Oasis Dental Care (Central) Limited

St Neots

Inspection Report

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Ratings

Overall rating for this service	No action ✓
Are services safe?	No action ✓
Are services effective?	No action ✓
Are services caring?	No action ✓
Are services responsive?	No action ✓
Are services well-led?	No action ✓

Overall summary

We carried out an announced comprehensive inspection on 13 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

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?

Summary of findings

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

Background

St Neots (also known as Market Square Dental Practice) is part of the Oasis Dental Care network. The service provides a range of dental services for mainly private patients which accounts for approximately 75% of their work. The remaining 25% of the dental service provides NHS dentistry. The practice is situated in the centre of the town with several public car parks close by. The practice has five dental treatment rooms and a separate decontamination room for cleaning, sterilising and packing dental instruments. The building is on two levels with dental services provided on the ground and first floors.

The practice opens 8am to 7pm Monday to Wednesday and 8.15 am to 5.15pm on Thursday and Friday. The practice employs five dentists and a dental hygiene therapist. They are supported by a team of five dental nurses (two of whom also cover reception), one receptionist, a practice manager and a service co-ordinator. The company also employs a field nurse to cover practices in the local area and one field nurse was also based at St Neots.

At the time of the inspection, the practice manager was the registered manager but was due to take up a new post within the company the following week. A new manager had been appointed who would apply to become the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

We received feedback from five patients either in person or on CQC comments cards from patients who had visited the practice in the two weeks before our inspection. The feedback we received was all positive and patients told us the staff were caring and had a helpful attitude. Patients also told us they were happy with the care and treatment they had received.

Our key findings were:

- There was appropriate equipment for staff to undertake their duties and the equipment was well maintained.
- Staff had been trained to handle emergencies and life-saving equipment was readily available in accordance with current guidelines. Emergency medicines were available in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice. We found that a medicine used for the treatment of diabetic patients had not been stored correctly. The practice took immediate action to replace it.
- Infection control procedures were in place and followed by staff.
- Dentists provided dental care in accordance with current professional and National Institute for Care Excellence (NICE) guidelines
- The practice appeared clean and free from clutter.
- Staff received training and development and an annual appraisal.
- Patients told us they were able to get an appointment when they needed one and the staff were kind and helpful.
- Governance arrangements were effective in monitoring the quality of the service. Action was taken following most completed audits to help make improvements although there was no evidence of an analysis or actions following the last infection control audit. Patient feedback was sought, considered and appropriate actions were taken.

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

- Review the current legionella risk assessment and infection control audit to ensure that ant required actions are completed.
- Review the practice's sharps procedures giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013
- Review the protocol for completing accurate, complete and detailed records relating to employment of staff. This includes making appropriate notes of verbal reference taken and ensuring recruitment checks, including references, are suitably obtained and recorded.
- Review the monitoring systems used to ensure staff are up to date with their mandatory training and their Continuing Professional Development.

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?

No action

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

The practice had effective arrangements in place for managing infection control, clinical waste, medical emergencies and dental radiography (X-rays). However, we found that a medicine used for treating diabetic patients in an emergency situation was not correctly stored. The equipment used in the dental practice was well maintained. However, the practice had not yet considered safe systems for the management of sharp instruments in line with the Safer Sharps Regulations 2013. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents. There were sufficient numbers of suitably qualified staff working at the practice. However, recruitment records were not always checked or completed in a timely manner. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

Are services effective?

No action

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 professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. Staff we spoke with described the care and treatment approach they used with their patients to ensure good patient outcomes. The staff received professional training and development appropriate to their roles and their learning and support needs were reviewed through an annual appraisal. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

Are services caring?

No action

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

Staff treated patients with dignity and respect and ensured their privacy was maintained. Patient information and data was handled confidentially. We received feedback from five patients who used the service. They told us the quality of dental care was very good and staff were welcoming, treated them with respect and were friendly and supportive.

Are services responsive to people's needs?

