Oasis Dental Care (Central) Limited

Wessex Dental Specialist Centre

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 15 December 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
Wessex Dental Specialist Centre is a dental practice providing specialist private treatment for both adults and children and oral surgery services under NHS arrangements. The oral surgery services are commissioned by local NHS commissioners of services. The practice is based in purpose-built premises in Fareham, a town situated in south Hampshire.

The practice has nine dental treatment rooms. Two of which are based on the ground floor and separate dedicated decontamination room used for cleaning, sterilising and packing dental instruments. The ground floor is accessible to wheelchair users, prams and patients with limited mobility.

The practice employs 15 dentists, two hygienists, 15 dental nurse, eight reception staff and a practice manager.

Summary of findings

The practice's opening hours are between 8am and 7pm on Monday, 8am and 8pm Tuesday, 8am and 6pm on Wednesday and Thursday and 8am and 5pm on Friday.

There are arrangements in place to ensure patients receive urgent medical assistance when the practice is closed.

The practice manager is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) 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.

We obtained the views of 11 patients on the day of our inspection.

Our key findings were:

- We found that the practice ethos was to provide high quality specialist and general dental care in a relaxed and friendly environment.
- Effective leadership was provided by senior clinicians at the practice and an empowered practice manager.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment were readily available in accordance with current guidelines.
- The practice appeared clean and well maintained.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- Infection control procedures were robust and the practice followed published guidance.
- The practice had a safeguarding lead with effective processes in place for safeguarding adults and children living in vulnerable circumstances.
- There was a process in place for the reporting and shared learning when untoward incidents occurred in the practice.
- Dentists provided dental care in accordance with current specialist professional and National Institute for Care Excellence (NICE) guidelines.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Patients could access treatment and urgent and emergency care when required.
- Staff received training appropriate to their roles and were supported in their continued professional development (CPD) by the company.
- Staff we spoke with felt well supported by the senior clinicians and practice manager and were committed to providing a high-quality service to their patients.
- Information from 12 completed Care Quality Commission (CQC) comment cards gave us a positive picture of a friendly, caring, professional and high quality service.

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

- Consider providing the hygienist with the support of an appropriately trained member of the dental team.
- Review the security of the domestic waste bin adjacent to the practice as this presents an arson risk.
- Provide an annual statement in relation to infection prevention control required under The Health and Social Care Act 2008: Code of Practice about the prevention and control of infections and related guidance.
- Review the safety arrangements of the window blinds in the practice, this could include either ensuring the pull cords are made secure or carrying out a suitable risk assessment in relation to the pull cords.
- Review the fire safety governance systems and processes for the practice including fire evacuation times and availability of routes and fire safety training.
- Review the suitability of having an evacuation chair on the premises when trained staff are unavailable.
- Review the facilities in the patient toilet to ensure that the waste bin meets the needs of wheelchair users.

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 robust arrangements for essential areas such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found that all the equipment used in the dental practice was well maintained.

The practice took its responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents.

Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

No action ✓

Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national specialist professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice.

We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals. The staff received professional training and development appropriate to their roles and learning needs.

No action ✓

Are services caring?

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

We obtained the views of 11 patients on the day of our visit. These provided a positive view of the service the practice provided.

All of the patients commented that the quality of care was very good. Patients commented on friendliness and helpfulness of the staff and dentists were good at explaining the treatment that was proposed.

No action ✓

Are services responsive to people's needs?

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

The service was aware of the needs of the local population and took these into account in how the practice was run.

Patients could access treatment and urgent and emergency care when required. The practice provided patients with access to telephone interpreter services when required.

The practice had two ground floor treatment rooms and level access into the building for patients with mobility difficulties and families with prams and pushchairs.

No action ✓

Summary of findings

Are services well-led?

No action

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

Effective leadership was provided by senior clinicians and an empowered practice manager. The clinicians and practice manager had an open approach to their work and shared a commitment to continually improving the service they provided.

There was a no blame culture in the practice. The practice had robust clinical governance and risk management structures in place.

We saw evidence of systems to identify staff learning needs which were underpinned by an appraisal system and a programme of clinical audit. Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council.

Staff told us that they felt well supported and could raise any concerns with the senior clinicians and practice manager. All the staff we met said that they were happy in their work and the practice was a good place to work.

