The Whyte House Limited

Devon Teeth Straightening Clinic

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 6 March 2017 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

Devon Teeth Straightening Clinic is located in the centre of the city of Exeter, Devon. It is situated on the ground floor with two treatment rooms, a patient waiting area/ reception and has a purpose built decontamination room for the cleaning and sterilising of dental instruments. There is nearby parking in city centre car parks. The practice provides general dental services, dental hygiene, cosmetic teeth straightening and teeth whitening systems under private patient care. Approximately 1,650 patients are registered at the practice.

The staff structure of the practice consists of a group director/dentist, practice manager/dental nurse/ receptionist, dentist, dental hygienist and two dental nurses.

The practice is open from Monday to Friday 10am – 6pm, with some occasional Saturday opening by appointment/ patient request. There is an answer phone message directing patients to emergency contact numbers when the practice is closed.

The group director 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.

The inspection took place over one day and was carried out by a CQC inspector, who had access to remote advice from a specialist advisor.

Twenty eight patients provided feedback directly to CQC about the service. All were positive about the care they received from the practice. They were complimentary about the friendly, professional and caring attitude of the dental staff and the dental treatment they had received.

Our key findings were:

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were effective systems in place to reduce and minimise the risk and spread of infection.
- There was a lead staff member for safeguarding patients. All staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Patients indicated that they felt they were listened to and that they received good care from the practice team.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- Patients could access treatment and urgent and emergency care when required.
- Patients could book appointments up to 12 months in advance.
- Appointment text/phone reminders were available on request 48 hours prior to appointments.
- The provider had a clear vision for the practice and staff told us they were well supported by the management team.
- Staff had been trained to handle emergencies and appropriate medicines were readily available in accordance with current guidelines.
- The practice appeared clean and well maintained.
- Staff received training appropriate to their roles and were supported in their continued professional development by the management team.
- Staff we spoke with felt supported by the management team and were committed to providing a quality service to their patients.

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

- Review the practice's infection control procedures and protocols taking into acount guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.'
- Review availability of equipment such as an automated external defibrillator (AED) to manage medical emergencies taking into account guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team. The provider must ensure a risk assessment is undertaken if a decision is made to not have an AED on-site.
- Review the arrangements for the sterile storage of local anaesthetic cartridges.
- Review the practice's audit protocols to ensure that where appropriate audits have documented learning points and the resulting improvements can be demonstrated.

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 systems to minimise the risks associated with providing dental services. The practice had policies and protocols, which staff were following, for the management of medical emergencies. The practice did not have an automated external defibrillator for use in a medical emergency, but the provision of such was being considered by the provider.

There were systems for identifying, investigating and learning from incidents relating to the safety of patients and staff members.

Staff had good awareness of safeguarding issues, which were informed by and supported by practice policies. There was an annual training plan to ensure staff training in safeguarding was appropriately maintained.

Infection control processes were safely managed. We have made recommendations regarding review of some processes.

Equipment used in the practice was checked for effectiveness.

Are services effective?

No action

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

The practice provided evidence-based care in accordance with relevant, published guidance, for example, from the National Institute for Health and Care Excellence (NICE). The practice monitored patients' oral health and gave appropriate health promotion advice.

Staff explained treatment options to ensure that patients could make informed decisions about any treatment. The practice worked well with other providers and followed up on the outcomes of referrals made to other providers.

Staff engaged in continuous professional development (CPD) and were meeting the training requirements of the General Dental Council (GDC). New staff had received an induction and were engaged in a probationary process to review their performance and understand their training needs.

Are services caring?

No action

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

We received positive feedback from 28 patients. The practice also received patient feedback via internal surveys and through the practice website. Feedback was consistently positive. Patient survey results were complimentary about the practice staff and treatment received. Patient survey results said that the staff were kind and caring and that they were treated with dignity and respect at all times.

Summary of findings

We found that dental care records were stored securely and patient confidentiality was maintained.

Are services responsive to people's needs?

No action

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

Patients had good access to appointments, including emergency appointments, which were available on the same day.

There was a complaints policy. Complaints were addressed in a timely way and resolutions aimed to the satisfaction of the complainant. Systems were in place for receiving more general feedback from patients, with a view to improving the quality of the service. This included patient testimonials sent directly to the practice via their website. Systems were in place to publicise responses from the practice about what had been done as a result of patient feedback.

The culture of the practice promoted equality of access for all. The practice had level access from the street and provided accessible facilities.

