Church Street Dental Surgery Ltd

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Inspection Report

19-21 Ashcroft Court
Church Street
Saffron Walden
Essex
CB10 1JW
Tel: 01799 528555
Website: www.churchstreetdentalsurgery.com

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Overall summary

We carried out an announced comprehensive inspection on 24 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

Church Street Dental Surgery provides private dental care only. The practice has two surgeries and two dentists work at the practice. The dentists are supported by two dental nurses and two members of reception staff.

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

On the day of the inspection we spoke with one patient who told us that they were satisfied with the services provided at the practice. They told us that they were treated with kindness, dignity and respect and their privacy was maintained. They said that explanations and costs were clear and they were involved in the decisions about their care and treatment.

We viewed ten comments cards that we had left for patients to complete prior to our inspection. The cards all contained positive comments about the services provided. Patients said that they were satisfied with the cleanliness of the practice, the politeness of the receptionists and the quality of the dentistry. The said the appointment system met their needs and that they received clear explanations about their care and treatment.

Summary of findings

Our key findings were:

- There were systems in place to manage safety incidents and complaints and to cascade any learning from them to staff.
- There were sufficient supplies of emergency medicines and equipment and staff had been trained in their use.
- All staff had received safeguarding training and were aware of the different signs of abuse and how to report incidents.
- Risks to patients and staff had been assessed and managed effectively. National patient safety and medicine alerts were monitored and acted upon.
- Recruitment processes were robust. Staff had been appropriately trained and received an annual appraisal
- Infection control procedures followed published guidance and staff were following the correct decontamination procedures.
- Treatments and consultations followed guidance from the National Institute for Health Care Excellence.
- An effective complaints process was in place and this was readily available for patients to view.
- Patients were treated with dignity and respect and staff were polite and courteous.
- The appointment system met the needs of patients including access to emergency dental care.
- The practice was well-led and the lead dentists set standards for staff to follow and monitored them.
- Patient and feedback was sought and monitored through the use of a monthly patient survey. Staff feedback was sought informally and at staff meetings.
- Staff were involved in the vision and strategy at the practice and worked as part of a team

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

- Ensure staff wear appropriate personal protective equipment when decontaminating dental instruments. Ensure staff manually cleaning instruments brush them under the water line to reduce the risk of cross contaminating through splashing.
- Ensure staff cleaning dental instruments follow hand washing guidance before and after the cleaning process.

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 effective systems and processes in place to ensure care and treatment was carried out safely. There were systems in place to record and analyse significant events and safety issues. Staff meetings were used to share learning with staff. All staff were aware of the procedures to follow and were encouraged to report them. National patient safety and medicines alerts were acted upon in a timely manner and shared with clinical staff. Staff had received training that met the needs of patients. All staff had received training in safeguarding vulnerable adults and children. Infection control procedures were robust and staff had received training. Infection control audits were not taking place at intervals in line with guidance but were effective. The systems for cleaning and sterilising dental instruments met Department of Health guidelines. Radiation equipment was suitably sited, maintained and used by trained staff only. Emergency medicines in use at the practice were stored safely and checked to ensure they did not go beyond their expiry dates. The practice was able to respond to emergencies and all staff had received training in basic life support.

Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations. Consultations were carried out in line with best practice guidance from the National Institute for Health and Care Excellence (NICE) and the dentists kept up with current best practice. Patients received a comprehensive assessment of their dental needs including updating their medical history. Explanations were given to patients in a way they understood and treatment options were discussed and supported by written treatment plans. Staff new to the practice were required to complete an induction process and received support and guidance. Patients were referred to other services in a timely way. Staff had an understanding of the Mental Capacity Act and the need to assess the capacity of some patients to understand their care and treatment.

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations. Patients were treated with dignity and respect and their privacy maintained. Patient information and data was handled confidentially. Patients told us they were listened to, given time to decide upon treatment options and that treatment was clearly explained. Patients who had dental emergencies were seen in a timely manner, often on the same day. Patients felt involved in the decisions about their care and treatment.