Wessex Dental Specialist Centre

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 15 December 2016. Our inspection was carried out by a lead inspector and a dental specialist adviser.

During our inspection visit, we reviewed policy documents and staff training and recruitment records. We obtained the views of 11members of staff.

We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the systems that supported the patient dental care records. We obtained the views of 11 patients on the day of our inspection.

Patients gave positive feedback about their experience 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

A practice manager we spoke with demonstrated a good awareness of RIDDOR 2013 (reporting of injuries, diseases and dangerous occurrences regulations). The practice had an incident reporting system in place when something went wrong; this system also included the reporting of minor injuries to patients and staff.

Records showed that two accidents occurred during 2015-16 and were managed in accordance with the practice's accident reporting policy.

We saw records of eight incidents that had occurred during 2016. We discussed with the practice manager the action they would take if a significant incident occurred, they detailed a process that involved a discussion and feedback with any patient that might be involved. This indicated an understanding of their duty of candour. Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA). Where relevant, these alerts were shared with all members of staff by the practice manager.

Reliable safety systems and processes (including safeguarding)

We spoke to a dental nurse about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current EU directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne diseases. The practice used a system whereby needles were not manually re-sheathed using the hands following administration of a local anaesthetic to a patient. The practice used a special safety syringe for the administration of dental local anaesthetics to prevent needle stick injuries from occurring. Dentists were also responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps.

We asked the staff how they treated the use of instruments used during root canal treatment. They explained that these instruments were single patient use only. The practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam. They explained that root canal treatment was carried out where practically possible using a rubber dam. 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. Rubber dams should be used when endodontic treatment is being provided.

The practice had a safeguarding lead, the practice manager, who was the point of referral should members of staff encounter a child or adult safeguarding issue. A policy and protocol was in place for staff to refer to in relation to children and adults who may be the victim of abuse or neglect. Training records showed that staff had received appropriate safeguarding training for both vulnerable adults and children. Information was available in the practice that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities.

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. Staff had received training in how to use this equipment.

The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had access to medical oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK

Are services safe?

guidelines. The practice maintained two sets of emergency medicines and oxygen, one on each floor. The emergency medicines and oxygen we saw were all in date and stored in a central locations known to all staff.

The practice held training sessions each year for the whole team so that they could maintain their competence in dealing with medical emergencies. Staff we spoke with demonstrated they knew how to respond if a person suddenly became unwell.

Staff recruitment

All of the dentists, dental hygienist and dental nurses had current registration with the General Dental Council, the dental professionals' regulatory body.

The practice had a recruitment policy that detailed the checks required to be undertaken before a person started work.For example, proof of identity, a full employment history, evidence of relevant qualifications, adequate medical indemnity cover, immunisation status and references.

We looked at five staff recruitment files and records confirmed they had been recruited in accordance with the practice's recruitment policy.

The systems and processes we saw were in line with the information required by regulations. Staff recruitment records were stored securely to protect the confidentiality of staff personal information.

We saw that all staff had received appropriate checks from the Disclosure and Baring Service (DBS). These are 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 or adults who may be vulnerable.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice maintained a comprehensive system of policies and risk assessments which included radiation, fire safety, general health and safety and those pertaining to all the equipment used in the practice.

We noted an emergency evacuation route on the first floor passed through a separate organisation which was only accessible when that organisation was open.

A fire escape route on the ground floor was not accessible to wheelchair users or people with limited mobility as the ground covering to the rear of the property was large pepples. An annual fire drill was carried out in November 2016 but the staff present or evacuation time was not recorded. We were told that staff training in Fire Safety had not been carried out for all staff in the previous 12 months. We spoke with the practice manager about these shortfalls and were assured a fire drill and training would be carried out as soon as practicably possible.

The practice had in place a well maintained Control of Substances Hazardous to Health (COSHH) file. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients.

We noted that the domestic waste bins to the rear of the practice were not secure and could pose as an arson risk. Window blinds in the practice with hanging pull cords which were insecure and available to unauthorised people.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The practice had in place an effective infection control policy that was regularly reviewed. It was demonstrated through direct observation of the cleaning process and a review of practice protocols that HTM 01 05 (national guidance for infection prevention and control in dental practices) Essential Quality Requirements for infection control was being exceeded. It was observed that audit of infection control processes carried out in March and September 2016 confirmed compliance with HTM 01 05 guidelines.

