements and fire safety. The induction itself however was not formalised or fully documented. The practice had not always recorded details of the dates on which information or training was provided and had not formalised the assessment of staff competence in a structured way. We saw evidence that members of the clinical team had completed appropriate training to maintain the continued professional development required for their registration with the General Dental Council. This included medical emergencies in dental practices, infection control, child and adult safeguarding, dental radiography (X-rays), and varied dental topics. The individual staff records contained details of confirmation of current General Dental Council (GDC) registration, current professional indemnity cover and immunisation status. However, there was no formalised system in place to help the practice monitor this on an ongoing basis.

Working with other services

We saw records that demonstrated that the dentists referred patients who required any specialised treatment to other dental specialists as necessary. The care and treatment required was explained to the patient and they were given a choice of other dentists who were experienced in undertaking the type of treatment required. A referral letter was then prepared with full details of the

Are services effective?

(for example, treatment is effective)

consultation and the type of treatment required. This was then sent to the practice who would provide the treatment so they were aware of the details of the treatment required. When the patient had received their treatment they would be discharged back to the practice for further follow-up and monitoring. Where patients had complex dental issues, such as oral cancer, the practice referred them to other healthcare professionals using their referral process.

Consent to care and treatment

The dentists and dental nurses we spoke with were aware of the need to gain valid consent from patients and understood the use of Gillick competency in young persons. Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. The dentists had a clear understanding of consent issues. We found that verbal consent was inconsistently recorded in the patient's records. They stressed the importance of communication skills when explaining care and treatment to patients. They understood that consent was an ongoing process and a patient could withdraw consent at any time. The dentist explained that they gave patients a detailed verbal explanation of the type of treatment required, including the risks, benefits and options..

The practice had a consent policy and had Department of Health guidance available about the Mental Capacity Act 2005. 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. The dentist explained how they would approach the issue of consent with patients who may not fully understand the implications of their treatment. Staff we spoke with assured us that if there was any doubt about their ability to understand or consent to the treatment, then they would postpone treatment. They said they would involve relatives and carers in discussions to ensure that the best interests of the patient were served as part of the process. The dental nurses spoken with had received in house training on the MCA and understood their responsibilities. Staff said they would take advice where appropriate to do so to help ensure people's best interests were considered and choice maintained.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to use to tell us about their experience of the practice. We collected 14 completed cards. These provided a very positive view of the service the practice provides. Patients told us the practice was welcoming and that the dentists were professional understanding, thorough and helpful. Several patients specifically commented that the dentists put them at ease and that this had helped them overcome their fear of going to the dentist. The practice had started to use the NHS Friends and Family test to gather patients' views. The results for the practice included the views of 39 patients. Thirty eight patients said they were extremely likely to use the practice again and one said they were neither likely nor unlikely. The majority had made additional positive comments about the dentists and staff. The comments echoed those in the CQC comment cards in that patients described how the practice staff always went the extra mile to help them.

Involvement in decisions about care and treatment

Patients commented they felt involved in their treatment and it was fully explained to them. Responses in the Care Quality Commission (CQC) comment cards and patients we spoke with said that treatment was explained and communicated clearly to them. They said that results, examinations and treatment options were discussed with them. Patients said that they were given the time needed to consider their treatment options. The practice provided patients with information to enable them to make informed choices about their dental treatment. Patients were informed about the range of treatments available in information leaflets, and notices in the practice. 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. We looked at a sample of patient records and saw that these included a brief summary of treatment explanations given to patients.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice information leaflet and information displayed in the waiting area described the range of services offered to patients, the complaints procedure, information about patient confidentiality and record keeping. The practice offered predominately private treatment but had some NHS patients. Costs and fee information leaflets were available.

Appointment times and availability met the needs of patients. Patients with emergencies such as those in pain were seen within 24 hours of contacting the practice, sooner if possible. The practice was open late on Tuesday evenings each week until 6pm. The practice's answering machine informed patients which service they should contact in an emergency when the practice was closed.

Tackling inequity and promoting equality

The practice had a range of policies around anti-discrimination and promoting equality and diversity. Staff we spoke with were aware of these policies. Staff told us although they had no patients requiring the use of an interpreter they could access this service for patients whose first language was not English and who needed support to understand the treatment they needed. The practice building was located in a central area in Much Wenlock and there was a pay and display car park located behind the practice. The premises had been a dental practice for a number of years and had extended into what had been a former shop and residential property. The reception, waiting room, patient toilet and one treatment room were on the ground floor. The other treatment room was located on the first floor accessible via stairs. The practice had considered the needs of patients who may have difficulty accessing services due to mobility or physical issues. The practice had steps at the front entrance of the building and step free access to the side of the building. The dentist told us that they were to explore options in the future for improving and maximising the full use of the premises. The practice future plans included considering a decontamination room, two further treatment rooms and another waiting area on the first floor.

