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Hewlett Road Dental Surgery

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 2nd February 2016

to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Hewlett Road Dental surgery is located in the centre of Cheltenham and provides private treatment to adult patients and NHS treatment to children. The practice consists of two treatment rooms, toilet facilities for patients and staff, a reception/ waiting area, office and a staff room. The practice offers routine examinations and treatment. There are three dentists and two hygienists.

The practice's opening hours are

8.00 to 17.30 on Monday

8.00 to 17.30 on Tuesday

8.00 to 17.00 on Wednesday

8.00 to 17.30 on Thursday

8.00 to 16.00 on Friday

There is an on-call dentist rota for emergencies out of these times.

We carried out an announced, comprehensive inspection on 2nd February 2016. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a dental specialist advisor.

Before the inspection we looked at the NHS Choices website. In the last twelve months there had been no comments about the practice.

For this inspection 29 people provided feedback to us about the service through CQC comment cards. Patients

Summary of findings

were positive about the care they received from the practice. They were complimentary about the service offered which they said was good. They told us that staff were professional, caring, respectful and friendly. Patients told us that the practice was clean and hygienic. We received a few negative comments from seven patients about lack of continuity because of staff changes. Four people commented that there was sometimes a long wait for their appointment.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. 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:

• Safe systems and processes were in place, including a lead for safeguarding and infection control.

• Staff recruitment policies were appropriate and most of the relevant checks were completed. Staff received relevant training.

• Risk assessments were in place and they were regularly reviewed.

• The clinical equipment in the practice was appropriately maintained. The practice appeared visibly clean throughout.

•The process for decontamination of instruments followed relevant guidance.

• The practice maintained appropriate dental care records and these were updated.

• Patients were provided with health promotion advice to promote good oral care.

• Written consent was obtained for dental treatment.

• The dentists were aware of the process to follow when a person lacked capacity to give consent to treatment.

• Feedback that we received from patients was mostly positive. Patients said that they received a caring and effective service.

• There were governance systems at the practice such as systems for auditing patient records, infection control and radiographs.

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

- Review the practice's recruitment policy and procedures to ensure references for new staff are requested and recorded suitably.
- Review the process for monitoring the defibrillator battery to make sure it is working
- Review the process for monitoring and recording of the immunity status of all clinical staff
- Review the system for recording the training and CPD of all staff in the practice so that it is clear that all the staff have up to date relevant training.
- Review the process for team meetings so that staff discuss developments in the practice such as learning from incidents and complaints.

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.

There were appropriate systems for reporting incidents and for learning from incidents. Staff had received training about safeguarding adults and children. There were policies about safeguarding and whistleblowing and staff knew how to report any concerns.

There were also arrangements for dealing with foreseeable emergencies, for fire safety and for managing risks to patients and to staff. There was a business continuity plan. Hazardous substances were managed safely.

Most of the appropriate checks were being made to make sure staff were suitable to work with vulnerable people. However, references were not always obtained. The necessary medicines were in place. Equipment was regularly serviced. X-rays were dealt with safely.

The surgeries were fresh and clean. We found that guidance about decontamination of instruments was being followed to prevent the risk of the spread of infection.

Are services effective?

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

The dentists took X-rays at appropriate intervals. The practice was checking the condition of the gums for every patient and they were checking for oral cancers. Patients completed medical history questionnaires but these were updated at each visit. The practice kept up to date with current guidelines and research. They promoted the maintenance of good oral health through information about effective tooth brushing. The dentists discussed health promotion with individual patients according to their needs.

The practice had sufficient staff to support the dentists. Staff received appropriate professional development and the expected training.

The practice had suitable arrangements for working with other health professionals and making appropriate referrals to ensure quality of care for their patients. Patients were asked for written consent to treatment. The dentists showed understanding about the Mental Capacity Act 2005 (MCA) and what they would do if an adult lacked the capacity to make particular decisions for themselves.

