Dental Care Direct Limited

Dental Care Direct - Lexicon House

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 28 November 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

Dental Care Direct - Lexicon House is situated in Leeds, West Yorkshire. It shares a building with an out of hours medical centre. The practice provides urgent dental care through the NHS 111 service; routine dental care is not provided. Dental Care Direct is a subsidiary of Local Care Direct.

The practice has two surgeries, a decontamination room, a waiting area and a reception area. All of the facilities and patient toilets are on the ground floor of the premises.

There are 36 dentists, 17 qualified dental nurses and seven receptionists who take part in the provision of the service. They are also supported by a practice manager and an administrative team which includes a safeguarding lead, an infection control lead, a support services manager, a head of workforce and the dental services director.

Summary of findings

The opening hours are 8-30am to 10-30pm seven days a week. The booking hub is open between 7-00am and 11-00pm.

The practice manager is 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.

During the inspection we received feedback from 16 patients. The patients were positive about the care and treatment they received at the practice. Comments included staff were friendly, kind and courteous. They also commented the service was efficient and their needs were met.

Our key findings were:

- The practice was visibly clean and uncluttered.
- The practice had some systems in place to assess and manage risks to patients and staff including health and safety and the management of medical emergencies. The practice should implement more dental specific risk assessments.
- Staff were qualified and had received training appropriate to their roles.
- The recruitment process required improvement as Disclosure and Barring Service checks were not sought at the point of employment for the dentists.
- Patients were involved in making decisions about their treatment and were given clear explanations about their proposed treatment including any risks.
- Dental care records showed treatment was planned in line with current best practice guidelines.
- We observed patients were treated with kindness and respect by staff.
- The practice had a complaints system in place and there was an openness and transparency in how these were dealt with.
- There was an effective process in place to contact patients to make an appointment.
- Patients were triaged and given an appointment appropriate to their individual needs.
- The practice had daily dedicated slots available for children in pain.
- The governance systems were effective but should be made more specific for the dental environment.
- There were clearly defined leadership roles within the practice and staff told us they felt supported, appreciated and comfortable to raise concerns or make suggestions.
- The practice regularly audited both clinical and non-clinical areas of work.

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

- Review the practice's governance arrangements ensuring policies and risk assessments are specific to the dental sector.
- Review the practice's system for sharing the learning from significant events.
- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society.
- Review the practice's waste handling policy and procedure to ensure waste is segregated and disposed of in accordance with relevant regulations giving due regard to guidance issued in the Health Technical Memorandum 07-01 (HTM 07-01).
- Review the practice's recruitment policy and procedures to ensure Disclosure and Barring Service (DBS) checks are carried out at the point of employment.

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.

Staff told us they felt confident about reporting incidents, accidents and the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). We were told learning from significant events was not always thoroughly disseminated to all staff.

Staff had received training in safeguarding at the appropriate level and knew the signs of abuse and who to report them to.

Staff were suitably qualified for their roles. We saw the practice had copies of Disclosure and Barring Service (DBS) checks for all dentists. These DBS checks were not carried out by the provider but used from a different location. We raised this issue on the day of inspection and we were told a new DBS check would be carried out for new dentists if their current DBS check was not completed within the previous three months.

Patients' medical histories were obtained before any treatment took place. The dentists were aware of any health or medication issues which could affect the planning of treatment. Staff were trained to deal with medical emergencies. All emergency equipment and medicines were in date and in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines.

The decontamination procedures were effective and the equipment involved in the decontamination process was regularly serviced, validated and checked to ensure it was safe to use. We noted the external clinical waste bin was overflowing and therefore not secure as clinical waste could be accessed by the public.

Rubber dam was not routinely used whilst using root canal instruments.

Are services effective?

No action

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

Clinical records were concise and included full details of the presenting complaint, its history and any special tests which were carried out. Patients were provided with a diagnosis and given options to consider.

The practice followed best practice guidelines when delivering dental care. These included Faculty of General Dental Practice (FGDP) and National Institute for Health and Care Excellence (NICE).

