Care Quality Commission

Woodbridge Dental Surgery Limited

Debenham Dental Practice

Inspection Report

76 The High Street
Debenham
Suffolk
IP14 6QR
Tel:01728861948
Website:www.debenhamdental.co.uk

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Overall summary

We carried out an announced comprehensive inspection on 17 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 this practice was providing effective care in accordance with the relevant regulations

Are services caring?

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

Are services responsive?

We found 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

The practice has one dentist, one dental nurse and shares a practice manager with another location. This practice manager is also a registered dental nurse and provides cover if needed. The practice provides primary dental services to private patients only and opens on Monday to Wednesday between 9am and 5pm.

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

We spoke with a patient and reviewed 9 CQC comment cards which had been completed by patients prior to the inspection. All the comments reflected positively on the staff and the services provided. Patients commented that the practice was clean and hygienic, they found it easy to book an appointment and they found the quality of the dentistry to be excellent. They said explanations were clear and that the staff were kind, caring and reassuring.

Our key findings were:

- The practice recorded and analysed significant events and complaints and cascaded learning to staff.
- Where mistakes had been made there was a policy that patients were notified about the outcome of any investigation and given a suitable apology.

Summary of findings

- Staff had received safeguarding and whistleblowing training and knew the processes to follow to raise any concerns.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Staff had been trained to handle emergencies; appropriate medicines and life-saving equipment were readily available.
- Infection control procedures were robust and the practice followed published guidance on the majority of occasions, however, there were minor areas for improvement.
- Patient care and treatment was planned and delivered in line with evidence based guidelines, best practice and current legislation.
- Patients received clear explanations about their proposed treatment, costs, benefits and risks and were involved in making decisions about it.
- Patients were treated with dignity and respect and confidentiality was maintained.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- There was an effective complaints system and the practice was open and transparent with patients if a mistake had been made.
- The practice sought feedback from staff and patients about the services they provided.

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

- Ensure that the appropriate tests were being carried out daily on equipment used for sterilising equipment.
- Establish a policy clearly outlining a timetable for completing audits of dental radiation and infection prevention.

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 effective systems and processes in place to ensure the majority of care and treatment was carried out safely. We were told that the practice carried out sedation of patients in certain circumstances. The staff carrying out these procedures need to comply with a set of guidelines and we saw this was not the case. When we spoke to the dentist about this he stated the practice would not carry out the procedure of conscious sedation until all the guidelines were met. The practice responded to national patients safety and medicines alerts and took appropriate action. Significant events, complaints and accidents were recorded appropriately, investigated, analysed and then improvement measures implemented. There was a policy that patients were informed if mistakes had been made and given suitable apologies; there had been no complaints received in the last 12 months. Staff had received training in safeguarding, whistleblowing and knew the signs of abuse and who to report them to. Staff were suitably trained and skilled to meet patient's needs and there were sufficient numbers of staff available at all times. Infection control procedures should be brought in line with published guidance but overall were robust and staff had received training. Radiation equipment was suitably sited however, there should be regular audits of radiography to comply with national guidance. Emergency medicines in use at the practice were stored safely and checked to ensure they did not go beyond their expiry dates. Sufficient quantities of equipment were in use at the practice; they were serviced and maintained at regular intervals.

Are services effective?

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

Consultations were carried out in line with best practice guidance from the National Institute for Health and Care Excellence (NICE). Patients received a comprehensive assessment of their dental needs including taking a medical history. Explanations were given to patients in a way they understood. Risks, benefits, options and costs were explained. Staff were supported through training and opportunities for development. Patients were referred to other services in a timely manner. Staff understood the Mental Capacity Act 2005 and offered support when necessary. Staff were aware of Gillick competency in relation to children under the age of 16.

Are services caring?

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

Patients were treated with dignity and respect and their privacy maintained. Patient information and data was handled confidentially. Patients told us they were listened to and not rushed. Treatment was clearly explained and they were provided with treatment plans. Patients were given time to consider their treatment options and felt involved in their care and treatment.

Are services responsive to people's needs?

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

Appointment times met the needs of patients and waiting time was kept to a minimum. Information about emergency treatment was made available to patients. A practice leaflet was available in reception to explain to patients about the

Summary of findings

services provided. The practice had made reasonable adjustments to accommodate patients with a disability or lack of mobility. Patients who had difficulty understanding care and treatment options were supported. The practice had a complaints policy that outlined an intention to deal with complaints in an open and transparent way and apologise when things went wrong. The practice had not received any complaints in the last year.