Are services responsive to people's needs?

We found that this practice was providing responsive care in accordance with the relevant regulations. Appointment times met the needs of patients, waiting time was kept to a minimum and a system was in place to remind patients about their appointment time. The practice responded to patients in need of emergency dental treatment and saw them the same day wherever possible. The practice had made reasonable adjustments to accommodate patients with a disability or lack of mobility. The practice had a system in place to manage complaints effectively. The practice acted on patient feedback through the use of regular surveys and by monitoring external sources.

Are services well-led?

We found that this practice was providing care which was well led in accordance with the relevant regulations. The lead dentist provided clear leadership and involved staff in their vision and values. Regular staff meetings took place

Summary of findings

and staff felt involved in the running of the practice. Meetings were minuted and there were clear audit trails when areas for improvement had been identified. Clinical audits took place which drove improvement. Staff were encouraged to develop and supported to maintain their training. The practice sought the views of staff and patients. Health and safety risks had been identified which were monitored and reviewed regularly.

Church Street Dental Surgery

Detailed findings

Background to this inspection

The inspection took place on 24 September 2015 and was conducted by two CQC inspectors and a specialist dental advisor.

Prior to the inspection we asked the practice to send us some information which we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, the details of their staff members, their qualifications and proof of registration with their professional bodies.

We also reviewed the information we held about the practice and consulted with other stakeholders, such as NHS England area team / Healthwatch, however we did not receive any information of concern from them.

During the inspection we spoke with the lead dentist, two dental nurses and a receptionist. We also spoke with one patient and reviewed comment cards that we had left prior to the inspection, for patients to complete, about the services provided at 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 a system in place to manage significant events, safety concerns and complaints and staff were aware of the procedures to follow. The system in place included recording, investigation and analysis, then identifying areas for improvement, implementing actions and cascading learning to staff either informally or through team meetings. The lead dentist had assumed responsibility for all safety issues and had oversight of the incidents.

We looked at one previous safety incident on the day of the inspection in relation to a slippery area of the practice where a patient and a member of staff had nearly fallen. We found that it had been effectively recorded and analysed and steps taken to reduce the risk of further incident. This included the provision of warning signs and applying a non-slip material to the affected area. This incident had been discussed at a staff meeting to keep all staff informed.

The practice had a system of managing national patient safety and medicines alerts that affected the dental profession. These were monitored by the lead dentist and cascaded to relevant staff. We found that where appropriate, action had been taken to identify patients at risk and measures put in place. There was a clear audit trail that reflected that the alerts had been considered.

Records we viewed reflected that the practice was following the guidance in relation to the control of substances hazardous to health (COSHH). Substances in use at the practice had been risk assessed and measures put in place to keep staff and patients safe.

Reliable safety systems and processes (including safeguarding)

The practice had a safeguarding policy which all staff were required to read and initial to show that they had understood the contents. Information was available to staff of external organisations that could offer support or that they could contact if they needed to. This included the telephone numbers of the local authority safeguarding team responsible for the investigations.

Staff at the practice had received safeguarding training for children and vulnerable adults and staff spoken with were aware of the procedures to follow. Staff were also aware of who to contact at the practice or externally if the need arose. They felt confident that incidents they reported would be dealt with professionally. We were told of an example where staff suspected a safeguarding issue with a child. They telephoned the local authority to seek advice and due to the circumstances they were advised not to report the matter. This reflected that they were considering the welfare of their patients and prepared to report incidents if required.

The dentist we spoke with on the day of the inspection used rubber dam for endodontic procedures. Rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth. This prevents inhalation of small instruments during treatment. It was practice policy not to re-use rubber dams and dentists spoken with were aware of this requirement.