Access to the service

Patients told us that they could access care and treatment in a timely way and the appointment system met their needs. Staff told us that where treatment was urgent patients would be seen on the same day, where possible and within 24 hours or as soon as an emergency appointment could be identified. Appointments were available Monday to Friday between 9am and 5pm and Tuesday from 9am to 6pm.

Information in CQC comment cards and the practice's completed Friends and Family test results described a responsive service where patients found it easy to get appointments, particularly when experiencing pain.

We looked more generally at appointments on the system and saw that the lengths of appointments varied according to the type of treatment being provided to meet patient's needs.

Concerns & complaints

The practice had a complaint procedure that explained to patients the process to follow, the timescales involved for investigation and the person responsible for handling the concern. The leaflet, notices in the reception area and it included details of other external organisations that a complainant could contact should they remain dissatisfied with the outcome of their complaint or feel that their concerns were not treated fairly.

Staff we spoke with were aware of the procedure to follow if they received a complaint. The practice manager and records showed that there had been one formal complaint made within the last seven months We saw that this complaint had been resolved quickly; to the patient's satisfaction and any learning derived from this had been appropriately shared with practice staff. The practice had received no negative feedback or comments from patients on the NHS Choices website.

Are services well-led?

Our findings

Governance arrangements

The practice had good governance arrangements with an effective management structure. There were arrangements for monitoring the quality of most processes within the practice. They had a well-defined management structure which all the staff were aware of and understood. All staff members had defined roles and were all involved in areas of clinical governance.

There were a number of policies and procedures in place which underpinned staff practices. There was a process in place to ensure that all policies and procedures were kept up to date. The practice had systems in place for monitoring and managing risks to staff and patients. Risks associated with dental treatments including risks of infection control and unsafe or inappropriate treatments, premises and fire had been recognised and there were plans in place to minimise and mitigate these risks.

Staff told us that they held daily regular informal discussions and monthly formal whole practice meetings. These formal meetings were all minuted and provided the opportunity to discuss any issues, updates, training, health promotion and key governance issues. For example, we saw minutes from meetings where issues such as infection control, information governance and complaints had been discussed. This facilitated an environment where improvement and continuous learning were supported.

The practice had undertaken audits to ensure their procedures and protocols were being carried out and were effective. These included audits of record keeping, X-rays and infection control. The audits supported the practice to identify and manage risks and ensured information was shared with all team members. Where areas for improvement had been identified action had been taken.

Care and treatment records were kept electronically and we found them to be complete, legible accurate and kept secure. Patients' care records were stored electronically; password protected and regularly backed up to secure storage. The practice had policies and procedures and training which supported staff to maintain patient confidentiality and understand how patients could access their records.

Leadership, openness and transparency

The staff group at the practice was small and on the day of the inspection we observed that the team worked together well and supported each other. They discussed any suggestions for improvements with the dentist who they felt were open to their advice and suggestions.

The culture of the practice encouraged candour, openness and honesty. Staff told us that they would approach the principal dentist if they had any concerns. Staff said they could also speak with other staff members. Staff said they were comfortable about raising concerns and felt they were listened to and responded to when they did so. They were aware that they could escalate concerns to external agencies, such as the Care Quality Commission (CQC), if necessary.

The staff we spoke with all told us they enjoyed their work and that they had a good team of staff who supported each other. There was a system of staff appraisals to support staff in carrying out their roles effectively and safely which included personal learning and development plans. Staff were aware of their rights in respect of raising concerns about their place of work under whistleblowing legislation. We saw that the practice had a whistleblowing policy in place.

Learning and improvement

Staff told us they had good access to training and personal development. Staff were regularly supervised and had an annual appraisal of their performance from which learning and development needs and aspirations were identified and planned for.

The practice audited areas of their practise each year as part of a system of continuous improvement and learning. A number of clinical and non-clinical audits had taken place where improvement areas had been identified. The outcome and actions arising from audits were cascaded and discussed with staff to ensure any identified improvements were made. Further audits such as that or clinical record recording of consents including verbal consents were to be considered.

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

The practice had started using the NHS Friends and Family test to gather patients' views. The results of these demonstrated patients were more than satisfied with the

Are services well-led?

care and treatment they received. The practice also carried out their own ongoing patient surveys feedback from patients was that they were happy with the treatment they received and confident about the quality of treatment.