

Briggate Dental Practice Limited

Briggate Dental Practice Limited

Inspection Report

4 Lower Briggate
Leeds
West Yorkshire
LS1 4AF
Tel: 0844 3878236
Website: www.briggatedentalpractice.co.uk

Date of inspection visit: 16 March 2016
Date of publication: 18/04/2016

Overall summary

We carried out an announced comprehensive inspection on 16 March 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

Briggate Dental Practice Limited is situated in Leeds city centre, West Yorkshire. It offers mainly NHS treatment to patients of all ages but also offers private dental treatments. The services include preventative advice and treatment, routine restorative dental care, implants and short term orthodontics.

The practice has three surgeries, a decontamination room, two waiting areas and a reception area. The reception area and one waiting area are on the ground floor. The three surgeries and the second waiting area are on the first floor.

There are two dentists, a dental hygiene therapist, four dental nurses (including two trainees) and two receptionists.

The opening hours are Monday to Thursday from 9-00am to 5-00pm and Friday from 9-00am to 4-30pm. They are closed between 12-00pm and 1-30pm for lunch.

The practice owner 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'.

Summary of findings

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 spoke with eight patients who used the service and reviewed 50 completed CQC comment cards. The patients were positive about the care and treatment they received at the practice. Comments included that the staff were caring, friendly and efficient. They also commented that the environment was safe and hygienic.

Our key findings were:

- The practice had some systems in place to assess and manage risks to patients and staff including infection prevention, control and health and safety and the management of medical emergencies.
- Staff were safely recruited and had received training appropriate to their roles.
- Patients were involved in making decisions about their treatment and were given clear explanations about their proposed treatment including costs, benefits and risks.
- Treatment was planned and provided in line with current guidelines.
- We observed that patients were treated with kindness and respect by staff. Staff ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood.
- Patients were able to make routine and emergency appointments when needed.
- There were clearly defined leadership roles within the practice and staff told us that they felt supported, appreciated and comfortable to raise concerns or make suggestions.

The practice had a complaints system in place and there was an openness and transparency in how these were dealt with.

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

- Review the practice's protocols for the storage of glucagon.
- Review the practice's waste handling policy to ensure waste is stored securely giving due regard to guidance issued in the Health Technical Memorandum 07-01 (HTM 07-01).
- Review the practice's protocol for the storage of local anaesthetics.
- Review the practice's process for the auditing of infection control giving due regard to guidance issued in the Health Technical Memorandum 01-05 (HTM 01-05).
- Review the practice's protocol for the storage of mops giving due regard to guidance issued in the Health Technical Memorandum 01-05 (HTM 01-05).
- Review the practice's procedure for the storage of dental burs giving due regard to guidance issued in HTM 01-05.

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.

Staff told us they felt confident about reporting incidents, accidents and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

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 and the practice had undertaken the relevant recruitment checks to ensure patient safety.

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 accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines. However, we noted that the expiry date on the glucagon had not been amended in light of it not being stored in a fridge.

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.

Are services effective?

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

Patients' dental care records provided comprehensive information about their current dental needs and past treatment. The practice monitored any changes to the patient's oral health and made referrals for specialist treatment or investigations where indicated.

The practice followed best practice guidelines when delivering dental care. These included Faculty of General Dental Practice (FGDP), National Institute for Health and Care Excellence (NICE) and guidance from the British Society of Periodontology (BSP). The practice focused strongly on prevention and the dentists were aware of 'The Delivering Better Oral Health' toolkit (DBOH).

Staff were encouraged to complete training relevant to their roles. The clinical staff 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.

Are services caring?

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

During the inspection we spoke with eight patients who used the service and reviewed 50 completed CQC comment cards. Patients commented that the staff were caring, friendly and efficient. They also commented that they were involved in treatment options, everything was explained thoroughly and they received good feedback on the health of their teeth and gums.

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.

Summary of findings

Staff explained that enough time was allocated in order to ensure that the treatment and care was fully explained to patients in a way which they understood.

Are services responsive to people's needs?

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

The practice had an efficient appointment system in place to respond to patients' needs. There were vacant appointments slots for urgent or emergency appointments each day.