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations. Staff in the practice were polite and respectful when speaking to patients. Patients' privacy was respected and treatment room doors were closed during consultations. The practice used an electronic record system and the computer screens in reception were shielded so that they could not be seen by patients.

Patients were positive about the care they received from the practice. They reported that staff were kind, professional, caring, efficient and friendly. People were given treatment plans by the dentists, which they had signed to show their consent and agreement to them.

Are services responsive to people's needs?

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

Summary of findings

The practice had a system to schedule enough time to assess and meet patients' needs. Most patients who commented said that they could get an appointment easily. Four commented on a long wait to be seen. Emergencies were usually fitted in on the day they contacted the practice. The practice actively sought feedback from patients on the care being delivered. There was a procedure about how to make a complaint and the process for investigation. We saw evidence that the practice responded to feedback made direct to the practice and made changes when necessary. This included extending appointment times so patients had plenty of time for treatment and appointments would not run over.

There was an equality and diversity policy and staff had received training about equality and diversity. Several staff spoke different languages so that they could translate for people whose first language was not English. There was no level access for wheelchair users to the surgeries and people who could not use stairs were offered an appointment at another surgery that had level access. There was a hearing loop system for patients who had a hearing impairment.

Are services well-led?

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

The practice had systems for clinical governance such as audits of infection control, radiographs and record keeping. There were checks of equipment. The autoclave and compressor were serviced and there were daily checks of the autoclave.

The practice had a range of policies which were made available to staff.

The principal dentist was the lead for the practice supported by the practice manager who was new in post. There was a whistleblowing policy and information for staff about the duty of candour and the need to be open if an incident occurred where a patient suffered harm. So far there had been no such incidents.

There were six monthly team meetings and the practice manager planned monthly team meetings where staff could discuss developments in the practice such as learning from incidents. Staff were responsible for their own continuing professional development and kept this up to date.

The practice sought feedback from patients through patient satisfaction feedback forms and these were analysed by the principal dentist annually. There were also comment cards which were considered monthly. The principal dentist had made changes in the practice in response to this feedback.

Hewlett Road Dental Surgery

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 2nd February 2016. 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. We did not receive any information from Healthwatch however, NHS England raised some concerns about the dentist's training and continual professional development.

During our inspection visit, we reviewed policy documents and dental care records. We spoke with three members of staff and three dentists. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We observed the decontamination technician carrying out decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area.

Twenty nine patients provided feedback about the service by completing comment cards. Patients were positive about the care they received from the practice. They were complimentary about the friendly, professional, respectful and caring attitude of the dental staff. However, seven people commented that there had been lack of continuity because of changes of dentists. Four people said that sometimes there was a long wait before their appointment.

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 for reporting and learning from incidents. Incidents were reported to the practice manager or principal dentist, recorded and analysed. Incident report forms were completed and a copy was sent to NHS Gloucestershire and when relevant scanned on to the patient's notes. We saw an accident book. There was information in the front about when an incident needed to be reported to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had been some needlestick incidents in the practice in the past 12 months. A needlestick injury is when a person is injured by a needle or other sharp object. The practice manager said that they followed a needlestick injury protocol and if necessary the member of staff attended the nearby hospital. The principal dentist said that he followed up all accidents and learned from them to prevent reoccurrence. There had been team meetings about once every six months and we saw the minutes of two meetings which did not cover sharing learning from accidents or incidents. However, the new practice manager was setting up monthly team meetings with learning from accidents and incidents as an ongoing agenda item.

The principal dentist had guidance about the duty of candour and being open with patients if they are harmed as a result of their care. They had given each of the dentists a copy of the guidance to follow and placed a copy on the staff notice board.

Reliable safety systems and processes (including safeguarding)

There was a procedure on the wall in each surgery about what to do if a member of staff had a sharps injury. There had been some incidents which had been dealt with according to the protocol. We saw evidence that most staff were immunised against blood borne viruses (Hepatitis B) to ensure the safety of patients and staff. However, there was no evidence that two of the dentists had been immunised. The principal dentist sent us this information after the inspection visit.

