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Parchmore Dental Centre

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 18 June 2015 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.

Parchmore Dental is located in the London Borough of Croydon. The premises consist of two treatment rooms and two dedicated decontamination rooms and an X-ray room. There are also toilet facilities, a waiting room, a reception area, an administrative office and a store room.

The practice provides NHS and private dental services and treats both adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers, crowns and bridges, tooth whitening and oral hygiene.

The staff structure of the practice is comprised of two principal dentists (who are also the owners), one dentist, a dental nurse, a practice manager and two receptionists.

The practice is open Monday to Wednesday from 9.00am to 5.00pm, Thursday from 9.00am to 6.00pm and Friday from 9.00am to 4.00pm.

One of the principal dentists was the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Summary of findings

We carried out an announced, comprehensive inspection on 18 June 2015. The inspection took place over one day and was carried out by two CQC inspectors and a dentist specialist advisor.

We received 50 CQC comment cards completed by patients and spoke with three patients during our inspection visit. Patients we spoke with, and those who completed comment cards, were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the staff.

Our key findings were:

- Patients' needs were assessed and care was planned in line with best practice guidance, such as from the National Institute for Health and Care Excellence (NICE).
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, oxygen cylinder and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and patient practice team.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- The principal dentist had a clear vision for the practice and staff told us they were well supported by the management team.
- There were governance arrangements in place and the practice effectively used audits to monitor and improve the quality of care provided.

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

- Ensure that at least two references are sought and kept for all members of staff when they are recruited.
- Review the protocol for sterilising instrument trays with due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices.
- Ensure all staff, including the staff who have responsibility for cleaning the premises, have received training in infection control processes.
- Reassess the arrangements for the storage and checking of medicines, including the monitoring of the fridge and stock-checking protocols.
- Consider having in place a formal business continuity plan to ensure continuity of care in the event that the practice's premises could not be used for any reason.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had systems in place to minimise the risks associated with providing dental services. The practice had policies and protocols related to the safe running of the service. Staff were aware of these and were following them. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse. Equipment was well maintained and checked for effectiveness. The practice had systems in place for the management of infection control and waste disposal, management of medical emergencies and dental radiography.

However, we also found that the practice had a recruitment policy in place, but had not sought references for all members of staff. The practice did not have a business continuity plan in place to ensure continuity of care in the event that the practice's premises could not be used for any reason. There were generally good infection control processes, although instrument trays were not routinely sterilised and some staff, who had responsibility for cleaning the premises, had not received formal training in infection control. The fridge where medicines were stored was not being monitored to ensure that temperatures remained within a safe range. Some items stored in the fridge and stock cupboard were out of date.

Are services effective?

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

The practice could demonstrate they followed relevant guidance, for example, issued by 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. There were systems in place for recording written consent for treatments.

The practice maintained appropriate medical records and details were updated appropriately The practice worked well with other providers and followed patients up to ensure that they received treatment in good time.

Staff engaged in continuous professional development (CPD) and were meeting the training requirements of the General Dental Council (GDC).

Are services caring?

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

We received feedback from patients through comment cards that they were treated with dignity and respect. They noted a positive and caring attitude amongst the staff. We found that patient records were stored securely and patient confidentiality was well maintained.

Are services responsive to people's needs?

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. Members of staff spoke a range of languages which supported good communication between staff and patients. The needs of people with disabilities had been considered in terms of accessing the service. Patients were invited to provide feedback via a satisfaction survey, including the use of the 'Friends and Family Test', in the waiting area. There was a clear complaints procedure and information about how to make a complaint was displayed in the waiting area.

Summary of findings

Are services well-led?

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

There were good clinical governance and risk management systems in place. There were regular staff meetings and systems for obtaining patient feedback. We saw that feedback from staff or patients had been carefully considered and appropriately responded to.

The principal dentists had a clear vision for the type of practice they wanted to provide. These values were shared and understood by other members of staff. Staff felt well supported and confident about raising any issues or concerns with the principal dentists or practice manager.

Parchmore Dental Centre

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 18 June 2015. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a dentist specialist advisor.

We reviewed information received from the provider prior to the inspection. We also informed the NHS England area team and the local Healthwatch that we were inspecting the practice; however we did not receive any information of concern from them.

During our inspection visit, we reviewed policy documents and dental care records. We spoke with six members of staff, including the management team. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We observed dental nurses carrying out decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area.

