

GHB Oral Health Limited

GHB Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 14 July 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

GHB Dental Practice is situated in the Greenhill area of Sheffield, South Yorkshire. It offers private dental treatments to adults and NHS dental treatments to children under 18. The services include preventative advice and treatment and routine restorative dental care. They also offer domiciliary visits to their own patients for denture work. It has been a well-established practice for over 50 years and the current providers have owned the practice since 2012.

The practice has four surgeries, a decontamination room, an X-ray room, a waiting area and a reception area. The reception area, waiting area and two surgeries are on the ground floor. The other two surgeries and the X-ray room are on the first floor. There are accessible toilet facilities on the ground floor of the premises.

There are three dentists, a dental hygiene therapist, eight qualified dental nurses (who also cover reception duties) and a practice manager (who is also a qualified dental nurse).

The opening hours are Monday from 9-00am to 5-30pm, Tuesday from 9-00am to 6-30pm, Wednesday and Thursday from 8-30 to 5-30pm and Friday from 9-00am to 4-30pm.

One of the practice owners 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 received feedback from 63 patients. The patients were positive about the care and treatment they received at the practice. Comments included that the premises were clean and hygienic and that staff were caring, respectful and professional. Patients also commented that the dentists explain what the procedures entail before they begin.

Our key findings were:

- The practice appeared clean and hygienic.
- The practice had 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 qualified 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.
- Oral health advice and treatment were provided in-line with the 'Delivering Better Oral Health' toolkit (DBOH).
- 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.
- The practice had a complaints system in place and there was an openness and transparency in how these were dealt with.
- Patients were able to make routine and emergency appointments when needed.
- The governance systems were effective.

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

- Review the practice's protocols for domiciliary visits, giving due regard to 2009 guidelines published by British Society for Disability and Oral Health in the document "Guidelines for the Delivery of a Domiciliary Oral Healthcare Service".

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 date and in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines. We noted the emergency drug kit did not have buccal midazolam. A risk assessment had been completed as to why the provider had taken this decision.

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.

No action



Are services effective?

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

Patients' dental care records provided information about their current dental needs and past treatment. The practice monitored any changes to the patient's oral health and provided treatment when appropriate.

The dentists were aware of 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).

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.

No action



Are services caring?

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

During the inspection we received feedback from 63 patients. Patients commented that staff were wonderful, caring, respectful and professional. They also commented that their comfort was checked throughout.

No action



Summary of findings

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.

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.

The practice was accessible for patients with a disability or limited mobility to access dental treatment.

No action



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 owners were responsible for the day to day running of the practice.

Effective arrangements were in place to share information with staff by means of regular practice meetings.

The practice was proactive with regards to quality improvement. They regularly audited clinical and non-clinical areas as part of a system of continuous improvement and learning.

They conducted patient satisfaction surveys and were currently undertaking the NHS Friends and Family Test (FFT).

No action



GHB Dental Practice

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 received feedback from 63 patients. We also spoke with two dentists, four dental

nurses and the practice manager. To assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had clear guidance for staff about how to report incidents and accidents. We reviewed the incidents which had occurred in the last year and these had been well documented, investigated and reflected upon by the dental practice. We saw that as a result of a particular incident immediate action was taken to prevent the incident from happening again. Any accidents or incidents would be reported to the practice owners or practice manager. Any incidents would be discussed at staff meetings in order to disseminate learning. It was evident that the practice adopted a proactive approach towards learning from incidents.

The registered manager understood the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) and the referral criteria for RIDDOR was freely available within a folder in the staff room. RIDDOR notification forms were also available within this folder.

The practice 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, actioned if necessary and stored for future reference.

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. The practice owner was the safeguarding lead for the practice and all staff had undertaken the appropriate level of safeguarding training. Staff were knowledgeable about the signs and symptoms of abuse or neglect and were aware of whom to report them to.

The practice had systems in place to help ensure the safety of staff and patients. These included the use of a single handed needle removing device, a protocol whereby only clinicians handle sharps and guidelines about responding to a sharps injury (needles and sharp instruments).

The dentists told us they routinely used a rubber dam when providing root canal treatment to patients in line with guidance from the British Endodontic Society. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured.

Patients' clinical records were paper based. These were locked away in secure 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 practice kept an emergency resuscitation kit, medical emergency oxygen and emergency medicines. Staff knew where the emergency kits was kept. The practice had an Automated External Defibrillator (AED) to support staff in a medical emergency. (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.).

Records showed weekly checks were carried out on the AED, emergency medicines and the oxygen cylinder. These checks ensured that the oxygen cylinder was full, the AED was fully charged and the emergency medicines were in date. We saw that the oxygen cylinder was serviced on an annual basis.