Are services well-led?

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

The practice provided clear leadership and involved staff in their vision and values. Staff meetings did not take place regularly but minutes were taken when they occurred. We looked at care and treatment records to ensure standards had been maintained. Staff were supported to maintain their professional development and skills. There was a pro-active approach to identify safety issues and making improvements in procedures. There was candour, openness, honesty and transparency amongst all staff we spoke with. There was a lack of clinical and non-clinical audits taking place but the registered manager undertook these after our visit and provided evidence to us. The dental nurses did not have sufficient insurance cover to indemnify them in respect of professional indemnity but this was rectified post our inspection. The practice sought the views of staff and patients, and there had been an on-going patient survey. Health and safety risks had been identified which were monitored and reviewed regularly.

Debenham Dental Practice

Detailed findings

Background to this inspection

The inspection took place on 17 June 2015 and was carried out by a CQC inspector and a dental specialist advisor. 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. Prior to the inspection we asked the practice to send us some information which we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, the details of their staff members, their qualifications and proof of registration with their professional bodies. We also reviewed the information we held about the practice and consulted with other stakeholders, such as the NHS England area team and Healthwatch; however we did not receive any information of concern from them. During the inspection we spoke with the dentist, the practice manager and a dental nurse; we reviewed policies, procedures and other documents. We spoke with a patient and reviewed 9 CQC comment cards which had been completed by patients prior to the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

We looked at complaints the practice had received in the last twelve months and found there were none reported. There was a policy in place and we spoke with both the dentist and the practice manager about complaints. We found they knew what constituted a complaint and we saw a folder where such complaints would be filed. The practice responded to national patient safety and medicines alerts that were relevant to the dental profession. These were sent to a dedicated email address and actioned by the dentist. Where they affected patients a note was made on their electronic patient record which alerted the dentist each time the patient attended the practice. Records we viewed reflected that the practice had undertaken a risk assessment in relation to the control of substances hazardous to health (COSHH). Each type of substance used at the practice that had a potential risk was recorded and graded accordingly. Measures were clearly identified to reduce such risks including the wearing of personal protective equipment and safe storage. The practice maintained clear records of significant events. Staff were aware of the reporting procedures in place and were encouraged to bring safety issues to the attention of the dentist or the practice manager.

Reliable safety systems and processes (including safeguarding)

All staff at the practice were trained in safeguarding and the practice manager was the identified lead. We spoke to all grades of clinical staff and the practice manager, all were aware of the different types of abuse and who to report them to if they came across a vulnerable child or adult. A policy was in place for staff to refer to and this contained telephone numbers of who to contact outside of the practice if there was a need. There had been no safeguarding incidents since this practice had registered. Staff spoken with on the day of the inspection were aware of whistleblowing procedures and who to contact outside of the practice if they felt that they could not raise any issue with the dentist or practice manager. However they felt confident that any issue would be taken seriously and action taken by the manager if necessary. We were told the dentist always used rubber dams during root canal treatment . 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

We checked that the practice had the necessary emergency medicines and equipment as listed in the British National Formulary (BNF) and the Resuscitation Council (UK) guidelines. We saw that emergency medicines and oxygen were present but there was no Automated External Defibrillator AED in the practice. An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. We spoke with the practice manager who told us the practice was reliant on the NHS system or local facilities that contained an AED. We discussed this with the dentist. The assistance from outside the practice may be unavailable and thus pose a risk to patients who required emergency treatment. After our visit the dentist told us he was going to purchase an AED. so the practice could respond without the need for external assistance. All staff had been trained in basic life support and were able to respond to a medical emergency. All emergency equipment was readily available and staff knew how to access it. We checked the emergency medicines and found that they were of the recommended type and were all in date. A system was in place to monitor stock control and expiry dates. All clinical staff we spoke with could identify the signs indicating equipment and drug use and stated they felt confident in their ability to respond should the need arise.

Staff recruitment

The practice had a recruitment policy that described the process when employing new staff. This included obtaining proof of identity, checking skills and qualifications, registration with professional bodies where relevant, references and whether a Disclosure and Barring Service (DBS) check was necessary. We looked at three staff files and found that the process had been followed. There were sufficient numbers of suitably qualified and skilled staff working at the practice. A system was in place to ensure that where absences occurred, staff from a different practice but owned by the same provider, were contacted

to attend the practice and cover for their colleagues. The practice did not employ agency staff but the practice manager was aware of the checks into qualifications and competencies should this become necessary in the future.