We reviewed 50 Care Quality Commission (CQC) comment cards completed by patients and spoke with two patients in the waiting area. Patients we spoke with and those who completed comment cards were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

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 an effective system in place for reporting and learning from incidents. There had been no incidents or accidents reported in the past year. However, there was a policy in place which described the actions that staff needed to take in the event that something went wrong or there was a 'near miss'. The practice manager and dentist confirmed that if patients were affected by something that went wrong, they would be given an apology and informed of any actions taken as a result.

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

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding adults. This included contact details for the local authority safeguarding team, social services and other agencies, such as the Care Quality Commission. This information was displayed in the administrative office.

The dentist and the receptionist, who had prior experience of working with vulnerable children, took the lead in managing safeguarding issues. They were aware of local issues regarding foster care and kept a list of potentially vulnerable children and their carers so that they could offer appropriate support. Staff had completed safeguarding training and were able to describe what might be signs of abuse or neglect and how they would raise concerns with the safeguarding lead. There had been no safeguarding issues reported by the practice to the local safeguarding team.

Staff were aware of the procedures for whistleblowing if they had concerns about another member of staff's performance. Staff told us they were confident about raising such issues with the principal dentist or practice manager.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, a practice-wide risk assessment had been carried out in December 2014 which covered topics such as fire safety, the safe use of X-ray equipment, disposal of waste, and the safe use of sharps (needles and sharp instruments). The practice manager could demonstrate that they followed up any issues identified during audits as a method for minimising risks. For example, the fire safety audit had identified that an emergency light needed replacing and we observed that this had been done.

The practice followed national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments. 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.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. All staff had received training in emergency resuscitation and basic life support. This training was renewed annually. The staff we spoke with were generally aware of the practice protocols for responding to an emergency. However, one of the principal dentists was unaware of the location of the emergency equipment. They were made aware of this on the day of the inspection.

The practice had suitable emergency equipment in accordance with guidance issued by the Resuscitation Council UK. This included relevant emergency medicines and oxygen. There were face masks of different sizes for adults and children. The equipment was regularly tested by staff and a record of the tests was kept. However, the practice did not have an automated external defibrillator (AED). (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 had considered this risk and had made an arrangement with a local medical centre and with a supermarket located on the same road to use their AED in the event of an emergency. They were also looking into purchasing their own AED as part of the development plan for the practice.

Staff recruitment

The practice staffing consisted of two principal dentists (who were also the owners), one dentist, a dental nurse, a practice manager and two receptionists. We reviewed the staff files and saw that the practice carried out some relevant checks to ensure that the person being recruited

Are services safe?

was suitable and competent for the role. This included the checking of qualifications, identification, registration with the General Dental Council (where relevant) and checks with the Disclosure and Barring Service (DBS). However, we noted that the practice had not kept copies of references for all members of staff. We saw that a reference had been kept for the receptionist, but not for the dentist or dental nurse. The practice manager subsequently sent us a reference obtained for the dentist via email which was dated after the inspection. The dental nurse had no professional reference as it was their first job, but references were not sought from other people who had known the nurse for some time.

We noted that the practice had carried out DBS checks for all members of staff within the past three years, regardless of the date when they had initially been recruited.

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety policy in place. The practice had been assessed for risk of fire and there were documents showing that fire extinguishers had been recently serviced.

There were effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors that were associated with hazardous substances had been identified and actions were described to minimise these risks. We saw that COSHH products were securely stored.

The practice responded promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. MHRA alerts arrived via email to the practice manager who then disseminated these alerts to the other staff, where appropriate. The practice manager kept records of alerts received. We could see that the practice had responded to some alerts, for example, information about Ebola risk was displayed in the waiting area following an alert.

The practice did not have a business continuity plan in place to ensure continuity of care in the event that the practice's premises could not be used for any reason.

Infection control

There were systems in place to reduce the risk and spread of infection. 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. The dental nurse was the infection control lead. Staff files we reviewed showed that staff regularly attended external training courses in infection control.

The practice had 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)'. 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 rooms which ensured the risk of infection spread was minimised.

We examined the facilities for cleaning and decontaminating dental instruments. There were two dedicated decontamination rooms; one for 'dirty' and one for 'clean' instruments. The dental nurse showed us how they used the rooms and demonstrated a good understanding of the correct processes. The dental nurse wore appropriate protective equipment, such as heavy duty gloves and eye protection. Items were manually cleaned before being place in an ultrasonic cleaner. An illuminated magnifier was used to check for any debris during the cleaning stages. Items were placed in an autoclave (steriliser) after cleaning. Instruments were placed in pouches after sterilisation and a date stamp indicated how long they could be stored for before the sterilisation became ineffective. However, we noted that the instrument trays were only placed in the autoclave on a weekly rather than daily basis, although they were manually cleaned between patients and covered with a protective paper after each use.