Are services well-led?

No action

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

The practice had clinical governance and risk-management structures in place. Clinical audits were not yet fully developed to inspire improvements and learning.

Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the management team. They were confident in the abilities of the managers to address any issues as they arose.

Devon Teeth Straightening Clinic

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.

We carried out an announced, comprehensive inspection on 6 March 2017. The inspection was led by a CQC inspector who had access to remote advice from a specialist advisor.

We reviewed information received from the provider prior to the inspection. During our inspection we reviewed policy documents and spoke with three members of staff (practice manager, dentist and locum dental nurse). We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. The practice manager/dental nurse demonstrated how they carried out decontamination procedures of dental instruments.

Twenty eight patients provided feedback about the service. We also looked at written comments about the practice on the practice website and patient survey results. Patients were positive about the care they received from the practice. They were complimentary about the friendly, professional and caring attitude of the dental staff. Patients commented that they were likely to recommend the practice.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There was a system for reporting and learning from incidents. There had been no significant events related to patients, visitors or staff in the past year.

We discussed the investigation of incidents with the management team. They confirmed that if patients were affected by something that went wrong, they were given an apology and informed of any actions taken as a result. Practice staff were aware of their responsibilities under the Duty of Candour, although the term was not immediately recognised by the staff. The practice manager told us they would source leaflets for the staff team and include discussion of this in the next staff meeting. (Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity).

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any such incidents in the past 12 months.

There was a small staff team of six at the practice. Whole staff team meetings were held bi-monthly and there were daily team briefs before the practice opened. Team meetings were recorded and we looked at a sample of team meeting minutes. We saw that there were records of when actions resulting from team meetings were addressed and signed off as closed.

Reliable safety systems and processes (including safeguarding)

The group director was the named practice lead for child and adult safeguarding. We spoke with the staff on duty, who were able to describe the types of behaviour a child might display that would alert them to possible signs of abuse or neglect. They also had a good awareness of the issues around vulnerable elderly patients who presented with dementia.

The practice had a safeguarding policy, reviewed in the last 12 months. The policy referred to national and local guidance. Information about the local authority contacts for safeguarding concerns was held in a file in a staff only area. The staff we spoke with were aware of the location of this information. There was evidence in staff files showing that all staff had been trained in safeguarding adults and children to an appropriate recommended level of training for their roles.

The practice had carried out a range of risk assessments with a view to keeping staff and patients safe. For example, we asked staff about the prevention of needle stick injuries. The practice had a current policy on the re-sheathing of needles, giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Staff were aware of the contents of this policy. The staff we spoke with demonstrated a clear understanding of the practice policy and protocol with respect to handling sharps and needle stick injuries.

The practice followed other national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments in line with guidance from the British Endodontic Society. (A rubber dam is a thin, rectangular sheet, usually latex-free rubber, used in dentistry to isolate the operative site from the rest of the mouth).

Medical emergencies

The practice had arrangements to deal with medical emergencies. The practice had an oxygen cylinder, and other related items, such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The practice did not have an automated external defibrillator for use in a medical emergency, but the provision of such was being considered by the provider. (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). The practice staff told us that there was a public AED nearby (approximately 150 metres), available for use during opening hours of the practice.

The practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. The emergency medicines were all in date and stored securely with emergency oxygen in a location known to all staff.

Are services safe?

Staff received annual training in using the emergency equipment. The staff we spoke with were all aware of the location of the emergency equipment. This equipment was checked for safe use each day the practice was open.

Staff recruitment

The staff structure of the practice consisted of a group director/dentist, practice manager/dental nurse/ receptionist, dentist, dental hygienist and two dental nurses.

There was a recruitment policy which stated that all relevant checks would be carried out to confirm that any person being recruited was suitable for the role. This included the use of an application form, interview, review of employment history, evidence of relevant qualifications, the checking of references and, where relevant, a check of registration with the General Dental Council.

It was practice policy to carry out a Disclosure and Barring Service (DBS) check for all members of staff prior to employment and periodically thereafter. We saw evidence that all members of staff had a DBS check. (The DBS 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 looked a selection of staff files. Required information was included in the files we viewed.

Monitoring health & safety and responding to risks

There were arrangements to deal with foreseeable emergencies. We saw that there was a health and safety policy in place. The practice had considered the risk of fire, had clearly marked exits and an evacuation plan. There were also fire extinguishers situated at suitable points in the premises. The practice carried out annual fire drills to ensure staff followed the fire evacuation protocol. Records showed fire detection systems and extinguishers were regularly serviced.