The practice policy was to perform DBS checks on all clinical staff and the receptionist; we looked at the records and found that all these staff had a current certificate of check completed. DBS checks are checks to 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.

Monitoring health & safety and responding to risks

A health and safety policy and risk assessment was in place at the practice. This covered the risk to staff and patients who attended the practice. Risks had been identified and control measures put in place to reduce them. There were other policies and procedures in place to manage risks. These included infection prevention and control, a legionella risk assessment, fire evacuation procedures and risks associated with Hepatitis B. Processes were in place to monitor and reduce these risks so that staff and patients were safe. We saw the practice had commissioned a private contractor to carry out a fire assessment of the building, this had been done in February 2015.

Infection control

The practice was visibly clean, tidy and uncluttered. We saw cleaning contracts in place and spoke to the dental nurse about how they cleaned the consultation rooms. An infection control policy was in place and a lead had been identified. The policy clearly described how cleaning was to be undertaken at the premises including the surgeries and the general areas of the practice. The types of cleaning and frequency were detailed in the policy and checklists were available for staff to follow. We looked at the records kept and found that they had been completed correctly. Records held reflected that the quality of the cleaning was being monitored and feedback given to the cleaning staff accordingly. We saw there was no infection control audit being carried out by the practice and no history of previous audits. We spoke with the dentist about this who undertook to complete one as a matter of urgency. Since the date of inspection we have been provided with evidence that this has been completed. We found there were adequate supplies of liquid soaps and hand towels throughout the premises and hand washing techniques were displayed in the toilet facilities. Sharps bins were properly located, signed, dated and not overfilled. A clinical waste contract was in place and waste was stored securely until collection. We looked at the procedures in place for the decontamination of used dental instruments. The practice had a dedicated decontamination room that was set out according to the Department of Health's guidance, Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices. We found that instruments were being cleaned and sterilised in line with published guidance (HTM 01:05) with some minor exceptions. On the day of our inspection, a dental nurse demonstrated the decontamination process to us and used the correct procedures. We saw that the water in the sterilization machine was being kept there overnight. This could lead to contaminated water being used the following day and the practice manager stated this procedure would be amended immediately. We also saw that part of the work top needed to be secured to the wall and sealed effectively where it had become loose.. At the end of the sterilising procedure the instruments were correctly packaged, sealed, stored and dated with an expiry date. We looked at the sealed instruments in the surgeries and found that they all contained an expiry date that met the recommendations from the Department of Health. All instruments were bagged and appropriately stored. The decontamination room had clearly defined dirty and clean zones in operation to reduce the risk of cross contamination. Staff wore appropriate personal protective equipment during the process which included disposable gloves and aprons but face masks were not being worn. The equipment used for cleaning and sterilising was maintained and serviced as set out by the manufacturers. Daily, weekly and monthly records were kept of sterilisation cycles and tests and when we checked those records it was evident that the equipment was in good working order and being effectively maintained. There were no daily checks being carried out on the autoclave machine which are needed to ensure the machine is working correctly each day. An autoclave is a device for sterilising dental and medical instruments. Staff told us that they wore personal protective equipment when cleaning instruments and treating people who used the service. Staff files examined showed that all clinical staff were up to date with Hepatitis B immunity. The practice had a legionella risk assessment in place and conducted regular tests on the water supply. There was a contract with an external company to carry out

Are services safe?

checks for legionella; however, the last visit was in 2010. It is expected that legionella checks are carried out every two years unless the risk suggests this frequency should be increased. An alternative to this, is the practice completing a risk assessment stating why the checks should not be carried out. The practice manager stated that a further independent test on the water supply would be carried out. Legionella - is a term for particular bacteria which can contaminate water systems in buildings.

Equipment and medicines

Records we viewed reflected that equipment in use at the practice was regularly maintained and serviced in line with manufacturers guidelines. Portable appliance testing (PAT) took place on all electrical equipment. Fire extinguishers were checked and serviced regularly by an external company and staff had been trained in the use of equipment and evacuation procedures. Medicines in use at the practice were stored and when out of date disposed of in line with published guidance. Medicines in use were checked and found to be in date. There were sufficient stocks available for use and these were rotated regularly. The ordering system was effective. Emergency medical equipment was monitored regularly to ensure it was in working order and present in sufficient quantities. We spoke to clinical staff, all of which understood the indications for the use of emergency medicines. Staff stated they felt confident to intervene in the event of emergency.