Patients commented they could access treatment for urgent and emergency care when required. There were clear instructions for patients requiring urgent care when the practice was closed.

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.

Are services well-led?

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 all staff felt supported and appreciated in their own particular roles. The practice owner was responsible for the day to day running of the practice.

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

They conducted were currently undertaking the NHS Friends and Family Test (FFT) which enabled patients to provide feedback to the practice.

Briggate Dental Practice Limited

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 and Healthwatch that we were inspecting the practice; however we did not receive any information of concern from them.

During the inspection we spoke with eight patients who used the service and reviewed 50 completed CQC comment

cards. We also spoke with two dentists, the dental hygiene therapist, two dental nurses and a receptionist. 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. We reviewed the incidents which had occurred and these had been documented, investigated and reflected upon by the dental practice. We saw that as a result of a particular incident further staff training had been implemented. Any accidents or incidents would be reported to the practice manager. Any incidents would be discussed at staff meetings in order to disseminate learning. We discussed an incident which had occurred recently and it was evident that this had led the practice adapt to prevent this from occurring again.

Staff understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR) and provided guidance to staff within the practice's health and safety policy.

The practice owner received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) that affected the dental profession. These would then be discussed with staff and actioned if necessary.

Reliable safety systems and processes (including safeguarding)

The practice had child and vulnerable 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. One of the dental nurses was the safeguarding lead for the practice and all staff had undertaken level two safeguarding training. Staff described to us when a patient was referred to the safeguarding team due to dental neglect.

The practice used a system whereby needles were not re-sheathed using the hands following administration of a local anaesthetic to a patient. The practice used the 'scoop' method for recapping used needles. It was also practice policy that the discarding of the used needle was the dentist's responsibility.

Rubber dam (this is a square sheet of latex used by dentists for effective isolation of the root canal and operating field and airway) was used in root canal treatment in line with guidance from the British Endodontic Society.

We saw that patients' clinical records were computerised, and password protected to keep people safe and protect them from abuse. Any paper documentation relating to dental care records were locked in cabinets when the practice was closed.

Medical emergencies

The practice had procedures in place which provided staff with clear guidance about how to deal with medical emergencies. This was in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). 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 emergency resuscitation kits, oxygen and emergency medicines were stored in the store room on the second floor. Staff knew where the emergency kits were kept. The practice had an Automated External Defibrillator (AED) to support staff in a medical emergency. The AED was stored in the reception area. (An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm).

Records showed weekly checks were carried out on the emergency medicines and the oxygen cylinder. These checks ensured that the oxygen cylinder was full and the emergency medicines were in date. We were told that then AED was checked every day by one of the reception staff. However, this was not documented. We were told that the AED checklist would be added to the one already being used for the emergency medicines and oxygen cylinder.

Staff recruitment

The practice had a policy and a set of procedures for the safe recruitment of staff which included an interview, seeking references, proof of identity, checking relevant qualifications and professional registration. We reviewed a sample of staff files and found the recruitment procedure had been followed. We were told the practice carried out Disclosure and Barring Service (DBS) checks for all newly

Are services safe?

employed staff. 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. We reviewed records of staff recruitment and these showed that all checks were in place.

All clinical staff at this practice that were qualified were registered with the General Dental Council (GDC). There were copies of current registration certificates and personal indemnity insurance (insurance professionals are required to have in place to cover their working practice).

Monitoring health & safety and responding to risks

A health and safety policy and risk assessment was in place at the practice. This identified the risks to patients and staff who attended the practice. 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 infection prevention and control, fire evacuation procedures, pregnant workers, slips trips and falls and risks associated with Hepatitis B.

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.

Infection control

There was an infection control policy and procedures to keep patients safe. These included hand hygiene, safe handling of instruments, managing waste products and decontamination guidance. 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)'.

Staff received training in infection prevention and control. We saw evidence that 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. We noted the colour coded mops were all stored in the same bucket. We also noted that dental burs were stored in the surgeries unbagged. HTM 01-05 states that any reusable instruments should be bagged if they are stored in the surgery for more than a day. These issues were raised with the practice owner and we were told they would be addressed.