The autoclave was checked daily for its performance, for example, in terms of temperature and pressure. A log was kept of the results demonstrating that the equipment was working well. The ultrasonic cleaner was also being checked with a 'foil' test, although only a single foil was kept in the records. The foils that were kept indicated that the cleaner was working effectively.

There had been regular, six-monthly infection control audits and an external infection control audit had been carried out by NHS England in March 2015. This had not identified any issues.

Are services safe?

The practice used a system of individual consignments and invoices with a waste disposal company. Waste was being appropriately stored and segregated. This included clinical waste and safe disposal of sharps. Staff demonstrated they understood how to dispose of single-use items appropriately.

Records showed that a Legionella risk assessment had been carried out by an external company in March 2015. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). This process identified some risks. The practice demonstrated that they had acted on this advice to minimise the risks. For example, they could demonstrate they were now testing and recording hot and cold water temperatures on a monthly basis. We also saw evidence that dental water lines were being flushed in accordance with current guidance in order to prevent the growth of Legionella.

The premises appeared clean and tidy. There was a good supply of cleaning equipment which was stored appropriately. The practice had a cleaning schedule that covered all areas of the premises and detailed what and where equipment should be used. This took into account national guidance on colour coding equipment to prevent the risk of infection spread. However, we noted that the practice manager and receptionist, who had responsibility for cleaning the premises, had not received any training in infection control.

There were good supplies of protective equipment for patients and staff members including gloves, masks, eye protection and aprons. There were hand washing facilities in the treatment rooms, the decontamination room and the toilets.

All of the staff were 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.

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. Portable appliance testing (PAT) was completed in accordance with good practice guidance. PAT is the name of a process during which electrical appliances are routinely checked for safety.

Prescription pads were kept to the minimum necessary for the effective running of the practice. They were individually numbered and stored securely in the administrative office.

Batch numbers and expiry dates for local anaesthetics were recorded in the clinical notes. These medicines were stored safely and could not be accessed inappropriately by patients.

Some medicines were stored in a fridge and further stock supplies were stored in one of the treatment rooms. The practice was not monitoring and recording the fridge temperature. Therefore staff could not be sure that medicines stored in the fridge had been maintained in line with manufacturer's guidance and there was a risk that they had become ineffective. There were also two items, one stored in the fridge and one in the stock cupboard, which were out of date. We discussed these issues with the practice manager who decided that they would now take responsibility for recording the fridge temperature and managing stock appropriately.

Radiography (X-rays)

The practice kept a radiation protection file in relation to the use and maintenance of X–ray equipment. There were suitable arrangements in place to ensure the safety of the equipment. The local rules relating to the equipment were held in the file and displayed in clinical areas where X-rays were used. The procedures and equipment had been assessed by an external radiation protection adviser (RPA) within the recommended timescales. One of the clinical dental team members was the radiation protection supervisor (RPS). All clinical staff including the RPS had completed radiation training. X-rays were graded and audited as they were taken.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We reviewed dental care records kept by the dentist and discussed patient care with the principal dentist, dentist and practice manager. We found that the dentists regularly assessed patient's gum health and soft tissues (including lips, tongue and palate). Details of the treatment included local anaesthetic details such as the type, site of administration, batch number and expiry date. Dentists took X-rays at appropriate intervals, as informed by guidance issued by the Faculty of General Dental Practice (FGDP). They also recorded the justification, findings and quality assurance of X-ray images taken.

The records showed that an assessment of periodontal tissues was periodically undertaken using the basic periodontal examination (BPE) screening tool. (The BPE is a simple and rapid screening

tool used by dentists to indicate the level of treatment need in relation to a patient's gums.) Different BPE scores triggered further clinical action.

The dentist always checked people's medical history and medicines prior to treatment. The receptionist supported this work by checking each day the list of patients who needed to complete a new, written medical history form.

The practice kept up to date with current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to deciding appropriate intervals for recalling patients, antibiotic prescribing and wisdom teeth removal. The dentists were aware of the Delivering Better Oral Health Toolkit when considering care and advice for patients.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. Staff told us they discussed oral health with their patients, for example, effective tooth brushing or dietary advice. Dentists identified patients' smoking status and recorded this in their notes. This prompted them to provide advice or consider how smoking status might be impacting on their oral health. Dentists also carried out examinations to check for the early signs of oral cancer.

We observed that there were a range of health promotion materials displayed in the waiting 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. There was information in the waiting area which described the local availability of stop smoking services.