Patients attending for their consultation had their medical history reviewed on each occasion to ensure that any health conditions or medicines being taken could be considered before receiving care or treatment. New patients were required to complete medical history forms and these were checked by the dentist during their consultation.

Medical emergencies

Emergency medicines, a first aid kit, a defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm) and oxygen were readily available if required. The emergency equipment in use was in line with the 'Resuscitation Council UK' and 'British National Formulary' guidelines.

All staff had been trained in basic life support and were able to respond to a medical emergency. All emergency equipment was readily available and staff knew how to access it.

We checked the emergency medicines and found that they were of the recommended type. All medicines were in date and monitored every four months to ensure they did not go out of date or that stocks ran low. Records were being kept and dated back a number of years.

Staff recruitment

Are services safe?

The practice had a recruitment policy that described the process when employing new staff. This included obtaining proof of identity, checking skills and qualifications, registration with professional bodies where relevant and the taking of references.

We spoke with a recently employed member of staff who told us that they had been required to provide appropriate documentation prior to starting work at the practice. These included proof of identity, a disclosure and barring service check (to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable), evidence of previous experience, skills and qualifications and two references. They said they had been through a formal interview process.

We looked at three staff records on the day of our visit and found that training had been confirmed and that disclosure and barring service checks were present. In addition relevant training certificates were in place demonstrating that they were suitable for the role. Appropriate registration evidence of registration with their professional bodies were also present in the files of clinical staff.

There were sufficient numbers of suitably qualified and skilled staff working at the practice. A system was in place to ensure that where absences occurred, staff were contacted to attend the practice and cover for their colleagues. The practice did not use agency staff or locum dentists or dental nurses.

Monitoring health & safety and responding to risks

A health and safety policy and risk assessment was in place at the practice. This identified the risks to patients and staff who attended the practice. A regular health and safety audit took place at the practice to ensure the environment was safe for both patients and staff.

There were a range of other policies in place at the practice to manage risks. These included infection prevention and control, a legionella risk assessment, fire evacuation procedures and the risks associated with Hepatitis B. Processes were in place to monitor and reduce these risks so that staff and patients were safe. The practice had an induction process for all new staff members and this included familiarisation with health and safety issues.

The practice was developing a business continuity plan that outlined the procedures to follow in the event that services were disrupted. This involved liaison with a local dentist that would offer support in the event of an emergency that affected the services provided.

Infection control

The practice was visibly clean, tidy and uncluttered. An infection control policy was in place and a lead had been identified. The policy included guidance on needle stick injuries, inoculations against Hepatitis B and the handling of clinical waste.

The policy also clearly described how cleaning was to be undertaken at the premises. Check lists were made available to support staff and the contract cleaner to ensure that each area of the practice was cleaned appropriately. The policy explained the types of cleaning and the frequency. Records held reflected that the quality of the cleaning was being monitored and feedback given accordingly. This was achieved through a regular cleaning audit that was provided to the contract cleaned. Where improvements had been identified these were being monitored.

We found that the mops in use at the practice needed replacing as they presented a contamination risk. The lead dentist agreed to remove them on the day of our inspection and we were informed the following day they had been replaced with new ones.

During our inspection we visited two surgeries and found them to be visibly clean and tidy. The daily cleaning of each surgery was the responsibility of the dental nurses and they completed checklists to reflect that appropriate tasks had been undertaken. Dental nurses spoken with were aware of the infection control procedures in place and had received training. Sufficient quantities of personal protective equipment were available for clinical staff and we were told that clean surgical gloves and masks were worn for each patient.

Infection control audits had been carried out every six months and they dated back over a number of years. The last one took place in May 2015 and the results reflected that robust processes were in place. Where areas for improvement had been identified, these had been recorded then actioned and discussed at team meetings. Appropriate staff had received infection control training and this was being monitored.

Are services safe?