There were hand washing facilities in the treatment room 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 stored in the second floor store room prior to being put in the external waste bin. This room did not have a lock on it, therefore could not be considered secure. This was brought to the attention of the practice owner and we were told that a lock would be put on this door to ensure that clinical waste was securely stored.

Decontamination procedures were carried out in a dedicated decontamination room in accordance with HTM 01-05 guidance. An instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which minimised the risk of the spread of infection.

One of the dental nurses showed us the procedures involved in disinfecting, inspecting and sterilising dirty instruments; packaging and storing clean instruments. The practice routinely manually cleaned used instruments, examined them visually with an illuminated magnifying glass, and then sterilised them in a validated autoclave. The decontamination room had clearly defined dirty and clean zones in operation to reduce the risk of cross contamination. Staff wore appropriate PPE during the process and these included disposable gloves, aprons and protective eye wear.

Are services safe?

The practice had systems in place for daily and weekly quality testing 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.

The practice had an efficient method of recording in the decontamination room. We saw a “batch book” which recorded the batch number of different items including cleaning materials were used. This enabled the practice to track back to a particular batch of the materials if there were any issues. They also held an infection control incident report which would be used if any instruments inadvertently went through the decontamination process with any remaining materials on. There were no entries in this book.

The practice had carried out an audit relating to infection control. This included checking areas including whether staff had their hair appropriately tied back, they were aware of the correct hand washing techniques and whether they were familiar with aseptic techniques. However, the practice had not carried out the Infection Prevention Society (IPS) self- assessment audit as stated in HTM 01-05. This was brought to the attention of the practice owner and we were told that this would be completed from now on every six months.

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 quarterly tests on the on the water quality to ensure that 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. Portable appliance testing (PAT) had been completed in April 2015 (PAT confirms that portable electrical appliances are routinely checked for safety).

Prescriptions were stamped only at the point of issue to maintain their safe use. Prescription pads were kept locked away when not needed to ensure they were secure.

The practice had a CAD/CAM (computer aided design and computer aided manufacturing) machine. This machine was used to make inlays, onlays, veneers and crowns. We were told that the practice owner had notified the MHRA that dental appliances were being manufactured in the practice.

We saw that the glucagon was stored in the emergency medicine kit and had not had its expiry date appropriately altered. Glucagon is a medicine used for the emergency treatment of hypoglycaemia. Guidance states that if this medicine is kept at room temperature then the expiry date should be reduced by 18 months. This was brought to the attention of the practice owner and we were told that this would be done.

We saw that local anaesthetic cartridges were stored in the surgery drawers. The cartridges were not in their blister packs. This was discussed with the practice owner and we were told that these local anaesthetic cartridges would now be stored in their own original blister packs.

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 that the X-ray equipment was regularly tested, serviced and repairs undertaken when necessary. A Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure that 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 all surgeries and within the radiation protection folder for staff to reference if needed. We saw that a justification, grade and a report was documented in the dental care records for all X-rays which had been taken.

The practice used a manual technique to develop X-rays which involved submerging X-rays in different chemicals. These were developed in specially designed dark boxes to ensure the X-rays developed were of optimal quality. The X-ray developer and fixer fluids were changed on a weekly basis (or more often if required) and a test X-ray was developed to ensure the quality of developing.

Are services safe?

X-ray audits were carried out every three months. This included assessing the quality of the X-rays which had been taken. The results of the most recent audit undertaken confirmed they were compliant with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept up to date detailed electronic and paper dental care records. They contained information about the patient's current dental needs and past treatment. The dentists carried out an assessment in line with recognised guidance from the Faculty of General Dental Practice (FGDP). This was repeated at each examination in order to monitor any changes in the patient's oral health. The dentist used NICE guidance to determine a suitable recall interval for the patients. This takes into account the likelihood of the patient experiencing dental disease.

During the course of our inspection we discussed patient care with the dentists and checked dental care records to confirm the findings. Clinical records were comprehensive and included details of the condition of the teeth, soft tissue lining the mouth, gums and any signs of mouth cancer.