No action

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

Appointment times met the needs of patients and waiting times were kept to a minimum. Patients could access treatment and urgent and emergency care when required. The practice had made reasonable adjustments to the service to ensure it was accessible and the service

Summary of findings

could be tailored to individual needs. Information was available to patients and there was access to interpreter services if this was required. The practice was on one level which made it accessible to patients with mobility difficulties and families with prams and pushchairs. A complaints process was in place and we saw these had been well managed.

Are services well-led?

No action

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

The practice manager and staff had an open approach to their work and worked together as a team to continually improve the service. Governance procedures were in place. Policies and procedures were regularly updated and quality monitoring checks were used to measure performance and take improvement actions when it was required. However, we found the practice had no clear system for monitoring progress with training and improvement was needed to recruitment records and the labelling of prescribed medicines supplied to the patient.

Patient feedback was sought, considered and acted upon. Staff told us that they felt well supported and could raise any concerns with the practice manager or dentists.

St Neots

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

This inspection took place on 13 December 2016 and was led by a CQC Inspector who was supported by a specialist dental advisor. Before the inspection, we asked the practice to send us some information for review and this included a summary of complaints received.

During the inspection we spoke with two dentists, three dental nurses, the practice manager and two reception staff. We reviewed policies, procedures and other documents. We also obtained the views of four patients on the day of the inspection and received six comment cards that we had provided for patients to complete during the two weeks leading up to the inspection.

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 process in place for reporting and recording accidents, incidents and significant events. An accident book was in place and we saw that two accidents had been reported during the last two years. We saw that two significant events had been reported in the last two years. All accidents, incidents and significant events were recorded, reported to head office and appropriate action taken. There were also examples of learning from these incidents. For example when mercury was found in the autoclave (used to sterilise dental instruments) the incident was discussed at a team meeting and a change in policy was put in place.

The practice manager described the process used for reporting of RIDDOR (The reporting of injuries diseases and dangerous occurrences regulations) incidents to head office.

The practice manager received national patient safety alerts such as those relating to medicines or the safety of clinical equipment. These were shared with the dentists and dental nurses as appropriate and we found that staff were aware of recent alerts.

The practice manager had a broad understanding of the principles of the duty of candour and we saw that patients had received an apology when they experienced a poor service.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for safeguarding vulnerable adults and children which linked to the local guidelines. The practice manager was the designated lead for safeguarding concerns and escalated these to the corporate safeguarding lead to advise on further action. Information on the reporting process was visible and accessible to staff who had received relevant training and were able to demonstrate sufficient knowledge in recognising safeguarding concerns. There had been no referrals made.

We spoke with dentists and dental nurses to ask about the use of rubber dam for root canal treatments and found this was in routine use. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work. Staff were able to describe their assessment of the risk and the importance of documenting this in the patient's dental care record.

Medical emergencies

Staff had access to an automated external defibrillator (AED) in line with Resuscitation Council UK guidance and the General Dental Council (GDC) standards for the dental team. 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. Staff checked this equipment on a daily basis to ensure it was ready for use. Additional equipment for use in medical emergencies included oxygen which was checked on a weekly basis to ensure the cylinder was full and within its expiry date. The practice also held medicines and equipment used for managing medical emergencies for diabetic patients with a low blood sugar level. This medicine was stored in a medicines fridge. However, we found the fridge temperature was too high to store the medicine safely. Daily temperature checks were in place but these did not include a check of the maximum and minimum temperature to ensure the medicine was stored at the correct temperature. The practice manager ordered a replacement medicine and agreed to review its storage in line with manufacturer's guidelines. Staff had received update training in dealing with medical emergencies and practiced the management of emergency scenarios twice a year.

The practice had emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice. We checked the emergency medicines and saw that the items were all within their expiry dates. There was a system in place to ensure that the dental nurses checked the expiry dates of medicines on a weekly basis.

Staff recruitment

All of the employed dental professionals had current registration with the General Dental Council, the dental professionals' regulatory body.Staff recruitment records were stored securely in a locked cabinet to protect the confidentiality of staff personal information. We saw that relevant staff had received appropriate checks from the Disclosure and Barring Service (DBS). These are checks to

Are services safe?

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.