Staffing

Staff told us they received appropriate professional development and training. We reviewed staff files and saw that this was the case. The training covered all of the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies and infection control. There was an induction programme for new staff to follow to ensure that they understood the protocols and systems in place at the practice.

The staff files showed that staff had been engaged in an appraisal process because records were kept of meetings that had been held. The meetings identified staff training needs and career goals. There were training review records which showed when training goals had been met.

Working with other services

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients. The dentist used a system of onward referral to other providers, for example, for oral surgery or advanced conservation. The practice kept a file with referral forms for local secondary and tertiary providers. The practice manager and the receptionist ensured that referral letters were sent out on the same day that the dentist made the recommendation. All letters were scanned into patient's notes kept on the computer. Patients were offered a copy of their referral letters to ensure they understood which service they had been referred to. When the patient had received their treatment they were discharged back to the practice for further follow-up and monitoring.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. Staff discussed treatment options, including risks and benefits, as well as costs, with each

Are services effective?

(for example, treatment is effective)

patient. Patients confirmed that treatment options, and their risks and benefits were discussed with them. However, our review of the clinical records found that these discussions were not consistently recorded.

Formal written consent was obtained using standard treatment plan forms. Patients were asked to read and sign these before starting a course of treatment. We also saw that the practice had written consent forms for specific procedures such as wisdom teeth removal or teeth whitening.

Dentists and dental nurses were aware of the Mental Capacity Act (2005). They could accurately explain the meaning of the term mental capacity and described to us their responsibilities to act in patients' best interests, if patients lacked some decision-making abilities. 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.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The comments cards we received and the patients we spoke with all commented positively on staff's caring and helpful attitude. Parents were pleased with the level of care their children received. Patients who reported some anxiety about visiting the dentist commented that the dental staff mad them feel comfortable and were well-supported by the staff.

We observed staff were welcoming and helpful when patients arrived for their appointment. The receptionist spoke politely and calmly to all of the patients. The practice manager was often available to speak to in the waiting area and they clearly knew some of the patients well. The practice manager supported patients during their visit, for example, by providing verbal reassurance or by speaking to people in their preferred language.

Doors were always closed when patients were in the treatment rooms. Patients indicated they were treated with dignity and respect at all times.

Patient records were stored electronically and in a paper-based format. Electronic records were password protected and regularly backed up. Paper records were stored in locked filing cabinets in the administrative office. Staff understood the importance of data protection and confidentiality. They described systems in place to ensure that confidentiality was maintained. For example, the receptionist was careful to close and lock the desk to ensure separation was maintained between the waiting and reception areas. The receptionist's computer screen was positioned in such a way that it could not be seen by patients in the waiting area. The receptionist showed us the policies on confidentiality and data protection with her own highlighted notes demonstrating that she took the time to understand the protocols. Staff also told us that people could request to have confidential discussions in an empty treatment room or in the administrative office, if necessary.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area which gave details of NHS and private dental charges or fees. On the day of our inspection we observed the receptionist took time to explain NHS charges to patients in detail.

Staff told us that they took time to explain the treatment options available. They spent time answering patients' questions and gave patients a copy of their treatment plan. There was a range of information leaflets in the waiting area which described the different types of dental treatments available. The patient feedback we received via discussions and comments card confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff. They told us that treatment options were well explained; the dentist listened and understood their concerns, and respected their choices regarding treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. The practice manager gave a clear description about which types of treatment or reviews would require longer appointments. The dentist used a colour-coded system on the practice computer to indicate the type of treatment required so that the receptionist knew how long the appointment needed to be. The dentist also specified the timings for some patients when they considered that the patient would need an appointment that was longer than the typical time.

The dentist told us they had enough time to treat patients and that patients could generally book an appointment in good time to see them. The feedback we received from patients confirmed that they could get an appointment within a reasonable time frame and that they had adequate time scheduled with the dentist to assess their needs and receive treatment.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. Staff spoke a range of different languages and also had access to a telephone translation service. We observed the practice manager assisting a patient who did not have English as their first language on the day of the inspection. The practice manager was able to support the patient through providing a verbal translation of the medical history form.

The practice provided written information for people who were hard of hearing and large print documents for patients with some visual impairment. The practice was wheelchair accessible with level access to the reception area and treatment rooms. The toilet was also suitable for wheelchairs and included appropriate hand rails.