Records showed patients were made aware of the condition of their oral health and whether it had changed since the last appointment. Medical history checks were updated by each patient every time they attended for treatment and entered in to their electronic dental care record. This included an update on their health conditions, current medicines being taken and whether they had any allergies.

The practice used current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, following clinical assessment, the dentists followed the guidance from the FGDP before taking X-rays to ensure they were required 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

The practice provided preventative care and support patients to ensure better oral health. The dentists had an awareness of the 'Delivering Better Oral Health' toolkit (DBOH). DBOH published Public Health England is an evidence based toolkit used by dental teams to improve oral health in a primary and secondary care setting. For example, the practice applied fluoride varnish and fissure sealants to children at high risk of tooth decay.

The practice had a good selection of dental products on sale in the reception area to assist patients with their oral health. Patients were given advice regarding maintaining good oral health. When required, high fluoride toothpastes were prescribed.

The medical history form patients completed included questions about smoking and alcohol consumption. We saw evidence in dental care records that patients were given advice appropriate to their individual needs such as smoking cessation or dietary advice. There were health promotion leaflets available in the waiting room and surgery to support patients.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. The induction process included making the new member of staff aware of the location of emergency medicines and arrangements for fire evacuation procedures. New recruits were provided with a "practice manual" which included a summary of all relevant policies, procedures and protocols. As part of the induction process new recruits had regular performance meetings with the practice owner to ensure the new staff member was happy and whether they required any additional support.

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). The practice organised training for medical emergencies and infection control to help staff keep up to date with current guidance on treatment of medical emergencies in the dental environment. Records showed professional registration with the GDC was up to date for all staff and we saw evidence of on-going CPD.

Staff told us they had bi-annual appraisals and training requirements were discussed at these. We saw evidence of completed appraisal documents. Staff also felt they could approach the practice owner at any time to discuss continuing training and development as the need arose.

Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. For example, referrals were made to hospitals and

Are services effective?

(for example, treatment is effective)

specialist dental services for further investigations or specialist treatment including orthodontics and sedation. Patients would be given options as to where they could be referred.

The practice completed detailed proformas or referral letters to ensure the specialist service had all the relevant information required. A copy of the referral letter was kept in the patient's dental care records. Letters received back relating to the referral were first seen by the referring dentist to see if any action was required and then stored in the patient's dental care records for future reference.

We were told that the practice aimed to carry out as much treatment as possible in house to prevent the need to refer patients out. However, the dentists were aware of their own limitations and when to refer more complex cases.

Consent to care and treatment

Patients were given appropriate verbal and written information to support them to make decisions about the treatment they received. For example, we saw models which one of the dentists would use in order to describe short term orthodontics to patients.

Staff were knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent. Staff 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.

Staff had an understanding 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 and this was signed by the patient. This consent was in the form of a signed document outlining the costs involved with the treatment. Where verbal consent was given, for example, for an examination this was documented in the dental care records. Patients considering expensive or complex treatments were positively encouraged to take time to consider the options, risks and benefits, this would also involve speaking to family members and friends. Staff were aware that consent could be removed at any time.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Feedback from patients was positive and they commented that they were treated with care, respect and dignity. Staff told us that 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. We saw that patients were encouraged to use the first floor waiting room in order to prevent patients overhearing conversation in the ground floor waiting/reception area. Dental care records were not visible to the public on the reception desk. We observed staff were helpful, discreet and respectful to patients. Staff said that if a patient wished to speak in private, an empty room would be found to speak with them.

Patients' electronic care records were password protected and regularly backed up to secure storage. Paper documentation relating to dental care records were locked in cabinets when the practice was closed.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients commented they felt involved in their treatment and it was fully explained to them. Staff described to us how they involved patients' relatives 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. One of the dentists showed us models relating to the short term orthodontic treatment which was provided. They felt that this enabled patients to more fully understand the proposed treatment. One patient specifically told us that treatment was very well described and it was obvious that financial reward to the dentist had no impact on treatments which were proposed. The dentists later told us that this was an example of the practice's ethos towards patient care.

Patients were also informed of the range of treatments available (including the practice's membership plan) in the practice information leaflet and on notices in the waiting area.