We found that there were adequate supplies of liquid soaps and hand towels throughout the premises and hand washing techniques were displayed. Sharps bins were properly located, signed and dated and not overfilled. Clinical waste was stored securely and the practice had a clinical waste collection contract in place.

We looked at the procedures in place for the decontamination of used dental instruments. The practice had a dedicated decontamination room that was set out according to the

Department of Health's guidance, Health Technical Memorandum 01-05 (HTM 01-05):

Decontamination in primary care dental practices.

We found that instruments were being cleaned and sterilised in line with published guidance (HTM 01-05). On the day of our inspection, a dental nurse demonstrated the decontamination process to us and used the correct procedures.

The practice cleaned their instruments using a combination of either manual cleaning or the use of a washer/disinfector. After cleaning the instruments they were with a magnifying glass then 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 contained an expiry date that met the recommendations from the Department of Health. Instruments designed for single use only were disposed of after use.

The practice used sterilised instruments in a clinical area for one day only. If not used that day they went through the sterilisation process again. This was in line with the guidance.

The decontamination room had been set up to reduce the risk of cross contamination. Staff wore some personal protective equipment during the process and these included disposable gloves. However protective eye wear was not routinely worn. We also found that instruments were being cleaned under a running tap rather than being cleaned when immersed in cleaning solution, to reduce the risk of splashing and contamination. The dental nurse demonstrating the process followed said that they did not wash their hands before and after the decontamination process.

We discussed this with the lead dentist and a dental nurse on the day of the inspection and they assured us that they would follow the guidance. This was a relatively minor issue and we were assured that appropriate guidance would be followed in the future. We were told that this would be discussed at a staff meeting to ensure all staff were following the guidance.

The equipment used for cleaning and sterilising was maintained and serviced as set out by the manufacturers. Daily, weekly and monthly records were kept of decontamination cycles and tests and when we checked those records it was evident that the equipment was in good working order and being effectively maintained. Dental unit water lines (used for connecting the dentist's drills and other devices to the dental unit on a dental chair) were being cleaned in line with published guidance and flushed through as required.

Staff were well presented and told us they wore clean uniforms daily and this included reception staff. They also told us that they wore personal protective equipment when treating people who used the service. Staff files reflected that staff had received inoculations against Hepatitis B and received blood tests to check the effectiveness of that inoculation.

The one patient we spoke with after their consultation told us that the dentist and the dental nurse wore protective glasses, visors and gloves while undertaking treatment or examinations.

The practice had undertaken a legionella risk assessment in March 2015 and appropriate control measures were in place and recorded. Legionella is a term for particular bacteria which can contaminate water systems in buildings.

Equipment and medicines

Records we viewed reflected that equipment in use at the practice was regularly maintained and serviced in line with manufacturers guidelines. A fire risk assessment had been conducted by Essex Fire Service and recommendations adopted and actioned. Fire extinguishers were in place throughout the practice and they had been checked and serviced regularly by an external company. Staff had been trained in the use of equipment and evacuation procedures.

Are services safe?

X-ray machines were the subject of regular visible checks and records had been kept. The X-ray equipment had records of critical examination tests to ensure they were emitting the correct levels of radiation.

All equipment used for the cleaning and sterilising of medical instruments had been serviced and maintained regularly. Records reflected that it was in working order at the time of the inspection.

Radiography (X-rays)

X-ray equipment was situated in suitable areas and X-rays were carried out safely and in line with local rules that were relevant to the practice and equipment. These rules described the safe use of X-rays and the procedures to follow if the X-ray equipment failed to operate properly.

A radiation protection advisor and a radiation protection supervisor had been appointed to ensure that the equipment was operated safely and by qualified staff only. Prior risk assessments had taken place, including detailed plans about the location of the X-ray equipment to reduce the risk of radiation exposure to patients.

The practice's radiation protection file contained the necessary documentation covering the names and the qualifications of those permitted to use the equipment. Other staff had signed the procedures section and local rules to demonstrate that they understood the regulations for the safe use of the equipment.