The practice had policies and procedures for child protection and safeguarding adults. This included contact details for the local authority social services which were also posted on the office wall. The principal dentist was the safeguarding lead for the protection of vulnerable children and adults. We saw certificates to show that staff had completed e-learning about safeguarding adults and children. Staff would raise concerns with the principle dentist. We spoke with the principal dentist who knew how to make a referral to the safeguarding team if they had a concern. There had been no safeguarding issues reported by the practice to the local safeguarding team. There was a whistleblowing policy which staff could follow if they had concerns about another member of staff's performance.

Medical emergencies

The practice had arrangements to deal with medical emergencies. Staff had received in–house training in emergency resuscitation and basic life support and this was refreshed every year. We saw certificates for this training. The staff we spoke with were aware of the practice procedures for responding to an emergency. During the inspection there was a medical emergency and staff responded according to their medical emergency procedure. They gave the patient emergency treatment to keep them stable until an ambulance arrived and the crew took over. The practice had emergency equipment in accordance with guidance issued by the Resuscitation Council UK. This included relevant emergency medicines and oxygen and 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). There were defibrillator pads for both adults and children. There was no recorded log of who checked the AED to see if the battery was working. The oxygen cylinder and resuscitation mask were in date. The oxygen cylinder was being routinely checked for effectiveness and we saw records for these daily tests. The oxygen cylinder was used on the day of our visit and the principal dentist ordered a new one. We reviewed the contents of the emergency medicines kit. We saw records of weekly and monthly audits of the medicines and equipment. There were two systems for logging the emergency drugs and it was not clear which one staff should follow. As a result we found that some of the emergency medicines were not in date. The principal dentist immediately replaced these with in-date medicines and took away the out of date ones.

Recruitment

Are services safe?

The practice staffing consisted of the principal dentist, three dentists, two hygienists, three dental nurses, a receptionist and a practice manager. Before the inspection we received some information on the CQC website raising concerns about recruitment checks and checks about continual professional development. We looked at the records of recruitment checks for five staff and found that most of them had the right recruitment information. Each member of staff had submitted a curriculum vitae with their employment history and a list of their qualifications and training. They each had a disclosure and barring service (DBS) check and had a copy of their passport as proof of identity and information about their right to work in the UK. Two dentists had only one reference, from their previous employer. One of these had only worked in one practice. One of the nurses had no references. New staff had an induction and probationary period. There was a record of the immunisation status of the nurses, a hygienist and two of the dentists. We saw that appropriate checks of registration with the General Dental Council (GDC) had been carried out for all the qualified staff.

Monitoring Health and Safety and responding to Risk

There were arrangements to deal with foreseeable emergencies. We saw that there was a health and safety policy. The practice had a fire risk assessment dated September 2015 and there were certificates showing that the fire alarm system and emergency lighting had been serviced. There were records of fire drills. The principal dentist said that they aimed to carry out a fire drill every six months and the records confirmed this. There was a health and safety risk assessment for the whole practice dated September 2015. There was a risk assessment, dated November 2015, for the general risks in the practice such as infection control, blood borne virus exposure, decontamination, personal, protective equipment and waste.

There were arrangements to meet the Control of Substances Hazardous to Health 2002 (COSHH) Regulations. There were COSHH risk assessments dated November 2015.

The practice followed national guidelines on patient safety. For example, the practice used a rubber dam for root canal treatments. 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.

The practice had a business continuity plan to ensure continuity of care in the event that the practice's premises could not be used for any reason.

Infection control

There were systems to reduce the risk and spread of infection. There was a decontamination technician who was the infection control lead for the practice. There was a comprehensive infection control policy. Clinical staff were 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. We saw confirmation of this for the nurses and all but one of the dentists. The principle dentist sent us evidence of this dentist's immunisation status following the inspection. 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 toilet. The dentists, nurses and hygienist wore uniforms in the clinical areas and they were responsible for laundering these.