Staff had completed training relevant to their roles and were up to date with their continuing professional development (CPD).

Referrals were made to secondary care services if the treatment required was not provided by the practice.

Summary of findings

Are services caring?

No action

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

During the inspection we received feedback from 16 patients. The patients were positive about the care and treatment they received at the practice. Comments included staff were friendly, kind and courteous.

We observed the staff to be welcoming and caring towards the patients.

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection.

Are services responsive to people's needs?

No action

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

The practice had a system in place which enabled patients who required urgent dental treatment to get an appointment in a timely manner. The practice had dedicated daily slots for children who were in pain. The average time between receiving a patient's details to seeing them was 18 hours and 20 minutes. This ranged from seven minutes to nearly 48 hours. A triage system was in place to identify those at greatest need.

There was a procedure in place for responding to patients' complaints. This involved acknowledging, investigating and responding to individual complaints or concerns. Staff were familiar with the complaints procedure.

The practice was fully accessible for those with limited mobility or wheelchair users.

Are services well-led?

No action

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

There was a clearly defined management structure in place and staff felt supported and appreciated in their own particular roles. The practice manager was responsible for the day to day running of the practice. The dental services director provided clinical leadership.

Due to the nature of the workforce (predominantly part time) information sharing was a challenge. Bi-monthly bulletins were sent to staff, there were quarterly dental forums and the dental nurses had meetings once or twice a year.

The practice regularly audited clinical and non-clinical areas as part of a system of continuous improvement and learning.

The practice carried out a rolling patient satisfaction survey in order to seek feedback from patients.

Dental Care Direct - Lexicon House

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 registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

We informed local NHS England area team that we were inspecting the practice. We did not receive any information of concern from them.

During the inspection we received feedback from 16 patients. We also spoke with two dentists, three dental nurses, one receptionist, the safeguarding lead, the infection control lead, the dental services director and the practice manager. To assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

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 clear guidance for staff about how to report incidents and accidents. Staff were familiar with the importance of reporting significant events. We reviewed the significant events which had occurred in the last 12 months. These had been well documented and analysed. Significant events were categorised by type of event. For example, health and safety, work related issues, prescribing and patient condition. Any accidents or incidents would be reported to the practice manager who would pass them on to the quality team for further analysis. These would also be discussed at the bi-monthly board meetings to be signed off. We were told staff were informed about significant events via e-mail. Staff told us this did not always happen. We raised this issue on the day of inspection and we were told a more effective process would be implemented to ensure all staff received notifications about relevant significant events.

Staff understood the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

The practice received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) that affected the dental profession. These were actioned if necessary.

Reliable safety systems and processes (including safeguarding)

The practice had child and adult safeguarding policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff. Staff had access to contact details for both child protection and adult safeguarding teams. There was a dedicated safeguarding lead for the organisation who oversaw related issues. The practice manager was also a safeguarding contact for the dental team. All staff had undertaken safeguarding training appropriate to their role. We discussed a recent safeguarding incident which had been referred to the local safeguarding board. This had been done in line with the practice's policy and procedures. There was a display in the waiting area highlighting the issue of safeguarding. This included domestic abuse and neglect. There were contact details within the display for patients to contact if they had concerns about themselves or others.

We spoke with staff about the use of safer sharps in dentistry as per the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The practice was using a safer sharps system in line with this guidance.

The dentists told us they did not routinely used a rubber dam when using root canal instruments. On the occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured. This was not done. 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.

We saw patients' clinical records were computerised and password protected to keep personal details safe. Any paper documentation relating to patients' records were stored in lockable cabinets.

Medical emergencies

The practice had procedures in place which provided staff with clear guidance about how to deal with medical emergencies. Staff were knowledgeable about what to do in a medical emergency and had completed training in emergency resuscitation and basic life support within the last 12 months.

The practice kept an emergency resuscitation kit, medical emergency oxygen and emergency medicines. Staff knew where the emergency kits was kept. We checked the emergency equipment and medicines and found them to be in date and in line with the Resuscitation Council UK guidelines and the BNF.