All staff who were involved in taking X-rays were suitably trained and qualified and had received up to date training in relation to dental radiography. Dental nurses and other staff we spoke with were aware of the safety procedures to follow and where to stand when a patient received an X-ray.

The practice conducted regular audits on the quality of the X-rays and records had been maintained over a number of years. Any learning identified was shared with other staff. This ensured that they were of the required standard and reduced the risk of patients being subjected to further unnecessary X-rays.

Patients were required to complete medical history forms to assess whether it was safe for them to receive X-rays. This included identifying where patients might be pregnant. All X-rays were justified and this was recorded in the notes of the patients.

Are services effective?

(for example, treatment is effective)

Our findings

The practice carried out consultations and assessments in line with recognised guidance from the National Institute for Health and Care Excellence (NICE) and General Dental Council (GDC) guidelines. The lead dentist we spoke with was aware of the latest NICE guidelines and the preventative care and advice known as "Delivering Better Oral Health Toolkit". This involved identifying patients at high risk of tooth decay and then taking appropriate action to improve their oral health.

Each patient received an oral examination prior to deciding whether further care and treatment was required. This assessment included an examination covering the condition of a patient's teeth, gums and soft tissue and whether there were any signs of mouth cancer. Patients were then made aware of the condition of their oral health and treatment discussed with them.

At each visit, dentists checked the medical history of each patient and recorded any changes in the patient record. We looked at ten patient records on the day of our inspection and found that they had been completed to a satisfactory standard. There was clear evidence of the record of the examination and the findings and the entries made followed NICE guidance.

Following a consultation X-rays were taken in line with Faculty of General Dental Practice (FGDP) guidelines. This identifies patient's risk factors and gives suggested intervals to take X-rays in order to diagnose or monitor tooth decay. All X-rays taken were justified, graded and reported on and recorded in the clinical records. A diagnosis was then discussed with the patient and appropriate treatment was planned. Care was taken to ensure that patients who were or maybe pregnant were risk assessed before an X-ray was taken.

Patients who required treatment were given a written treatment plan which included details of the treatment required. This also included the costs associated with the treatment.

There was evidence that recall intervals were adjusted to an individual patient's needs. This was in line with NICE guidelines. This recall interval was based on risk factors including tooth decay, gum disease, medical history and soft tissue condition.

Health promotion & prevention

The waiting room and reception area at the practice contained a range of posters that explained the services offered at the practice in addition to information about effective dental hygiene and how to reduce the risk of poor dental health. Free samples of recommended toothpastes were available for patients.

The dentist we spoke with confirmed that adults and children attending the practice were advised during their consultation of steps to take to prevent tooth decay and this was monitored at subsequent visits to ensure it had been effective. Smoking cessation and lifestyle advice were given to patients where appropriate. This was evident in the ten patient records that we viewed.

Patients were recalled at appropriate intervals to check on their teeth to ensure that prevention methods were effective.

Staffing

The practice employed two dentists, both supported by dental nurses. The ratio of dentists to dental nurses was one to one. There were two receptionists at the practice who covered for each other during times of annual leave or sickness. There were sufficient numbers of staff working at the practice to meet the needs of patients.

The practice had been registered with the Care Quality Commission since March 2014 and not all staff working there were due for an appraisal. The lead dentist was in the process of undertaking appraisals on those staff eligible for them

All staff spoken with felt supported and they told us that training was available for them to undertake if it met the needs of patients or was relevant to their future development. They told us that the dentists working at the practice were supportive and always available for advice and guidance.

We found that team meetings were being used to provide support to staff. This included helping them to understand the implications of the Health and Social Care Act regulations, explaining infection control guidance and discussing changes to practice procedures. We viewed staff records and found that training was being monitored.

We looked at the staff files for three members of staff working there and found that they were appropriately

Are services effective?