We found the practice did not produce an annual statement in relation to infection prevention control required under The Health and Social Care Act 2008: Code of Practice about the prevention and control of infections and related guidance.

We saw that the nine dental treatment rooms, waiting area, reception and toilets were visibly clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available including liquid soap and paper towel dispensers in each of the treatment rooms. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

Are services safe?

The drawers of two treatment rooms were inspected and these were clean, ordered and free from clutter. Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

The dental nurse we spoke with described to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. They demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a term for particular bacteria which can contaminate water systems in buildings); they described the method they used which was in line with current HTM 01 05 guidelines. We saw that a Legionella risk assessment had been carried out at the practice by a competent person in May 2016. The recommended procedures contained in the report were carried out and logged appropriately. These measures ensured that patients and staff were protected from the risk of infection due to Legionella.

The practice had a separate decontamination room for instrument cleaning, sterilisation and the packaging of processed instruments. This was staffed by a decontamination assistant. They demonstrated the process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a combination of an ultra-sonic cleaning bath and manual scrubbing for the initial cleaning process, following inspection with an illuminated magnifier; the instruments were dried with a lint free drying cloth, pouched and pouches were dated with an expiry date in accordance with current guidelines; the pouched instruments were then placed in an autoclave (a device for sterilising dental and medical instruments).

We were shown the systems in place to ensure that the autoclaves used in the decontamination process were working effectively. It was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were complete and up to date. All recommended tests utilised as part of the validation of the ultra-sonic cleaning bath were carried out in accordance with current guidelines, the results of which were recorded in an appropriate log file.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers and clinical waste was properly maintained in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. The clinical waste was stored in a separate locked location adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection.

We saw that general environmental cleaning was carried out according to a cleaning plan developed by the practice. Cleaning materials and equipment were stored in accordance with current national guidelines.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclaves had been serviced and calibrated in December 2016. The practice's X-ray machines had been serviced and calibrated as specified under current national regulations in 2015 and were due to be tested again in 2018.

Portable appliance testing (PAT) had been carried out in July 2015.

The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored securely.

The practice had in place a prescription logging system to account for the prescriptions issued to prevent inappropriate prescribing or loss of prescriptions. The practice also dispensed their own medicines as part of a patients' dental treatment for certain oral surgery procedures. These medicines were a range of antibiotics, the dispensing procedures were in accordance with current secondary dispensing guidelines and medicines were stored according to manufacturer's instructions

We saw that there was a recording system for the prescribing and recording of the medicine temazepam, which is used in situations where a patient required oral

sedation, this included the reversal agent for the sedative medicine if required. There was a written system of stock control and the secure storage for the medicine used in oral sedation.

We observed that the practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid and mercury spillage.

Radiography (X-rays)

We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the three yearly maintenance logs and a copy of the local rules. The local rules must contain the name of the appointed Radiation Protection Advisor, the identification and description of each controlled area and a summary of the arrangements for restriction access. Additionally, they must summarise the working instructions, any contingency arrangements and the dose investigation level.

We were shown that a radiological audit for each dentist had been carried out in 2016. Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured. These findings showed that the practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. We saw training records that showed staff where appropriate had received training for core radiological knowledge under IRMER 2000 Regulations.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The specialist and generalist dentists carried out consultations, assessments and treatment in line with recognised specialist and general professional guidelines. We looked at a range of dental care records across the specialist services provided. This included root canal therapy, periodontology and oral surgery as well as general dental services. The records we saw were very detailed, complete and fit for purpose.

Some patients attending the practice required conscious sedation as part of their treatment. The practice used a visiting medical anaesthetist to provide this service. To provide assurance that the visiting professional was providing services in accordance with current guidelines, the practice has a written agreement in place.

The governance systems supporting safe sedation included a sedation file that contained pre-and post-sedation treatment checks, emergency equipment requirements, medicines management, sedation equipment checks, personnel present, patient's checks including consent, monitoring of the patient during treatment, discharge and post-operative instructions and staff training.

We found that patients were appropriately assessed for sedation. We saw dental care records that showed that all patients undergoing sedation had important checks made prior to sedation this included a detailed medical history, blood pressure and an assessment of health using the American Society of Anaesthesiologists classification system in accordance with current guidelines. The records demonstrated that during the sedation procedure important checks were recorded at regular intervals which included pulse, blood pressure, breathing rates and the oxygen saturation of the blood. The measures in place ensured that patients were being treated safely and in line with current standards of clinical practise.