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. Staff told us that patients who requested an urgent appointment would be seen the same day. We saw evidence in the appointment book that there were dedicated emergency slots available each day. If the emergency slots had already been taken for the day then the patient was offered to sit and wait for an appointment if they wished.

Patients commented they had sufficient time during their appointment and they were not rushed. We observed the clinics ran smoothly on the day of the inspection and patients were not kept waiting.

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. Due to the nature of the building, wheelchair access was not possible. This was because all of the surgeries were located on the first floor of the premises. This issue would be made clear to any potential new patients to the practice and details of this was also in the patient information leaflet. Patients with limited mobility or in a wheelchair would be signposted to the NHS 111 service to provide assistance with finding another suitable practice.

Access to the service

The practice displayed its opening hours in the premises, in the practice information leaflet and on the practice website. The opening hours are Monday to Thursday from 9-00am to 5-00pm and Friday from 9-00am to 4-30pm. The practice is closed between 12-00pm and 1-30pm for lunch.

Patients told us that they were rarely kept waiting for their appointment. Patients could access care and treatment in a timely way and the appointment system met their needs. When treatment was urgent, patients would be seen the same day. The practice had a system in place for patients requiring urgent dental care when the practice was closed. Patients were signposted to the NHS 111 service on the telephone answering machine. Information about the out of hours emergency dental service was also displayed in the waiting area and in the practice's information leaflet.

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 the practice's information leaflet. The practice owner was responsible for dealing with complaints when they arose. Staff told us they raised any formal or informal comments or concerns with the practice owner to ensure responses were made in a timely manner. We were told that they aimed to resolve complaints in-house initially. We reviewed the complaints which had been received in the past 12 months and found that they had been dealt with in line with the practice's policy.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients. We found there was an effective system in place which helped ensure a timely response. This included acknowledging the complaint within five working days and providing a formal response within 14 working days. If the practice was unable to provide a response within 14 working days then the patient would be made aware of this.

Are services well-led?

Our findings

Governance arrangements

The practice owner was responsible for the day to day running of the service. There was a range of policies and procedures in use at the practice. We saw they had systems in place to monitor the quality of the service and to make improvements. The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately.

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. For example, we saw risk assessments relating to fire safety, the use of equipment, pregnant workers and infection control.

There was an effective management structure in place to ensure that responsibilities of staff were clear. Staff told us that 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. This was evident when we looked at the complaints they had received in the last 12 months.

Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. These were discussed openly at staff meetings where relevant and it was evident that the practice worked as a team and dealt with any issue in a professional manner.

The practice held quarterly staff meetings including all staff members. These staff meetings were for most of a morning or afternoon as staff felt that they gained more from longer as opposed to more frequent staff meetings. These meetings were well minuted for those who were unable to attend. If there was more urgent information to discuss with staff then an informal staff meeting would be organised to discuss the matter.

All staff were aware of whom to raise any issue with and told us that the practice owner was approachable, would

listen to their concerns and act appropriately. If the issue related to the practice owner then there were other contacts available within the whistleblowing policy. We were told that there was a no blame culture at the practice and that the delivery of high quality care was part of the practice's ethos.

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 clinical audits such as dental care records and X-rays. We looked at the audits and saw that the practice was performing well. We saw as a result of a historical X-ray audit that repairs were made to an X-ray machine's arm. This was followed up by a repeat audit which confirmed that the actions had had a positive outcome on the quality of X-rays taken.

Staff told us they had access to training to help ensure essential training was completed each year; this included medical emergencies and basic life support. Staff working at the practice were supported to maintain their continuous professional development as required by the General Dental Council.

All staff had bi-annual appraisals at which strengths, weaknesses, areas for development and any problems since the previous appraisal were discussed. We saw evidence of completed appraisal forms in the staff folders.

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 the NHS Friends and Family Test (FFT) and informal comments made by patients. The FFT is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. The most recent results of the FFT showed that 92% of patients would recommend the practice to friends and family.

We were told that as a result of patient feedback that the display stand for oral hygiene products had been moved from behind the reception desk so that its perusal by patients could be easier and now the dentists would always discuss the option of finance for any treatments exceeding £500.