The practice followed a detailed recruitment policy that included 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 and references. We reviewed the recruitment files for three staff that had joined the practice within the last two years. We found there was proof of identification, professional registration (where relevant) training and experience. However, there was no record of an interview process for any staff. There were no references or a DBS check for one member of staff who also worked at another location run by the provider. This was because the documents had not been shared or copied to them. Another member of staff had commenced employment three months prior to the practice receiving a satisfactory employment reference. This demonstrated that recruitment checks were not always completed in a timely manner.

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 manager led on health and safety issues and there were a number of general risk assessments in place. These included lone working, slips, trips and falls and the operation of key equipment. The assessments were detailed but required a review. Assessment information for the Control of Substances Hazardous to Health (COSHH) was available and included a wide range of dental and cleaning materials. Safety kits were available in the practice for cleaning and disposing of spillages of mercury or body fluids in a safe way. A first aid kit was also available and there was a designated first aider.

The practice had procedures in place to for staff to follow if they were injured with a sharp dental instrument. No such injuries had occurred during the last two years. Dentists handled sharp instruments and ensured safe disposal of them. We found the practice had not yet considered the use of safer style syringes to reduce the risk of injury although they were moving towards the use of disposable matrix bands for all dentists. A sharps risk assessment had been completed in February 20016. Relevant staff had received immunisation for Hepatitis B and records were monitored.

A fire risk assessment had been completed in December 2016 with minimal recommendations. Fire drills took place at six monthly intervals. Staff received fire training and there were three members of staff with responsibility for being a fire marshal.

The practice had a business continuity plan in place to deal with any emergencies that could disrupt the safe and smooth running of the service. Copies of the plan were held by senior members of staff and a copy was stored at the reception.

Infection control

The lead dental nurse had overall responsibility for ensuring that effective decontamination processes were being followed. The practice had an infection control policy that was regularly reviewed. It was demonstrated through direct observation of the cleaning process, discussion with staff and a review of practice protocols that HTM 01 05 (national guidance for infection prevention control in dental practices') Essential Quality Requirements for infection control were being met.

An infection control audit was last completed in July 2016. However there was no evidence that the results were considered, discussed or actioned.

We saw that the dental treatment rooms, waiting area, reception and toilet were clean, tidy and clutter free. In the treatment rooms, there were clearly marked areas to separate the clean from dirty areas to prevent any cross contamination. Hand washing facilities were available including liquid soap and paper towel dispensers in each of the treatment rooms and toilet. Hand washing protocols were also displayed appropriately in various areas of the practice.

The practice had a separate decontamination room for instrument processing. The dental nurse working in the decontamination room demonstrated the process from taking the dirty instruments through the cleaning process to ensure they were fit 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. Once items had been cleaned, they were stored in a central clean storeroom.

There were systems in place to ensure that the equipment used in the decontamination process was working effectively. Records showed that regular daily, weekly and monthly validation tests were recorded in an appropriate log book. The practice had three autoclave machines for sterilising dental instruments. Two were in regular use however one was only used on occasional basis therefore tests were run before and after its use. The practice manager has since sought advice from the manufacturer and a weekly test has been put in place. 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). Dental nurses described the method they used which was in line with current HTM 01 05 guidelines. A legionella risk assessment had been completed in May 2016. We saw that some recommendations from this had been actioned by the practice and the report containing other recommendations had been shared with the provider at head office. No additional action had been taken by them to ensure that all of the recommendations were addressed.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. Arrangements were in place to ensure that an approved contractor removed clinical waste from the premises on a weekly basis. We observed that sharps containers, clinical waste bags and municipal waste were properly managed although staffs was not aware that sharps bins should be replaced after three months of use as maximum time Cleaning equipment for the premises was stored in line with current guidelines. A contracted cleaner was responsible for the general cleaning and completed daily schedules to demonstrate that cleaning had taken place. The dental nurses were responsible for clinical cleaning and records of this were maintained.

Equipment and medicines

There were systems in place to check that the equipment had been serviced regularly and in accordance with the manufacturer's instructions. Items included the items used for decontamination of the dental equipment, electrical items and firefighting equipment. There was no contract to service the dental chairs but the practice manager has since confirmed that servicing has now been arranged.