The practice had an Automated External Defibrillator (AED) to support staff in a medical emergency. (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.).

Records showed regular checks were carried out on the AED, emergency medicines and the oxygen cylinder. These checks ensured the oxygen cylinder was full and in good working order, the AED battery was charged and the emergency medicines were in date.

Are services safe?

Staff recruitment

The practice had a policy and a set of procedures for the safe recruitment of staff which included seeking references, proof of identity, checking relevant qualifications and professional registration. We reviewed a sample of staff files and found recruitment procedures had been followed.

We saw the practice had copies of Disclosure and Barring Service (DBS) checks for all dentists. These DBS checks were not carried out by the provider but used from a different location. We raised this issue on the day of inspection and we were told a new DBS check would be carried out for new dentists if their current DBS check was not completed within the previous three months. The provider carried out DBS checks on new dental nurses. These checks 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.

All clinical staff at this practice were qualified and registered with the General Dental Council (GDC).

Monitoring health & safety and responding to risks

A health and safety policy and risk assessments were in place at the practice. This identified the risks to patients and staff who attended the practice. The risks had been identified and control measures put in place to reduce them.

There were policies and procedures in place to manage risks at the practice. These included slips, trips and falls and manual handling. We noted there were no risk assessments specific to a dental practice. For example, there was no risk assessment for the use of the autoclave.

The practice maintained a file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including substances such as disinfectants, and dental materials in use in the practice. The practice identified how they managed hazardous substances in its health and safety and infection control policies and in specific guidelines for staff, for example in its blood spillage and waste disposal procedures. We noted the COSHH folder was not organised in a way which allowed a substance to be identified in the event of an incident. This was raised on the day of inspection and we were told this would be addressed.

Infection control

There was an infection control policy and procedures to keep patients safe. This policy was not specific to the dental setting and did not outline the processes for the decontamination and sterilisation of dental instruments. We saw a draft copy of a dedicated dental infection control policy had been drawn up. This was awaiting approval from the board prior to being finalised. We saw procedures for decontaminating and sterilising instruments were displayed in the decontamination room.

The practice followed the guidance about 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)'. There was a dedicated infection control lead within the practice who was responsible for ensuring procedures were followed.

Staff had received training in infection prevention and control. We saw evidence staff were immunised against blood borne viruses (Hepatitis B) to ensure the safety of patients and staff.

We observed the treatment rooms and the decontamination room to be clean and hygienic. Work surfaces were free from clutter. Staff told us they cleaned the treatment areas and surfaces between each patient and at the end of the morning and afternoon sessions to help maintain infection control standards. There was a cleaning schedule which identified and monitored areas to be cleaned. There were hand washing facilities in the treatment rooms and staff had access to supplies of personal protective equipment (PPE) for patients and staff members. Posters promoting good hand hygiene and the decontamination procedures were clearly displayed to support staff in following practice procedures. Sharps bins were appropriately located, signed and dated and not overfilled. We observed waste was separated into containers for disposal by a registered waste carrier and appropriate documentation was retained. We saw the waste bin was located outside the building. The waste bin was overfilled and hence could not be closed and locked. Even though this bin was fenced in, the bags of clinical waste could be reached by the public. We were advised by the provider this would be looked into to ensure it was not overfilled.

Decontamination procedures were conducted in a dedicated decontamination room in accordance with HTM 01-05 guidance. An instrument transportation system had

Are services safe?

been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room. This minimised the risk of the spread of infection.

We found instruments were being cleaned and sterilised in line with published guidance (HTM01-05). The dental nurses were well-informed about the decontamination process and demonstrated correct procedures.

The practice had systems in place for daily and weekly quality testing of the decontamination equipment and we saw records which confirmed these had taken place. There were sufficient instruments available to ensure the services provided to patients were uninterrupted.