Health promotion & prevention

The practice was focused on the prevention of dental disease and the maintenance of good oral health for patients attending for general dental services as well as specialist care. To facilitate this aim, the practice appointed two dental hygienists to work alongside of the dentists in delivering preventative dental care.

Staffing

We observed a friendly atmosphere at the practice. All clinical staff had current registration with their professional body, the General Dental Council.

We noted that the external name plate which detailed names of the dentists working at the practice did not include their General Dental Council (GDC) registration number in accordance with GDC guidance from March 2012. We were told the practice was soon to be rebranded, with new signage outside, including GDC numbers, in the meantime these were all displayed on the Patient Information board in the patient foyer.

All of the patients we asked told us they felt there was enough staff working at the practice. Staff told us there were enough staff. Staff we spoke with told us they felt supported by the dentists and practice manager. They told us they felt they had acquired the necessary skills to carry out their role and were encouraged to progress.

The practice employed 15 dentists, two hygienists, 15 dental nurse, eight reception staff and a practice manager.

There was a structured induction programme in place for new members of staff.

The dental hygienists did not always work with chairside support. Sometimes this was down to hygienist preference. The practice manager explained that if the hygienist did require support this was always provided by the practice.

Working with other services

Wessex Dental Specialist Centre is a practice which accepts referrals from other practices and therefore does not need to refer patients to other service very often. The practice manager explained how they would work with other services when required. The practice used referral criteria and referral forms developed by secondary care providers such as consultant oral surgery services.

Consent to care and treatment

A dentist who specialised in oral surgery explained how they implemented the principles of informed consent; they had a very clear understanding of consent issues. The dentist explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure

Are services effective?

(for example, treatment is effective)

they had an understanding of their treatment options. The dentist explained that this approach to obtaining informed consent was common across the specialists who provided care at the practice.

The dentist went on to explain how they would obtain consent from a patient who suffered with any mental impairment that may mean that they might be unable to fully understand the implications of their treatment. If there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed. They added they would involve relatives and carers if appropriate to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005. Although the dentist treated children very rarely they were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. Again, the dentist explained that this approach to obtaining informed consent from patients who lacked capacity or children who were Gillick competent was common across the specialists who provided care at the practice.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting areas and we saw that doors were closed at all times when patients were with dentists.

Conversations between patients and dentists could not be heard from outside the treatment rooms which protected patients' privacy. Patients' clinical records were stored in both electronic and paper formats. Computers which contained patient confidential information were password protected and regularly backed up to secure storage; with paper records stored in an area of the practice not accessible to unauthorised members of the general public.

Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff were aware of the importance of providing patients with privacy and maintaining confidentiality.

We obtained the views of 12 patients prior to the day of our visit and 11 patients on the day of our visit. These provided a wholly positive view of the service the practice provided. All of the patients commented that the dentists were good at treating them with care and concern. Patients commented that treatment was explained clearly and the staff were caring and put them at ease. They also said that the reception staff were helpful and efficient. During the inspection, we observed staff in the reception area, they were polite and helpful towards patients and the general atmosphere was welcoming and friendly.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs.

The dentist we spoke with paid particular attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we looked at examples of information available to patients. We saw that the practice waiting area displayed a variety of information. These explained opening hours, emergency 'out of hours' contact details and arrangements and how to make a complaint. The practice website also contained useful information to patients such as how to provide feedback to the practice and details of the types of treatment offered by the practice. We observed that the appointment diaries were not overbooked and that this provided capacity each day for patients with dental pain to be fitted into urgent slots for each dentist.

The dentists decided how long a patient's appointment needed to be and took into account any special circumstances such as whether a patient was very nervous, had an impairment and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to help prevent inequity for patients that experienced limited mobility or other barriers that may hamper them from accessing services.

We noted that a number of improvements could be made including the provision of a hearing loop for patients who were hearing aid users. We spoke to the practice manager about this and a hearing loop was purchased during our visit.