(for example, treatment is effective)

trained and registered with their professional body and this was checked annually. Staff were encouraged to maintain their continuing professional development (CPD) to maintain their skill levels and certificates were present to reflect that training had been undertaken.

Staff new to the practice went through a role specific induction process. The induction included familiarisation with health and safety procedures and how the practice was managed. New staff received support from other colleagues including personal time with the lead dentist to help them carry out their role.

Staff numbers were monitored and identified staff shortages were planned for in advance wherever possible. Staff had ready access to the procedures and policies of the practice which contained information that further supported them in the workplace.

Working with other services

The practice had systems in place to refer patients for specialist treatment if it was required. These were dealt with on the day of the consultation in the majority of cases. Letters were prepared and information about the patient was included to support the specialist in their consultation.

Consent to care and treatment

Clinical staff spoken with had a clear understanding of consent issues in relation to children, adults and vulnerable persons. They understood that consent could be withdrawn by a patient at any time. The practice had a consent policy in place to support staff. Some dental treatments required written consent and forms were available for this purpose. Patients were made aware that consent could be withdrawn at any time.

Staff were clear about consent in relation to children under the age of 16 years who attended for treatment without a parent or guardian. This is known as Gillick competence. The dentist we spoke with displayed knowledge of the guidelines of the Mental Capacity Act 2005 and explained how they would take consent from a patient if their mental capacity was such that they might be unable to fully understand the implications of their treatment.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We found that staff at the practice treated patients with dignity and respect and maintained their privacy. The reception area was open plan but if a confidential matter arose, a private room was available for use.

The comment cards we reviewed reflected that patients were extremely satisfied with the way they were treated at the practice by clinical and non-clinical staff. They said that they were treated with dignity and respect and their confidentiality maintained.

A data protection and confidentiality policy was in place of which staff were aware. Staff spoken with understood the need to handle patient information securely and had read and signed the policy to reflect that they had understood it.

Patients who had undergone a tooth extraction were supplied with a courtesy bag to support them. This included after-care instructions, guidance on taking pain relief medicine and contact numbers in the event that they required further advice or emergency support.

Involvement in decisions about care and treatment

The ten comment cards we viewed reflected that patients felt that the dentists listened to them and involved them in the decisions about their care and treatment. They told us that consultations and treatment options were clearly explained to them followed up by a written treatment plan that explained the costs involved.

We spoke with one patient on the day of our inspection and were told that explanations were clear and they were involved in the decisions about the care and treatment proposed.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice offered private treatment only and costs were clearly displayed in the practice. The practice had a continuous system of obtaining feedback from patients in order to improve their services.

Patients were given questionnaires to complete on a regular basis and the results were monitored. They also gave new patients a feedback questionnaire to complete after their first consultation at the practice. These questionnaires were used to identify where they could improve.

We found that the results of these surveys reflected that the majority of patients either found the

services good or excellent. Where areas for improvement had been identified these had been actioned.

Tackling inequity and promoting equality

The practice was accessible for those patients with mobility issues, using wheelchairs or mobility scooters and the practice had made reasonable adjustments to accommodate them.

All surgeries were on the ground floor and accessible to all patients. The practice had a toilet that was suitable for use by the disabled. Patients with mobility issues were supported by staff when they needed it.

Access to the service

Appointment times and availability met the needs of patients. The practice was open Mondays, Tuesdays and Thursdays between the hours of 8.45am and 5pm and from 8.10am to 3.30pm on a Friday. They also opened until 7pm on a Wednesday. Information about opening times was displayed for patients to read.

Patients needing an appointment could book by phone or attend the practice personally. Patients with emergencies could usually get an appointment on the same day or within 24 hours. Time was allocated for emergencies each day. A system was in place for patients to obtain emergency dental treatment out of normal surgery hours. An answer phone at the practice directed them to a dentist in the local area that could provide this service.