An effective system was in place for the prescribing, dispensing, use and stock control of the medicines used in clinical practice such as antibiotics and local anaesthetics. We found that the practice stored prescription pads securely and had a clear tracking system to monitor prescriptions that were issued. Prescriptions for antibiotics were issued appropriately although we noted that boxes of medicines supplied did not include the address of the dental practice or the name of the dentist who had prescribed the treatment.

Radiography (X-rays)

The practice had 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 Advisors for the practice and the Radiation Protection Supervisor. It also included the necessary documentation in relation to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for each X-ray set along with the three yearly maintenance logs and a copy of the local rules. The maintenance logs were within the current recommended interval of three years.

We saw that radiographic audits were completed regularly and actions were taken in response to any findings. Dental care records included information when X-rays had been taken, how these were justified, reported on and quality assured. This showed the practice was acting in accordance with national radiological guidelines to protect both patients and staff from unnecessary exposure to radiation. Training records showed all staff where appropriate, had received training for core radiological knowledge under IRMER 2000.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists we spoke with carried out consultations, assessments and treatment in line with recognised general professional guidelines. Patients completed a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered and these were updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and observing for the signs of mouth cancer. Dental records we were shown demonstrated this process was followed. Patients were informed of the condition of their oral health including whether it had changed since the last appointment. The outcomes of the assessment were discussed with the patient and treatment options were explained to them if relevant.

Patients were provided with preventative dental information which included dietary advice and general dental hygiene procedures to help improve patient outcomes. The patient's dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through attendance of follow up appointments at regular and appropriate intervals in accordance with their individual need.

Staff we spoke with described ways they assessed the condition of patient's gums and soft tissues of the mouth using the basic periodontal examination (BPE) scores. The BPE score is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need. These were completed as part of a dental health assessment.

Health promotion & prevention

The dentists focussed on the preventative aspects of their practice to promote better oral health and dental hygiene. A dental hygiene therapist worked alongside the dentists to deliver preventive dental care. Appropriate internal referrals were made and patients could also self-refer. Patients received advice during their consultation of the steps to take in order to maintain healthy teeth. This included dietary, smoking and alcohol advice. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. Fluoride varnish was applied for children on a biannual basis and high concentration fluoride toothpaste was prescribed for patients at risk of dental caries.

The waiting room and reception area contained leaflets that explained the services offered at the practice. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area.

Staffing

The practice employed four dentists and a dental hygiene therapist. They were supported by a team of five trained dental nurses, one receptionist, a practice manager and a service co-ordinator. The staff were further supported by a corporate management and advisory team. Staff we spoke with told us they had enough staff to meet patient's needs.

Staff had access to essential training through the company's training academy and we saw records that showed staff completed core training through eLearning as well as in person. This included areas such as responding to medical emergencies. The practice manager did not yet have a system in place to monitor progress with staff training and had some plans to develop this.

An induction programme was in place for staff and these included regular reviews with their line manager through the three month probationary period. However, we found the field nurse did not have a bespoke induction to support the diverse nature of the role.

An appraisal system was in place to ensure that staff received an annual performance review. The practice manager also conducted a mid-year review to monitor progress with any development plans and review performance. Staff confirmed that the appraisal process was helpful and they were able to discuss their training and development needs with the practice manager who was very supportive.

Working with other services

When required, patients were referred to other dental specialists for assessment and treatment. The practice had a system in place for referring and recording patients for dental treatment and specialist procedures such as orthodontics, oral surgery and sedation. Where possible patients were offered a choice about the service they could

Are services effective?

(for example, treatment is effective)

be referred to so that the waiting time for an appointment could also be taken into consideration. We saw that dental records were updated with referral details and outcomes. Patients were offered a copy of their referral letters.

The dentists completed external referrals following discussion with the patient. Staff told us the care and treatment required was fully explained to the patient and referrals were completed promptly. The practice manager monitored referrals to ensure they were completed promptly and ensured that the patients' treatment was monitored once they had been referred back to the practice.