We found that the practice was following relevant guidance about cleaning and infection control. General cleaning was done by a cleaning company and the practice looked clean throughout. The nurses cleaned the surgeries. There was a separation of clean and dirty areas in the surgeries. Three patients we spoke with during our visit said that the practice was always clean and hygienic. Twenty six patients who completed comment cards confirmed that the environment was always clean and hygienic. Ten people who completed comment cards said that he environment was safe and hygienic.

We examined the facilities for cleaning and decontaminating dental instruments in the decontamination room. 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)' when setting up their decontamination room. In accordance with HTM 01-05 guidance dirty instruments were carried from the surgery to the decontamination room in a designated sealed box to ensure the risk of the spread of infection was minimised.

There was a clear flow from 'dirty' to 'clean.' There were two sinks, one for washing and one for rinsing and an ultrasonic bath. The decontamination technician showed

Are services safe?

us the process for decontamination of instruments. They put on personal protective equipment (PPE) including domestic style rubber gloves. They washed the instruments in the washing bowl after testing the temperature of the water and scrubbed the instruments with a long handled brush. They placed the instruments in an ultrasonic bath then rinsed them. They inspected them for debris under an illuminated magnifying glass, placed them on trays and put them into the autoclave to sterilise. An autoclave is a device for sterilising dental and medical instruments.

After the sterilisation cycle was complete they took the instruments out of the steriliser to the clean area of the room, put them into date stamped bags and put them into a clean container to take back to the surgery. The nurses also showed us how they cleaned down the surgeries and sanitised the surfaces between patients.

The autoclave was checked daily for its performance, for example, in terms of temperature and pressure. A log was kept of the results demonstrating that the equipment was working well. The principal dentist said that the autoclaves were serviced annually and we saw certificates for previous years. A service had been done recently. However, the principal dentist told us that they were waiting to receive the certificate.

Procedures to control the risk of infection were monitored as part of the daily checks and the practice had carried out cross infection audits. The practice had an on-going contract with a clinical waste contractor. Waste was being appropriately stored and segregated. This included clinical waste and safe disposal of sharps. There was a Legionella risk assessment (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). This was dated 2012 and further Legionella testing was booked in for 23rd February 2016. We saw a log book of monthly checks of the temperatures at the cold and hot water outlets. The nurse showed us how they flushed the dental water lines in accordance with current guidance in order to prevent the growth of Legionella.

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. We saw a portable appliance testing (PAT) certificate for all electrical items dated 2012. The policy of the practice was to PAT test every three to six years. Following the inspection the principal dentist sent us evidence that PAT testing had been completed. Records of health and safety checks showed that these checks included visual inspection of electrical appliances.

Medicines were stored securely in a cupboard and a designated fridge. Prescription pads were locked in the safe. The defibrillator was stored securely. However, there was no log of checks of the battery to make sure it was working. There was an oxygen cylinder with an up to date certificate. However, this was used on the day of our visit and the principal dentist ordered a new one.

Radiography (X-rays)

There was an X–ray unit in each of the two surgeries. There were suitable arrangements in place to ensure the safety of the equipment. There were logs to show that they were maintained. The name of an external radiation protection adviser (RPA) was made available and the principal dentist was the radiation protection supervisor (RPS). A digital system was used and X-rays were graded as they were taken. We saw records of audits of the radiographs for three dentists.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We reviewed 13 adult dental care records and 10 children's records. The dentists took X-rays at appropriate intervals, as informed by guidance issued by the Faculty of General Dental Practice (FGDP). They also recorded the justification, findings and quality assurance of X-ray images taken. The records showed that an assessment of periodontal tissues was undertaken using the basic periodontal examination (BPE) screening tool. (The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to a patient's gums.)

We found evidence that the practice conducted audits of infection control, radiographs and record keeping. Medical histories were recorded and updated at each visit. This information was kept up to date so that the dentists were informed of any changes in people's physical health which might affect the type of care they received.