Access to the service

The practice is open Monday to Wednesday from 9.00am to 5.00pm, Thursday from 9.00am to 6.00pm and Friday from 9.00am to 1.00pm. The practice displayed its opening hours on their premises and on the practice website. New patients were also given a practice information leaflet which included the practice contact details and opening hours. We noted that the opening hours displayed on the leaflet and website did not accurately match the opening hours displayed on the premises or described to us on the day. For example, the leaflet indicated the practice was open on a Saturday morning and the website showed the practice was open until 4.00pm on a Friday.

Patients could book an appointment up to two weeks in advance. Patients told us that they could get an appointment in good time and did not have any concerns about accessing the dentist. The receptionist showed us that she also kept a list of patients who wanted to be seen more quickly in the event that there were any late cancellations by other patients. She showed us an example of how she had used this list in the past week to enable some patients to access the dentist quickly following a cancellation.

We asked the receptionist about access to the service in an emergency or outside of normal opening hours. They told us the answer phone message and the practice leaflet gave details on how to access out of hours emergency treatment. She also displayed the information about local emergency dental services on the wall in the waiting area. The practice manager and receptionist told us that the dentist had some gaps in their schedule on any given day which meant that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, could be accommodated.

Concerns & complaints

Information about how to make a complaint was displayed in the reception area. There was a complaints policy describing how the practice would handle formal and informal complaints from patients. However, no complaints had yet been received by the practice. The complaints policy specified that the practice manager was responsible for leading investigations following any complaints and that they would seek advice from the dentist following any clinical complaint. The practice would acknowledge complaints within three days and aim to have them fully resolved within six months. The patients we spoke with told us they could approach the receptionist or the practice manager if they wanted to make a complaint.

The practice also collected feedback through the use of the 'Friends and Family Test'. The survey forms for this test were displayed in the waiting area. In the past, the practice had also used its own patient feedback survey to identify any

Are services responsive to people's needs?

(for example, to feedback?)

concerns. The majority of the feedback collected during the past year indicated a high level of satisfaction. There was some feedback regarding improving the waiting area environment. We saw that the practice had acted on this feedback. For example, they had now installed a drinking water machine in the waiting area.

Are services well-led?

Our findings

Governance arrangements

The practice had good governance arrangements with an effective management structure. New providers had taken over the running of the practice in November 2013. They had implemented, with the support of the practice manager, suitable arrangements for identifying, recording and managing risks through the use of scheduled risk assessments and audits. There were relevant policies and procedures in place. These were all frequently reviewed and updated. Staff were aware of these policies and procedures and acted in line with them. There were weekly informal practice meetings, as well as more formal staff meetings, where necessary, to discuss key governance issues. For example, we saw minutes from meetings where issues such as infection control and information governance had been discussed. This facilitated an environment where improvement and continuous learning were supported.

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 principal dentists or practice manager. They felt they were listened to and responded to when they did so.

We spoke with one of the principal dentists who told us they aimed to provide high-quality care in a sometimes challenging environment where, due to the relatively high level of population movement in the area, continuity of care could sometimes be difficult to achieve. They were committed to both maintaining and continuously improving the quality of the care provided. For example, they demonstrated how they had supported and responded to the dentist's requests to refurbish and improve the equipment available.

The staff we spoke with all told us they enjoyed their work and were well-supported by the management team. There was a system of staff appraisals to support staff in carrying out their roles to a high standard. Notes from these appraisals demonstrated that they successfully identified staff's training and career goals.

Management lead through learning and improvement

All staff were supported to pursue development opportunities. We saw evidence that staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the General Dental Council (GDC).

The practice had a programme of clinical audit in place. These included audits for infection control, clinical record keeping and X-ray quality. The audits showed a generally high standard of work, but identified some areas for improvement. For example, the records audit for the dentist showed that they could improve their recording of when standard treatment or consent forms had been given to, or discussed with, patients. The audits had all been initiated within the past six months and were due to repeat after a year to determine if any changes implemented had led to an improvement in performance.

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

The practice gathered feedback from patients through the use of a patient satisfaction survey during the past year. They had also collected information through the 'Friends and Family Test', with 80 responses received since April 2015. The overwhelming majority of feedback had been positive. For example, all but one of the people responding the 'Friends and Family Test' said that they would be 'likely' or 'extremely likely' to recommend this practice to someone else.

We noted that the practice acted on feedback from patients where they could. For example, some people had made a suggestion regarding the provision drinking water in the waiting area. We observed that a cold water machine had now been installed. This showed that the feedback had been used to improve patient's experiences of coming to the practice.

We also noted that the practice manager had carried out a survey with members of staff to gather their feedback about the running of the practice. Copies of the survey were held in the staff files. This survey also showed that staff were positive about the working environment and ability of staff to work together as a team to ensure a high quality service.