Consent to care and treatment

We found the practice staff sought valid consent from patients for all care and treatment. Staff confirmed individual treatment options, risks and benefits were discussed with each patient who then received a detailed treatment plan and an estimate of costs. This information was recorded in dental care records. Staff told us that if a patient was unable to give their consent, the treatment would not be completed.

Requests for patient information were not issued to a third party without the written consent of the patient.

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for them. All staff had received training in the MCA and were able to discuss competency issues with confidence and this included the Gillick test. This is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The reception desk and waiting area were in separate areas and this helped to minimise the risk of patients overhearing private conversations or personal details being discussed. The reception staff were very aware of their responsibilities in maintaining confidentiality and not disclosing personal information during conversations with patients at the reception desk or on the telephone. Patients could be taken to a more private area to discuss their needs if they preferred to do so. Treatment rooms were situated away from the waiting area and doors were closed at all times when patients were with dentists so that treatment and conversations remained private.

Patients' clinical records were stored electronically and computers were password protected. Practice computer screens could not be overlooked.

Before the inspection, we sent Care Quality Commission (CQC) comment cards to the practice for patients to share their experience of the practice. We received feedback from five patients as part of the inspection either through CQC patient comment cards or through speaking with patients on the day of our visit. The feedback gave a very positive view of the service. Patients told us the quality of dental care was very good and staff were welcoming, treated them with respect and were friendly and supportive.

During the inspection we observed that practice staff were polite and helpful towards patients. We saw that staff gave additional time and support to a patient who had not understood the treatment they had received during their consultation. The general atmosphere in the practice was welcoming and the staff knew the needs of their patients particularly when they required additional support.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed their treatment options and indicative costs. A poster detailing NHS and private treatment costs was displayed in the waiting area and similar information could be found on the practice website. Patients we spoke with confirmed that the dentists always explained their dental health needs and provided them with advice to enable them to make decisions about their treatment. We found 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

The practice waiting area contained an information folder for patients about the practice. This included opening times, access to urgent care out of hours, the code of practice and how to raise any concerns about the service. Other information displayed included costs for NHS and private dental care, dental care plans, basic dental health information and a copy of the standards for dentistry care issued by the General Dental Council providing details about what patients can expect from their dentist.

We reviewed the appointments system with reception staff and found that there were a sufficient number of available appointments. On the day of the inspection, there were appointments available for routine checks within two to three weeks. The practice did not hold appointments designated for emergency appointments as they were usually able to accommodate such requests at short notice. There was also capacity to arrange follow up appointments and the dentists advised when these should take place.

Staff took into account any special circumstances such as whether a patient had a disability and the level of complexity of treatment and booked the length of appointment that was most relevant to the patient's need. Staff told us they ensured that nervous patients were booked into appointments with staff they knew and trusted. Patients told us they were satisfied with the response they received from staff when they required treatment or an urgent appointment.

Tackling inequity and promoting equality

The treatment rooms were situated on the ground floor which made it very accessible to patients with disabilities. There was an accessible toilet and baby change facilities also available.

A hearing loop was available in the reception area and staff told us they used an interpreting service when patients did not have a suitable family member to attend with them. Staff explained that they provided support for patients who may need additional help to understand their treatment options or plans. They were also able to give examples of helping patients who had limited mobility and those who were partially sighted. The staff team told us they knew many of their registered patients who had been attending the practice for several years. This enabled them to respond appropriately and ensure that all patients had access to care and treatment particularly those who were more vulnerable. Staff demonstrated that patients were treated with respect and compassion.

Access to the service

The practice was open 8am to 7pm Monday to Wednesday and 8.15 to 5.15pm on Thursday and Friday. Patients registered with the practice were provided with an emergency contact number and an out of hours contact number when the practice was closed. This information was available on the telephone answering service.

Patients could book their appointments online or by calling the practice direct. Staff encouraged patients to book their next routine appointment once they had seen the dentist. Patients that we spoke with told us they had no difficulties arranging convenient appointments.