We saw evidence that the practice kept up to date with some current guidelines and research in order continually to develop and improve their system of clinical risk management. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to referring patients for removal of wisdom teeth and prescribing antibiotics. They also conducted risk assessments for patients to help them to decide appropriate intervals for recalling patients. We saw evidence that the practice had protocols and procedures in place for promoting the maintenance of good oral health giving due regard to guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'.

Health promotion & prevention

The dentists said that they discussed health promotion with individual patients according to their needs. This included discussions around oral hygiene, use of fluoride, smoking cessation, sensible alcohol use and dietary advice. We saw records of examinations of soft tissue to check for the early signs of oral cancer.

The practice promoted the maintenance of good oral health through information about effective tooth brushing.

We observed that there was some information about tooth brushing displayed in the waiting area. This could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition.

Staffing

The practice had a practice manager, a principal dentist, three dentists, three nurses, two dental hygienists, two receptionists. The principlal dentist told us that all staff received professional development and training. The practice used online training for each job role. Courses for all staff included safeguarding, cardio pulmonary resuscitation, medical emergencies, infection control, decontamination, health and safety, radiography and radiation protection. The dentists, hygienists and the nurses were responsible for their own continuing professional development (CPD.) They logged all their training hours online with the training provider and the General Dental Council (GDC.) We saw certificates to show that staff had received training about and the Mental Capacity Act 2005 (MCA,) safeguarding, cardiopulmonary resuscitation, medical emergencies and infection control. Certificates were kept in individual staff files. However, we noted that there was no central record in the practice of the training and CPD hours the dentists, nurses and hygienists had completed to ensure they were up to date with their training.

The principal dentist told us that they had engaged with the Postgraduate dental deanery at Bristol University to develop a plan to address this. They were following a plan to provide evidence that their clinical practice was conducted to the required standards in relation to diagnosis of disease, record keeping, radiographs, charting, treatment planning, valid consent and root canal treatment.

Annual appraisals were completed by the principal dentist for the nurses and records were seen of these. The principal dentist planned to introduce appraisals for the dentists and hygienists.

Working with other services

The practice had suitable arrangements for working with other health professionals to ensure quality of care for their patients. The dentists used a system of onward referral to other providers, for example, for oral surgery, orthodontics or endodontics. Where there was a concern about oral

Are services effective?

(for example, treatment is effective)

cancer a referral was made to the local hospital. Records showed that referral information was sent to the specialist service about each patient, including their medical history and x-rays.

Consent to care and treatment

The practice ensured that valid consent was obtained for all care and treatment. Records showed that the dentists discussed treatment options, including risks and benefits, as well as costs, with each patient. They provided treatment plans for private treatment and the patient signed these to show consent. NHS patients signed the NHS treatment plans. When treatment was needed for children the dentist obtained consent from their parents.

When we spoke with the dentists we found that they had understanding about the Mental Capacity Act 2005 (MCA.) The 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. One dentist gave examples of how they treated a person if they lacked capacity. They obtained consent for treatment for a person with dementia from their daughter who had power of attorney for the person's health and welfare. If a person lacked capacity and had no-one to act on their behalf they said that they would provide treatment in the person's best interests. We found evidence of training about the MCA for the dentists and nurses.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We observed that patient confidentiality was respected. The practice used an electronic record system. We noted that records were password protected so that they could not be seen by patients. Patients were afforded appropriate privacy as the treatment room doors were closed during consultations. The waiting room was away from the consulting rooms so that conversations could not be heard from the other side of the door. We observed that staff in the practice were polite and respectful when speaking to patients. Patients told us that they were treated with respect.

Patients who completed comment cards, were positive about the care they received from the practice. Patients reported that staff were kind, professional, caring, and friendly. They said that they provided a very good service. One patient commented that the dentist was very good with their children. Three patients we spoke with said that the dentist and nurse were very friendly.

Involvement in decisions about care and treatment

The practice provided treatment plans for private patients which gave options for treatment and indicative costs. There were also clear NHS treatment plans. Written consent was obtained for the dentists' treatment plans showing that people were involved in decisions about their care. One patient we spoke with said that they had signed their treatment plans and the dentist explained treatment to them very clearly so that they could make decisions. The other two patients we spoke with had not needed any treatment. The patient records showed that any issues or options for treatment were discussed with the patient.