An evacuation chair was situated at the top of the stairs to the first floor treatment rooms. This is a chair used to evacuate a person who is unable to independently walk down stairs in an emergency evacuation. We were told two staff at the practice had been trained to use it. We asked the practice to consider the availability of the chair when these staff were not available which would restrict access to the first floor for patients who may need the chair in an emergency situation.

The practice used a translation service, which they arranged if it was clear that a patient had difficulty in understanding information about their treatment.

To improve access for patients who found steps a barrier, the practice had level access and two treatment rooms were on the ground floor. A wheelchair accessible toilet was available but the waste paper foot operated bin was not accessible to wheelchair users.

Access to the service

The practice's opening hours were between 8am and 7.30pm on Monday, 8am and 8.30pm Tuesday, 8am and 6pm on Wednesday and Thursday and 8am and 5pm on Friday.

We asked 11 patients if they were satisfied with the hours the surgery was open; all but one patient said yes.

There are arrangements in place to ensure patients receive urgent medical assistance when the practice was closed. This information was publicised in the practice information booklet kept in the waiting area and on the telephone answering machine when the practice was closed.

Concerns & complaints

There was a complaints policy which provided staff with information about handling formal complaints from patients. Staff told us the practice team viewed complaints as a learning opportunity and discussed those received in order to improve the quality of service provided.

Information for patients about how to make a complaint was available in the practice's waiting room. This included contact details of other agencies to contact if a patient was not satisfied with the outcome of the practice investigation into their complaint.

We asked 11 patients if they knew how to make a complaint if they had an issue and all but one said yes.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was an effective system in place which ensured a timely response.

For example, a complaint would be acknowledged within two working days and a full response would be given in 10 days. We saw a complaints log which listed nine complaints received over the previous year which records confirmed seven had been concluded satisfactorily and two were ongoing.

Are services well-led?

Our findings

Governance arrangements

The governance arrangements of the practice were developed through a process of continual learning and improvement. The governance arrangements for this location consisted of an empowered practice manager who was responsible for the day to day running of the practice.

The practice maintained a comprehensive system of policies and procedures using a commercially available dental clinical governance system. All of the staff we spoke with were aware of the policies and how to access them. We noted management policies and procedures were kept under review by the practice manager on a regular basis.

Leadership, openness and transparency

Effective leadership was provided by the practice manager. The practice ethos focussed on providing high quality specialist patient centred dental care in a relaxed and friendly environment. The comment cards we saw reflected this approach.

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said they felt comfortable about raising concerns with the practice manager. There was a no blame culture within the practice. They felt they were listened to and responded to when they did raise a concern. We found staff to be hard working, caring and committed to the work they did.

All of the staff we spoke with demonstrated a firm understanding of the principles of clinical governance in dentistry and were happy with the practice facilities. Staff reported that the practice manager was proactive and aimed to resolve problems very quickly. As a result, staff were motivated and enjoyed working at the practice and were proud of the service they provided to patients.

Learning and improvement

We saw evidence of systems to identify staff learning needs which were underpinned by an appraisal system and a programme of clinical audit. For example, we observed that all staff received an annual appraisal. There was a system of peer review in place to facilitate the learning and development needs of the dentists and dental nurses which took place on an annual basis.

We found there was a rolling programme of clinical and non-clinical audits taking place at the practice. These included infection control, clinical record keeping and X-ray quality. The audits demonstrated a comprehensive process where the practice had analysed the results to discuss and identify where improvement actions may be needed.

Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. Staff told us that the practice ethos was that all staff should receive appropriate training and development.

The practice manager encouraged staff to carry out professional development wherever possible. The practice used a variety of ways to ensure staff development including internal training and staff meetings as well as attendance at external courses.

The practice ensured that all staff underwent regular mandatory training in cardio pulmonary resuscitation (CPR), infection control, child protection and adult safeguarding and dental radiography (X-rays).

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

The practice gathered feedback from patients through surveys, compliments and complaints. We saw that there was a robust complaints procedure in place, with details available for patients in the waiting area.

Results of the most recent practice survey carried out indicated that 100% of patients, who responded, said they would recommend the practice to a family member or friend.

As a result of patient feedback the practice started to broadcast news on its television screen in the waiting area.

Staff told us that the dentists were very approachable and they felt they could give their views about how things were done at the practice. Staff told us that they had frequent meetings and described the meetings as good with the opportunity to discuss successes, changes and improvements. For example, changes included the provision of more room to change for female staff.