CQC comment cards we viewed commented positively about the appointment system Text messages were sent to patients to remind them of the day and time they should attend. The one patient spoken with on the day of the inspection told us that they were able to obtain an appointment at a time that suited them.

Concerns & complaints

The practice had a complaint policy that outlined the procedures to follow including the person responsible for handling complaints and the timescales involved. It also made clear to patients the details of other organisations they could contact if they wished to do so.

The complaint procedure was advertised in the reception area. Staff spoken with were aware of the procedure to follow if they received a complaint. There had been one complaint in the last 12 months. The record of this complaint demonstrated that it was dealt with to the satisfaction of the patient concerned. A suitable explanation and an apology had been supplied to the patient.

Are services well-led?

Our findings

Governance arrangements

The lead dentist was responsible for all matters relating to governance. The practice monitored their compliance with the Health and Social Care Act 2008 regulations and it was evident that time and resources had been allocated to achieve compliance with them. There was a clear understanding of the requirements of the act and how it applied to dental practices.

There was a full range of policies and procedures. These included health and safety, infection prevention control, patient confidentiality and clinical decision making. Staff were aware of the policies and they were readily available for them to access. They were required to read them and sign to indicate they had been understood. The policies had been the subject of review and were up to date.

We found that there was a timetable of audits carried out at the practice. There was clear evidence that these were taking place every four months and had been repeated over a number of years. Audits in place included medical histories, patient records, infection prevention control, X-rays and emergency drugs.

The findings of the audits included an analysis and a summary and where areas for improvement had been identified these had been actioned and discussed at team meetings. It was clear from these audits that they were being used to drive improvement and to maintain standards. The repeat audits evidenced that improvements had been maintained.

Leadership, openness and transparency

The practice had a small number of staff members and it was clear that they worked as part of a team. The culture of the practice encouraged, openness, honesty and a duty of candour.

There was strong leadership at the practice by the lead dentist. This was reflected in the way the practice was managed and staff told us that support was made available to them. All documents we viewed were clear and concise. Staff were being managed effectively and supervised to ensure standards were being maintained.

Staff spoken with told us that they were encouraged to report safety issues or to raise any concerns they had. They were aware of whom to raise any issue they would be listened to and their concerns acted upon appropriately. They felt confident that issues raised would be dealt with professionally.

Staff told us that team meetings were used to discuss relevant practice issues and their ideas for improvement were sought. Minutes were being kept of the staff meetings and there was a clear audit trail when improvements had been identified. Staff spoken with told us that they felt part of a team. We were told that there was a no blame culture at the practice and that the delivery of high quality care was part of the practice ethos. Staff told us that they worked in a happy environment and felt supported.

Management lead through learning and improvement

The practice was focused on achieving high standards of clinical excellence and this was monitored by the lead dentist at the practice. Staff at the practice were all working towards a common goal to deliver high quality care and treatment.

Staff meetings were held regularly and when required. Minutes were recorded which reflected that discussions had taken place about practice matters. We looked at the minutes of the last four meetings held this year. We found that safety issues and complaints had been discussed at these meetings to cascade learning to staff.

Meetings were also used to identify training and development needs that would provide staff with additional skills and to improve the experience of patients at the practice. Staff told us that they were encouraged to undertake their continuous professional development and to identify their training needs for development purposes. Staff told us that additional training was provided if requested.

The results of audits undertaken at the practice were used to drive performance and this led to improvements that were of benefit to the staff and the patients.

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

The practice acted on feedback from staff through staff meetings and informally. Staff spoken with told us that they felt part of a team and confirmed that they were consulted about areas for improvement and felt involved in identifying where services could be improved.

Are services well-led?

The practice used questionnaires for patients to help them identify where services could be improved. These included questions about the treatment received by patients, the appointment system, the facilities and cleanliness and staff friendliness and courtesy. The results of the surveys we saw over the last three years reflected that patients were very satisfied with the services provided and the majority of patients graded them as good or excellent.