Due to staff working shifts, the practice had implemented a process whereby the nurses would sign when they had put a load of instruments into the autoclave and would also sign when the instruments had been removed. This ensured that nurses knew that the cycle had been activated and avoided confusion.

The practice had carried out an Infection Prevention Society (IPS) self- assessment audit in July 2016 relating to the Department of Health's guidance on decontamination in dental services (HTM01-05).This is designed to assist all registered primary dental care services to meet satisfactory levels of equipment decontamination. The audit showed the practice was meeting the required standards.

Records showed a risk assessment process for Legionella had been carried out (Legionella is a term for particular bacteria which can contaminate water systems in buildings). The practice undertook processes to reduce the likelihood of Legionella developing which included running the water lines in the treatment rooms at the beginning and end of each session and between patients, monitoring cold and hot water temperatures each month and also monthly tests on the on the water quality to ensure Legionella was not developing.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as X-ray sets, the autoclaves and the compressor. The practice kept a maintenance log of when each piece of equipment needed servicing. We saw evidence of validation of the autoclaves and the compressor. Portable appliance testing (PAT) had been completed in July 2016 (PAT confirms that portable electrical appliances are routinely checked for safety).

We saw the practice was storing NHS prescription pads securely in accordance with current guidance. Prescriptions were stamped only at the point of issue.

Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. Records we viewed demonstrated the X-ray equipment was regularly tested, serviced and repaired when necessary. A Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure the equipment was operated safely and by qualified staff only. We found there were suitable arrangements in place to ensure the safety of the equipment. Local rules were available in both surgeries and within the radiation protection folder for staff to reference if needed. We saw a justification, grade and a report was documented in the dental care records when X-rays were taken.

An X-ray audit had been carried just prior to the inspection. This included assessing the quality of the X-rays. The results of the most recent audit confirmed they were compliant with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). No audit of the quality of X-rays had been conducted prior to this.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept up to date detailed electronic dental care records. The dentists carried out an assessment in line with recognised guidance from the Faculty of General Dental Practice (FGDP).

During the course of our inspection we discussed patient care with the dentists and checked dental care records to confirm the findings. Medical history checks were recorded for all patients. This included details of their health conditions, current medicines being taken and whether they had any allergies.

Clinical records were concise and included full details of the presenting complaint, its history and any special tests which were carried out. An intra-oral and extra-oral examination was also carried out to check for any signs of mouth cancer or spreading infection. Records showed patients were made aware of a diagnosis following a full assessment.

X-rays were taken in line with FGDP guidance to assist the dentists in coming to a differential diagnosis. This ensured each X-ray was clinically justified and necessary. Justification for the taking of an X-ray, quality assurance of each X-ray and a detailed report was recorded in the patient's care record.

Health promotion & prevention

Staff were aware of the 'Delivering Better Oral Health' toolkit (DBOH). DBOH is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. Due to the nature and scope of the service being limited to urgent care, preventative treatments such as fluoride varnish for the prevention of tooth decay was not provided. We saw that preventative advice was provided in some cases especially in order to advise children and parents. There were health promotion posters displayed in the waiting room highlighting issues relating to smoking and poor diet.

Staffing

New staff had a period of induction to familiarise themselves with the way the practice ran. The induction process was role specific. We were told the induction process for dentists included an offer to shadow a well-established clinician to see how the system works. It also included a detailed introduction to the computer system. Dental care record audits for the first three sessions were carried out to ensure the dentist was completing the relevant sections of the computer system. This was important for the on-going monitoring of the service being provided. This process also included making the new member of staff aware of the scope of the service, the location of the emergency kit and a tour of the premises. We saw evidence of completed induction checklists in personnel files.

Staff told us they had good access to on-going training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). For example, the practice organised and paid for all mandatory CPD for the dental nurses. This was also offered to the dentists but if they could not attend for any reason then they were asked to sign a disclaimer and show evidence they had completed the mandatory CPD as required by the GDC.

Working with other services

The practice worked with other clinicians where this was in the best interest of the patient and in line with current guidance. For example, referrals were made to hospitals and specialist dental services for further investigations or specialist treatment including oral surgery and sedation. A wide range of referral options was available to the dentists.