Support to cope with care and treatment

One patient commented that they were a little fearful and the dentist put them at ease. Another patient told us that they were nervous of the dentist and their dentist was very helpful with this. The principal dentist told us that the receptionists booked in a longer appointment when a dentist identified that a patient is nervous. They said that they allowed extra time for people with disabilities or with extra needs.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system to schedule enough time to assess and meet patients' needs. The practice reserved an appointment morning and afternoon to see emergencies. Overall patients commented that the staff provided a good service. Two patients told us that the practice was helpful in fitting in appointments when they needed them. One commented that it was difficult to get an early appointment and another patient said that they sometimes waited a long time in the waiting room before an appointment. A third patient said that they had had an appointment cancelled at short notice. The practice actively sought feedback from patients on the care being delivered. There were feedback forms in reception and the principal dentist analysed the responses once a year. There was also a comments box and staff checked this once a month so that they could respond to suggestions.

Tackling inequity and promoting equality

There was an equality and diversity policy dated July 2015 and staff had training about equality and diversity. There were some reasonable adjustments in place. Several staff spoke different languages and could help with translation. There was a loop system for patients with a hearing impairment. The surgeries were on the first floor with level access. There was a stair lift for people who could not manage stairs. However, the layout of the building and stairs meant that they could not provide a service to wheelchair users. People who could not use the stairs were offered a service at another nearby surgery run by the organisation.

Access to the service

The opening hours were displayed in reception and the website. Most patients who commented told us that they had no difficulty getting appointments. Emergencies were usually fitted in on the day they contacted the practice.

Concerns & complaints

There was a procedure about how to make a complaint, including timescales for responding to complaints and the process for investigation. Information about how to make a complaint was displayed in the reception area. Three patients we spoke with knew how to make a complaint. Information about concerns and complaints was logged on the computer. The principal dentist showed us information about formal complaints in the past year. This showed information about seven complaints, the response to each patient who complained and the learning and development points for the practice. The principal dentist said that they discussed the learning points with the other dentists. Changes were also made in response to complaints. For example, in response to a concern that appointment times run over the practice had increased check-up and hygienist appointment times.

Are services well-led?

Our findings

Governance arrangements

The practice had systems for clinical governance. There were audits of emergency medicines, infection control, records and radiographs. We saw that there was a range of policies which were made available to staff. These included safeguarding, whistleblowing, infection control, health and safety, complaints handling, fire safety, risk assessment, and information governance.

The practice carried out regular checks of equipment. We saw evidence that the autoclave and compressor were serviced. The decontamination technician told us that they conducted daily checks of the autoclave and we saw records of these tests. There were checks of the portable electrical appliances.

Leadership, openness and transparency

The principal dentist was the lead for the practice and they were also the lead for safeguarding and medical emergencies. The decontamination technician was the lead for infection control. We saw information for staff about the duty of candour and the need to be open if an incident occurred where a patient suffered harm. So far there had been no such incidents. We saw a whistleblowing policy which was made available to staff.

Management lead through learning and improvement

The principal dentist and practice manager told us that there were team meetings about every six months. We saw the minutes of meetings but they did not show that staff discussed developments in the practice such as learning from incidents and complaints. The practice manager, who was new in post, said that they were introducing monthly staff meetings. Learning from incidents and complaints was one of their planned agenda items. The nurses and dentists told us that they were responsible for their own continuing professional development and kept this up to date. They said that they had training for example for safeguarding, cardio pulmonary resuscitation, medical emergencies and infection control.

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

The practice had effective systems to seek feedback from patients. There were patient satisfaction feedback forms and these were analysed about once a year. There were also patient comment cards. These were analysed once a month. We saw information for patients about the practice's response to recent comments. Examples of changes and improvements included providing more golfing magazines in reception and extending appointment times.