There were arrangements to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. COSHH products were securely stored.

The practice had a system for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA). Relevant alerts were sent electronically to the dentists, hygienist and practice manager for discussion and action.

Infection control

There were systems to reduce the risk and spread of infection within the practice. There was an infection control policy, which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. However, there were no written protocols for the renewal of heavy duty gloves used in the decontamination and sterilisation of dental instruments, or for monitoring water temperatures when hand cleaning dental instruments. The practice policy on infection control had not identified risk to trainee dental nurses who were receiving immunisations to protect themselves from blood born viruses and the risks associated with assisting with clinical procedures during this time. The practice manager said that trainee dental nurses would not assist with invasive procedures before they had appropriate immunisations, and that this would be written into the infection control policy. They told us that a protocol for changing heavy duty gloves in the decontamination room on a weekly basis would be written. They also said that a thermometer would be purchased for the sink in the decontamination room, to ensure staff monitored and recorded suitable water temperatures when cleaning dental instruments.

There were bi-annual audits of infection control processes at the practice using a recognised industry assessment tool.

We observed that the premises appeared clean, tidy and clutter free. Clear zoning demarked clean from dirty areas in all of the treatment and decontamination rooms. Hand-washing facilities were available, including wall-mounted liquid soap, hand gels and paper towels in each of the treatment and decontamination rooms.

The practice manager (who was a dental nurse) described to us the end-to-end process of infection control procedures at the practice. The protocols described demonstrated that the practice followed the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)'.

Are services safe?

There was a purpose built decontamination room and two dental surgeries. The practice manager described the process they followed to ensure that the working surfaces, dental units and dental chairs were decontaminated. This included the treatment of the dental water lines. Environmental cleaning was carried out in accordance with the national colour coding scheme by the practice staff and there were written cleaning schedules.

We checked the contents of the drawers in the two treatment rooms. These were well stocked, clean, ordered and free from clutter. All of the instruments were pouched but we saw that there was some confusion with the date stamping of dental instruments, where some staff had stamped the date the instruments had been sterilised and others the date the sterilisation was effective until. The practice manager said their policy was to date with the day the sterilisation was effective until. They removed others incorrectly dated and said these would be re-sterilised, repackaged and re-date stamped. They also said a written protocol would be put up in the decontamination room for date stamping for the benefit of locum staff. Each treatment room had the appropriate personal protective equipment, such as gloves and aprons, available for staff and patient use. We noted, however, that local anaesthetic cartridges were stored loosely individually and not in recommended sealed blister packs to minimise cross infection. We raised this with the practice manager who told us they would revise this storage to the recommended guidance.

Instruments were manually cleaned in the treatment room then inspected under an illuminated magnification device and then placed in an autoclave (steriliser). When instruments had been sterilised, they were pouched and stored appropriately until required.

The practice carried out checks of the autoclave to assure that it was working effectively. Twice daily checks when the practice was open included the automatic control test and steam penetration test. A log book was used to record the essential daily validation checks of the sterilisation cycles.

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

Staff files showed that staff regularly attended training courses in infection control. Clinical staff were also required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. (People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections.)

The dental water lines were maintained to prevent the growth and spread of legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings). The practice manager described the method they used which was in line with current HTM 01-05 guidelines. A legionella risk assessment had most recently been carried out by an external contractor during 2015. The practice was following recommendations to reduce the risk of legionella, for example, through the regular testing of the water temperatures. The practice kept a record of the outcome of these checks on a monthly basis.

Equipment and medicines

We found that the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor, fire equipment and X-ray equipment had all been inspected and serviced. Certificates for pressure equipment had been issued in accordance with the Pressure Systems Safety Regulations 2000. Portable appliance testing (PAT) had been completed in accordance with current guidance. PAT is the name of a process during which electrical appliances are routinely checked for safety every two years as a minimum.

The expiry dates of medicines, oxygen and equipment were monitored using daily, weekly and monthly check sheets to support staff to replace out-of-date medicines and equipment promptly. Dental care products requiring refrigeration were stored in a fridge in line with the manufacturer's guidance.