Referrals were either made online or by completing proformas. A record of the referral was documented within the dental care records detailing the reason for the referral.

The practice had a procedure for the referral of a suspected malignancy. This involved sending an urgent fax the same day and a telephone call to confirm the fax had arrived.

The practice maintained a log of all referrals which had been sent. This allowed them to actively monitor their referrals. A monthly management information report was collated for all referrals sent to check if there were any trends developing which needed attention.

As the scope of the service did not extend to routine dental care, the staff advised patients to visit their own dentist for

Are services effective?

(for example, treatment is effective)

on-going treatment. We were told approximately two thirds of the patients did not have their own dentist and this presented a challenge as several of these patients became frequent attenders at the clinic.

Dental Care Direct - Lexicon House also acted as the central "booking hub" for the area. This involved receiving the patient details of those who required urgent treatment from the NHS 111 service. Approximately 50 local dental practices had contracts to see a small number of emergency patients. The details of these patients would be passed on to the practice in question to ensure they had all the correct information and were expecting the patient to attend.

Consent to care and treatment

Patients were given information to support them to make decisions about the treatment they received. Staff were knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent. The dentists described to us how valid consent was obtained for all care and treatment and the role family members and carers might have in supporting the patient to understand and make decisions. The dentists were familiar of the concept of Gillick competency about involving children in decision making and ensuring their wishes were respected regarding treatment. One of the dentists gave us an example of when they had applied the Gillick competency test.

Staff had completed training in the principles of the Mental Capacity Act (MCA) 2005 and how it was relevant to ensuring patients had the capacity to consent to their dental treatment.

Staff ensured patients gave their consent before treatment began. We were told that individual treatment options, risks and benefits were discussed with each patient. These discussions were documented within the dental care records. Consent forms for extractions were available which outlined the potential risks associated with the procedure.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Feedback from patients was positive and they commented staff were professional, caring and respectful. Staff told us they always interacted with patients in a respectful, appropriate and kind manner. We observed staff to be friendly and respectful towards patients during interactions at the reception desk and over the telephone.

We observed privacy and confidentiality were maintained for patients who used the service on the day of inspection. This included ensuring dental care records were not visible to patients and keeping surgery doors shut during consultations and treatment. The reception area was sufficiently segregated from the waiting area to allow confidentiality. There was also a television in the waiting area to distract patients from conversations which occurred at the reception desk.

We observed staff to be helpful, discreet and respectful to patients. Staff told us if a patient wished to speak in private an empty room would be found to speak with them.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Staff described to us how they involved patients' relatives, parents or carers when required and ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We found the practice had an efficient appointment system in place to respond to patients' needs. The "booking hub" received patients' details from the NHS 111 service in The NHS 111 service triaged the patients into either an emergency, urgent or less urgent. Once the booking hub received the patients details they aimed to call the patient back within two hours. We were told 98% of patients were called within the two hour time frame. Patients would then be booked an appointment at the most appropriate location. The appointments were prioritised and the diary was managed accordingly. For example, there were dedicated daily slot for children in pain. We were told that the average time a patient was seen in was 18 hours and 20 minutes (from data between May 2016 and October 2016). This ranged from seven minutes to nearly 48 hours.

The practice worked closely with local homeless charities. This enabled patients who had no fixed abode to access urgent dental treatment in a timely manner.

We were told the practice had once offered appointments overnight until 4-00am during Ramadan. This enabled patients who were fasting to receive urgent treatment without breaking their fast.

The practice displayed its "scope of service" in the waiting room. This highlighted what the practice was contracted to provide. This included the arrest of bleeding, treatment of dental trauma, extraction, removal of the tooth nerve or prescribing antibiotics.