Staff recruitment

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

Are services safe?

and Barring Service (DBS) checks for all newly 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 were qualified and 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 risks associated with fire, eye injury and slips, trips and falls. We saw that staff conducted weekly fire alarm tests and conducted bi-annual fire drills.

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. Staff were aware of the COSHH folder and when to reference it. The practice identified how they managed hazardous substances in its health and safety and infection prevention and control policies and in specific guidelines for staff, for example in its blood spillage and waste disposal procedures. The COSHH folder was reviewed regularly by the practice manager to check whether any new hazards had been identified for the substances included in the folder.

Infection control

There was an infection prevention and 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 and staff signed a log book to confirm this had been done. There were hand washing facilities in the treatment rooms and staff had access to supplies of personal protective equipment (PPE) for patients and staff members. Posters promoting good hand hygiene and the decontamination procedures were clearly displayed to support staff in following practice procedures. Sharps bins were appropriately located, signed and dated and not overfilled. We observed waste was separated into safe containers for disposal by a registered waste carrier and appropriate documentation retained.

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.

We were shown the procedures involved in disinfecting, inspecting and sterilising contaminated instruments; packaging and storing clean instruments. The practice routinely used an ultrasonic bath to clean the 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.

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.

Are services safe?

The practice had been carrying out the Infection Prevention Society (IPS) self- assessment audit relating to HTM01-05 every six months. This is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. The audit showed the practice was meeting the required standards.

Records showed a risk assessment process for Legionella had been carried out in February 2016 (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, the use of a water conditioning agent and quarterly tests on the on the water quality to ensure that Legionella was not developing. Staff had also completed training in relation to Legionella awareness.

Equipment and medicines

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

NHS prescriptions were stamped only at the point of issue to maintain their safe use. The practice kept a log of which prescription pad had been allocated to each dentist. Prescription pads were kept locked away when not needed to ensure they were secure.

The practice also dispensed a limited number of antibiotics for private patients. These were kept locked away and a log of which antibiotics had been dispensed was kept. All of these antibiotics were in date.

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 treatment rooms 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 an automated X-ray developing machine. We saw evidence that regular checks were undertaken on the machine to ensure the quality of processing was satisfactory. We saw that used X-ray developing chemicals were stored safely in containers for disposal by a registered waste carrier and appropriate documentation retained.

X-ray audits were carried out every year. This included assessing the quality of all 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 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 dentists used NICE guidance to determine a suitable recall interval for the patients. This takes into account the likelihood of the patient experiencing dental disease such as decay, gum disease or oral cancer.

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. If the patient had more advanced gum disease then a more detailed inspection of the gums was undertaken.

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 any alerts would be highlighted within the dental care records. This included an update on their health conditions, current medicines being taken and whether they had any allergies.

The dentists told us they followed FGDP guidelines on Selection Criteria for Dental Radiography. We saw limited evidence that X-rays were routinely taken at the recommended intervals. X-rays were justified, graded and reported in accordance with IRMER regulations.

Health promotion & prevention

The practice had a strong focus on preventative care and supporting patients to ensure better oral health in line with the 'Delivering Better Oral Health' toolkit (DBOH). DBOH is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. For example, the dentist applied fluoride varnish to children who attended for an examination.

Patients would be given detailed and tailored oral hygiene advice specific to their needs. The dentists informed us that they strongly recommended interdental brushes for patients and had seen improvements in patients' gum health as a result of their use.

The practice had a selection of dental products on sale in the reception area to assist patients with their oral health.

The medical history form patients completed included questions about smoking and alcohol consumption. We were told by the dentists and saw in dental care records that smoking cessation advice was given to patients where appropriate. Patients would be made aware of the link between smoking and gum health and oral cancer. There were health promotion leaflets available in the waiting room 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 covered topics such as waste storage, how to develop x-rays, and the location of emergency equipment, practice risk assessments and PPE. We saw evidence of completed induction checklists in the personnel files.

Staff 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 in house training for medical emergencies 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.

The practice used a dental hygiene therapist. Dental hygiene therapists are trained dental care professionals who are qualified to undertake certain treatments, for example, fillings, periodontal treatments and the extraction of deciduous teeth. The dentists could refer patients for such treatments to the dental hygiene therapist.

Staff told us they had annual appraisals and training requirements were discussed at these. We saw evidence of completed appraisal documents. After the appraisal staff formulated a personal development plan which set out their own aims and objectives for the coming year.

Are services effective?

(for example, treatment is effective)

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 specialist dental services for further investigations or specialist treatment including orthodontics and oral surgery. A process was also available for the referral of patients with a suspected malignancy.