Radiography (X-rays)

There was a radiation protection file, which was in the process of being completed at the time of the inspection, in

Are services safe?

line with the Ionising Radiation Regulations (IRR) 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor as well as the documentation pertaining to the maintenance of the X-ray equipment. We saw that the X-ray equipment had been serviced in 2016, within the three yearly recommended maintenance cycle.

We saw evidence that the dentists had completed radiation training in the last 12 months.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentist and hygienist carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. We spoke with the dentist and asked them to describe to us how they carried out their assessments. The assessment began with the patient completing a medical history update covering any health conditions, medicines being taken and any allergies suffered. We saw patients being asked to complete a medical history when they booked in for their appointment to give to the dentist. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and checking for the signs of mouth cancer. Patients were made aware of the condition of their oral health and whether it had changed since the last appointment.

The patients' dental care record was updated with the proposed treatment after discussing options with the patient. Treatment plans were printed for each patient, which included information about the costs. Patients were referred to the practice information leaflet, or website for cost information on routine treatments. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

We checked a sample of dental care records for the dentist and hygienist to confirm the findings. These showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums and soft tissues lining the mouth were noted using the basic periodontal examination (BPE) scores. (The BPE 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 carried out, where appropriate, during a dental health assessment.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. The dentist told us they discussed oral health with their patients, for example, around effective tooth brushing. They were aware of the need to discuss a general preventive agenda with their patients. They told us they held discussions with their patients, where appropriate, around smoking cessation, sensible alcohol use and diet. The dentist also carried out examinations to check for the early signs of oral cancer.

We observed that there were health promotion materials displayed in the reception area. These could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition.

Staffing

Staff told us they received appropriate professional development and training. We checked the staff recruitment files and saw that this was the case. The training covered the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, safeguarding, infection control and X-ray training.

There was a written induction programme for new staff to follow and evidence in the staff files that this had been used at the time of their employment.

Staff told us that the management team was supportive and invested in their staff through regular training opportunities to promote clinical excellence at the practice.

Working with other services

The practice had suitable arrangements for working with other health professionals to ensure quality of care for their patients.

Staff at the practice explained how they worked with other services, when required. The dentist and hygienist were able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. For example, the practice made referrals to other specialists for complex orthodontic work.

We reviewed the systems for referring patients to specialist consultants in secondary care. A referral letter was prepared and posted to the hospital with full details of the dentist's findings and a copy was stored on the practice's records system. We looked at examples of referral letters. These were comprehensively completed and referrals took place in a timely way to avoid delay to treatment. The receptionist kept an electronic record noting the dates when referrals were made, when the appointment had

Are services effective?

(for example, treatment is effective)

been completed and further actions required for follow up. They contacted other providers to check on the progress of their patients and kept the referring dentist informed about the outcomes.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. We spoke to the dentist about their understanding of consent issues. They explained that individual treatment options, risks, benefits and costs were discussed with each patient. Patients were asked to sign formal written consent forms for specific treatments. We looked at patient electronic records and saw consent to treatment was suitably recorded in the patient dental care records.

All of the staff were aware of the Mental Capacity Act 2005. (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 themselves). Clinical staff had completed formal training in relation to the MCA in 2016. The dentist could describe scenarios for how they would manage a patient who lacked the capacity to consent to dental treatment. They noted that they would involve the patient's family, check for appropriate lasting power of attorney authorisation to act on a person's behalf, along with other professionals involved in the care of the patient, to ensure that the best interests of the patient were met.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The 28 comments cards we received, all made positive remarks about the staff's caring, professional and helpful attitude. Patients indicated that they felt comfortable and relaxed with their dentist and that they were made to feel at ease during consultations and treatments. We also observed staff were welcoming and helpful when patients arrived for their appointment or made enquiries over the phone.

Staff were aware of the importance of protecting patients' privacy and dignity. The premises were small and there were two treatment rooms. One of the treatment rooms, used by the hygienist, was situated close to the reception area and had a folding door, which was put in place whilst consultations or treatment were taking place. However, this arrangement meant that on occasion patients in the waiting area would be able to hear conversations in this room. The practice manager told us that if patients preferred to be seen in the second treatment room that was further away from the reception area, this request was honoured. There was music playing in the reception area to reduce noise from the nearby treatment room.

Staff understood the importance of data protection and confidentiality and had received training in information governance. Patient records were electronically stored. Computers were password protected and regularly backed up.

Involvement in decisions about care and treatment

The practice detailed information about services on the practice website and in the practice information booklet. This gave details of the range of services available, dental charges or fees and payment options (such as membership of private dental schemes).