Concerns & complaints

The practice had a complaints policy and a procedure that set out how complaints would be addressed. This included the person with overall responsibility for dealing with a complaint and the timeframes for responding. Information for patients about how to make a complaint was seen in the waiting area and general feedback could be submitted through the practice website. None of the patients who gave us comments about the practice had needed to make a complaint and told us they would feel comfortable raising any concerns with the staff.

If a patient raised a concern, staff attempted to resolve it at the time. If staff were unable to do this, the issue would be referred to the practice manager. Patients received an apology when things had not gone well.

The practice had received two complaints in the last year. We reviewed the management of the complaints which were recorded on an electronic tracker and shared with the head office team. We saw these had been managed in a timely way and opportunities to improve the safety and the quality of the service had been taken. Staff received training in the management of concerns and complaints as part of their induction programme.

Are services well-led?

Our findings

Governance arrangements

The practice manager had responsibility for governance and quality monitoring and was supported in this by the corporate management team. This included shared business support services and policies issued by the provider which aimed to support a common approach. A range of policies and procedures were in use at the practice and were accessible to staff. These included health and safety, infection prevention and control and patient confidentiality and recruitment. Practice meetings were held for all staff every quarter and clinical meetings every six weeks. The meetings covered changes in corporate and national practice guidelines, incidents, training and patient feedback.

The practice manager monitored health and safety issues to ensure the environment was safe and well maintained for patients and staff. This included fire safety and health and safety risk assessments. However, the practice had not yet considered safe systems for the management of sharp instruments in line with the Safer Sharps Regulations 2013.

There were systems in place to maintain equipment such as machinery used in the decontamination process and other electrical equipment was checked and serviced regularly. Dental chairs? Clinical and non-clinical records were in place to demonstrate that quality measures were being followed. However we found that improvement was needed to recruitment records and the labelling of prescribed medicines supplied to the patient.

Leadership, openness and transparency

There was a clear leadership structure in place and staff understood their roles and responsibilities within the practice. For example there was a lead dental nurse, a lead receptionist, fire marshals, first aiders and a safeguarding lead. The practice manager had responsibility for monitoring the service overall and worked closely with all staff to achieve this.

Staff we spoke with told us that they worked well as a team and they were supported to raise any issues about the safety and quality of the service and share their learning. They told us that there was an open and transparent culture at the practice and they took pride in delivering a high standard of care. We found staff were hard working, caring and committed to providing patients with a positive dental experience. All staff knew how to raise any issues or concerns and were confident that action would be taken by the practice manager who listened and respected their views and opinions. Staff had signed up to the duty of candour policy to be open and honest in their work roles.

Learning and improvement

A staff appraisal system ensured that staff were supported to develop their knowledge and skills. The dentists also received performance reviews with the provider's clinical lead for the area. Staff had access to a range of training which included an annual core training programme through an online training system. Practice based and external training could also be accessed. We found there was no system to monitor the overall progress with planned training to ensure it was completed. The personnel files we sampled showed that up to date training certificates were available on an individual basis and staff told us they always supplied evidence of their training for the practice manager to place on their file. We found that staff registered with the General Dental Council, maintained the requirement to keep up to date.

An audit programme was in place which included clinical record keeping, infection control and X-ray quality audits. The audits we reviewed demonstrated the practice were focused on improving the service although we found there was no record of analysis or actions taken following the most recent infection control audit.

The area manager conducted quality and improvement visits that were shared with staff for action. For example, it had been identified that staff had been due to read and sign policies again in October 2016. This process was now being rolled out.

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

The practice provided several methods to gather feedback from patients on a regular basis. This included a corporate survey that was available on an ongoing basis. During November, seven patients had completed this and the results were displayed in the waiting room. This showed patients had scored the practice 95% for the quality of treatment they had received and 100% for being involved in their treatment and for recommending the practice to others

Are services well-led?

The practice also participated in the NHS Friends and Family test although there were low numbers of patients who completed this. During November 2016 five patients had provided good feedback to the practice. A general comments box was place in the waiting room although on the day of the inspection, there were no paper slips or pens available to encourage its' use.

Staff told us they felt valued, involved in the running of the practice and enjoyed working as part of the team.