There were also several notices and leaflets available in the waiting area relevant to the patient base attending for appointments. These included details of how to find an NHS dentist, local pharmacies (including opening times) and information about antibiotic guardianship. Antibiotic guardianship is a campaign which highlights the issue of antibiotic resistance. It advises that taking antibiotics does not necessarily resolve the problem or stop the pain, dental treatment is usually needed. This information made patients aware that antibiotics would not be prescribed unless absolutely necessary.

Tackling inequity and promoting equality

The practice had equality and diversity, and disability policies to support staff in understanding and meeting the needs of patients. The practice had been adapted to accommodate the needs of all patients. These included step free access to the premises, an automatic door and accessible toilet facilities. The surgeries were large enough to accommodate a wheelchair or a pram.

The practice had access to interpreter services and several posters in the waiting room were in different languages.

Access to the service

The practice offered extended opening hours to enable patients to access urgent care when necessary. Appointments were available from 8-45am to 11-00pm seven days a week. The booking hub was open from 7-00am to 11-00pm seven days a week.

Concerns & complaints

The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. There were details of how patients could make a complaint displayed in the waiting room and in a complaints leaflet. If patients complained at the reception desk they were given a complaints form to fill in which would then be passed on to the quality manager.

The quality manager was responsible for dealing with complaints when they arose. Staff told us they raised any formal or informal comments or concerns with the quality manager to ensure responses were made in a timely manner. If relevant the complaint was passed on to the dentist if it involved clinical work. If the dentist did not use their indemnity organisation to provide a response then the practice would check the response prior to sending it out to the patient. We reviewed some of the complaints which had been received in the past 12 months and found they had been dealt with in line with the practices policy.

The practice maintained a log of all complaints which had been received. This enabled them to ensure complaints were dealt with in a timely manner and to detect if there were any trends.

Are services well-led?

Our findings

Governance arrangements

The practice manager was responsible for the day to day running of the service. The dental services director provided clinical leadership.

A range of policies and procedures were in use. The infection control policy was not specific to the dental setting and did not focus on the processes for the decontamination and sterilisation of dental instruments.

The practice had an approach for identifying where quality or safety was being affected and addressing any issues**.** Health and safety and risk management policies were in place and we saw a risk management process to ensure the safety of patients and staff members. We noted there were no risk assessments specific to a dental practice. For example, there was no risk assessment for the use of the autoclave.

There was an effective management structure in place to ensure responsibilities of staff were clear. Staff told us they felt supported and were clear about their roles and responsibilities.

Leadership, openness and transparency

The culture of the practice encouraged candour, openness and honesty to promote the delivery of high quality care and to challenge poor practice. Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time.

Due to the nature of the workforce (predominantly part time staff) regular staff meetings were not possible. Instead, bi-monthly bulletins were sent out to all the dentists. These included information about referrals and significant events. The dental nurses had meetings once or twice a year.

Learning and improvement

Quality assurance processes were used at the practice to encourage continuous improvement. The practice audited areas of their practice as part of a system of continuous improvement and learning. This included audits such as infection prevention and control, dental care records and X-rays. They also carried out monthly performance reports which showed what treatments had been provided. This enabled the dental services director to identify if any clinicians were outliers with regards to different treatments. For example, inappropriate prescribing of antibiotics.

The dental nurses had access to training and this was monitored to ensure essential training was completed each year. The practice organised core CPD courses to be completed for the dental nurses. The dentists were asked to sign a disclaimer form to indicate they were up to date with their core CPD.

The practice also organised quarterly dental forums. This was an opportunity for all the dentists to meet to discuss cases and undertake training which was relevant to their roles. This training included dental trauma in children and safeguarding.

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

The practice had systems in place to involve, seek and act upon feedback from people using the service including carrying out a rolling patient satisfaction survey. The satisfaction survey included questions about whether the practice appeared clean, if the receptionist was helpful and if the charges associated with the treatment were explained. We were told as a result of feedback the practice had started to provide copies of dental care records and X-rays for patients to take to their own dentist. This would avoid the need to retake X-rays and enable the patient's own dentist to know what treatment had been carried out.

The practice also undertook the NHS Friends and Family Test (FFT). The FFT is a feedback tool which supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.