We spoke with the three staff on duty on the day of our inspection. All of these staff told us they worked towards providing clear explanations about treatment and prevention strategies. We saw evidence in the records that the dentist recorded the information they had provided to patients about their treatment and the options open to them. The patient feedback we received confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system to schedule enough time to assess and meet patients' dental needs. The dentist and hygienist decided on the length of time needed for their patient's consultation and treatment according to patient need. Additional same day urgent appointments were also scheduled for patients. The feedback we received from patients indicated that they felt they had enough time with the dentist and were not rushed.

Staff told us that patients could book an appointment in good time to see the dentist. The feedback we received from patients confirmed that they could get an appointment when they needed one, and that this included good access to emergency appointments on the day that they needed to be seen.

During our inspection we looked at examples of information available to people. The practice website contained a variety of information, including opening hours and costs. There was also a printed patient information leaflet at the practice.

Tackling inequity and promoting equality

The practice recognised the needs of different groups in the planning of its service. There was an equality and diversity policy for staff to refer to. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. The practice manager said that they could provide written information for people who were hard of hearing and translation services were available for patients speaking English as a second language.

The practice was purpose built and opened in 2015. It was designed with patient accessibility in mind. Patients who used a wheelchair could access the practice from the ground level access and there were ground floor treatment rooms with an accessible ground floor toilet.

Access to the service

The practice opening hours were from Monday to Friday 10am – 6pm, with some occasional Saturday opening by appointment/patient request. There was an answer phone message directing patients to emergency contact numbers when the practice was closed.

The practice manager told us that those patients, who needed to be seen urgently, for example because they were experiencing dental pain, were seen on the same day that they alerted the practice of their concerns. The feedback we received via comment cards confirmed that patients had good access to the dentist in the event of needing emergency treatment.

Concerns & complaints

Information about how to make a complaint was displayed in the reception area and in the practice leaflet. There was a formal complaints policy describing how the practice handled formal and informal complaints from patients. There had been seven complaints recorded in the last 12 months 2016 regarding appointment, dental work or fees. We looked at the complaints in detail. They were handled in a timely way and resolved to the satisfaction of the patient complaining.

Patients were also invited to give feedback via the practice webpage. The practice also used patient surveys, in which patients could remain anonymous. There were systems in place which publicised the action taken by the practice as a result of patient feedback through the practice website.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements and a management structure. The governance arrangements for this location were overseen by the practice manager who was responsible for

the day to day running of the practice. They were supported by the group director/practice owner.

There were relevant policies and procedures. Staff were aware of these and acted in line with them. There were arrangements for identifying, recording and managing risks through the use of risk assessment processes; although in this report we have made some recommendations regarding review of some practice protocols in relation to risk.

Regular staff meetings took place at the practice with records maintained of all staff meetings. Minutes from staff meetings were circulated electronically to staff.

The practice manager told us about the governance structures and protocols at the practice. A systematic process of induction and staff training was in place which ensured that staff were aware of, and were following, the governance procedures.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said that they felt comfortable about raising concerns with the senior managers at the practice. They felt they were listened to and responded to when they did so.

We found staff to be dedicated in their roles and caring towards the patients. We found the dentists provided effective clinical leadership to the dental team.

Staff told us they enjoyed their work and were supported by the senior managers. All staff had received a documented appraisal in the last 12 months.

Learning and improvement

There were clinical audits taking place at the practice. These included clinical record keeping and X-ray quality. However, there was not yet evidence of meaningful repeat audits as most were informally logged through discussion at team meetings, rather than formalised, standardised and therefore repeatable for comparison purposes. We discussed this with the practice manager who told us they would devise a formal annual audit cycle plan and devise standardised audit tools for recording the audits to improve the robustness of the audit cycle.

Staff were being supported to meet their professional standards and complete continuing professional development (CPD) standards set by the General Dental Council (GDC). We saw evidence that the clinical staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the GDC. Training was completed through a variety of resources including the attendance at face to face and online courses. Staff were given time to undertake training which would increase their knowledge of their role.

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

The practice gathered feedback from patients through the practice website and patient surveys. Actions had been taken as a result. For example, providing colouring books and pens in the reception area for children waiting to be seen by the dentist.

Staff told us that the management team were open to feedback regarding the quality of the care. All staff were aware of the practice whistleblowing policy and felt they could raise concerns, which would be acted upon by the management team.