The dentists 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. The practice kept a log of all referrals which had been sent. This allowed them to actively monitor the referrals which had been sent.

The practice sought verbal feedback from patients which had been referred to other services. This helped the practitioners to determine which the best service was in relation to different treatments.

Consent to care and treatment

Patients were given appropriate information to support them to make decisions about the treatment they received. Staff were knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent. 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 received training and had a good understanding of the principles of the Mental Capacity Act (MCA) 2005 and how it was relevant to ensuring patients had the capacity to consent to their dental treatment.

Staff ensured patients gave their consent before treatment began. We were told that individual treatment options, risks, benefits and costs were discussed with each patient. For more complicated or advanced treatments patients were provided with a written treatment plan which outlined the options available and the risks associated with each treatment. Patients were always given time to decide upon which treatment option suited them the best.

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. Dental care records were not visible to the public on the reception desk. We observed the staff working on the reception desk to be helpful, discreet and respectful to patients. She was aware that no personal details should be discussed at the reception desk to ensure the dignity of patients. She also told us that if a patient wished to speak in private, an empty room would be found to speak with them.

Patients' dental care records were stored securely in locked cabinets or cupboards.

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. For example, we were told that they would use simple terminology to discuss treatments with patients and avoid complicated words. They would also use models and provide leaflets to aid understanding.

When treating children we were told that they use the "tell-show-do" technique in order to help children overcome any anxieties. Staff understood the concept of Gillick competency with regarding to gaining consent from children under the age of 16.

Patients were also informed of the range of treatments available in the practice information leaflet and on the practice website.

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.

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. Reasonable adjustments had been made to the premises to accommodate patients with mobility difficulties. These included ramp access to the premises, a ground floor accessible toilet and a hearing loop. The ground floor surgeries were large enough to accommodate a wheelchair or a pushchair. We were told that the ground floor surgeries would be used for those patients who could not manage the stairs.

Access to the service

The practice displayed its opening hours in the premises and on the practice website. The opening hours are Monday from 9-00am to 5-30pm, Tuesday from 9-00am to 6-30pm, Wednesday and Thursday from 8-30 to 5-30pm and Friday from 9-00am to 4-30pm.

Patients could access care and treatment in a timely way and the appointment system met their needs. Where 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 111 service on the telephone answering machine. Information about the out of hour's 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. 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.

There were details of how patients could make a complaint displayed in a dedicated complaint leaflet which was freely available in the waiting room. The practice manager was in charge of dealing with complaints when they arose. Staff told us they raised any formal or informal comments or concerns with the practice manager to ensure responses were made in a timely manner. Staff told us that they aimed to resolve complaints in-house initially. The practice had not received any complaints in the previous 12 months. We saw that historically complaints had been dealt with in an open and transparent manner and an apology had been given.

Are services well-led?

Our findings

Governance arrangements

The practice manager and one of the practice owners were in charge of 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 effective 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, eye injury and slips, trips and falls.

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 that had been received. Staff told us there was an open culture within the practice and they felt comfortable 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 staff meetings approximately every month. These meetings were minuted for those who were unable to attend. Minutes of meetings were e-mailed to all staff for them to reference at a later date if necessary.

During these staff meetings topics such as infection prevention and control, training needs, personal development plans and audit results were discussed. 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 manager was approachable, would listen to their concerns and act appropriately. 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, X-rays and infection prevention and control. In addition to these, other audits were conducted and these included prescriptions, clinical waste collection and audits about whether staff had completed the lab work book and cleaning schedules. We looked at the audits and saw the practice was performing well. We saw that where improvements could be made these were identified and followed up by a repeat audit. Results of audits were regularly discussed at staff meetings in order to disseminate learning to all staff. It was evident that the practice embraced the culture of audit and used it as a tool for monitoring and continuous improvement.

Staff told us they had access to training and this was monitored to ensure essential training was completed each year; this included medical emergencies and basic life support. Training was completed on a variety of levels including online and attending courses. Staff working at the practice were supported to maintain their continuous professional development as required by the General Dental Council.

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. These included carrying out a rolling patient satisfaction survey. The practice had several different satisfaction surveys which were changed on a monthly basis. They aimed to get six to eight forms completed each day. Topics covered included about the cleanliness of the premises and whether fees were appropriately explained. The most recent patient survey showed a high level of satisfaction

Are services well-led?

with the quality of the service provided. We were told that as a result of patient feedback that the toilet facilities were upgraded in order to make it easier for patients with limited mobility to access.

The practice also undertook the NHS Friends and Family Test (FFT). 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 latest results showed that 100% of patients asked said that they would recommend the practice to friends and family.