Radiography (X-rays)

X-rays were carried out safely and in line with local rules that were relevant to the practice and equipment. These were clearly displayed. X-ray machines were the subject of regular visible checks and records had been kept. A specialist company attended at regular intervals to calibrate all X-ray equipment to ensure they were operating safely. Where faults or repairs were required these were actioned in a timely fashion. A radiation protection advisor and a radiation protection supervisor had been appointed to ensure that the equipment was operated safely and by qualified staff only. Those authorised to carry out X-ray procedures were clearly named in all documentation. This protected patients who required X-rays to be taken as part of their treatment. The practice's radiation protection file contained the necessary documentation demonstrating the maintenance of the X-ray equipment at the recommended intervals. Records we viewed demonstrated that the X-ray equipment was regularly tested, serviced and repairs undertaken when necessary. We saw records that indicated the practice was certified until November 2015 before the next inspection of its radiation equipment was due. We looked at the training records and saw the appropriate clinicians had received up to date training in the procedures for x-rays.

There had been no audit of radiography undertaken by the practice. Current regulations for the use of ionising radiation for medical and dental purposes (IRR99 and IR(ME)R2000) place a legal responsibility to establish and maintain quality assurance programs in respect of dental radiology. As part of this, it is necessary to ensure the consistent quality of radiographs through audit. We spoke with the dentist regarding this who undertook an audit after our inspection and provided evidence to us.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Patients attending the practice for a consultation received an assessment of their dental health after supplying a medical history covering health conditions, current medicines being taken and whether they had any allergies. There was also consideration whether the patient required an X-ray and whether this might put them at risk, for example if a patient may be pregnant. The dental assessments were carried out in line with recognised guidance from the National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC) guidelines. This assessment included an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following clinical assessment, the dentists followed the guidance from the Faculty of General Dental Practice before taking X-rays to ensure they were required and necessary. A diagnosis was then discussed with the patient and treatment options explained. Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included smoking cessation advice, alcohol consumption guidance and general dental hygiene procedures such as prescribing dental fluoride treatments. The patient notes were updated with the proposed treatment after discussing options with the patient. Patients were monitored through follow-up appointments and these were scheduled in line with NICE recommendations. Patients requiring specialised treatment were referred to other dental specialists. Their treatment was then monitored after being referred back to the practice once it had taken place to ensure they received a satisfactory outcome and all necessary post procedure care. Patients spoken with and comments received on CQC comment cards reflected that they were very satisfied with the assessments, explanations, the quality of the dentistry and outcomes.

Health promotion & prevention

The dentist provided advice to improve and maintain good oral health. Details of discussions between the clinician and their patient were recorded which included diet advice, the use of fluoride paste, rinses and smoking cessation advice. There was some information available for patients about oral health on the practice website and information leaflets were given out by staff. There was also a wide range of leaflets in the waiting room giving dental advice. The dentist we spoke with confirmed that adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. The dentist was aware of the NHS England publication for delivering better oral health which is an evidence based toolkit to support dental practices in improving their patient's oral and general health. CQC comment cards that we viewed reflected that patients were happy with the service and parents were satisfied with the services provided for their children; they had made positive comments about the advice they received.

Staffing

The practice had a dentist who works three days at this practice, in addition there were two dental nurses; one of which was also the practice manager. Dental staff were appropriately trained and those that were qualified were registered with their professional body. Staff were encouraged to maintain their continuing professional development (CPD) to maintain their skill levels. Staff training was being monitored and we found evidence of this in their personal files. The practice had identified training that was mandatory which included basic life support and safeguarding. All staff had received annual appraisals, staff we spoke with felt supported and involved in the appraisal process. They were given the opportunity to discuss their training and career development needs and were graded on their performance. Staff we spoke to felt the process was fair and they felt valued. They told us that the practice manager was supportive and always available for advice and guidance.

The practice did not use locum dentists or nurses; the dental nurse and dentist taking holiday at the same time, this avoided contracting staff when one or the other was away. We were told that the practice manager, who is a registered nurse, would cover any unforeseen absences. Staff had access to the practice computer system and policies, these contained information that further supported them in the workplace.. There was also a comprehensive list of written polices in the reception office. Staff meetings were used to seek feedback from staff about possible improvement areas.. Dental nurses were only covered by employee liability insurance and not professional indemnity insurance, the latter being required

Are services effective?

(for example, treatment is effective)

by GDC standards. This potentially exposed the nurses to financial and professional risk in the event of a claim from a patient. We spoke to the practice manager about this and since the inspection we have seen evidence this insurance is now in place.

Working with other services

The practice had a policy in place to refer patients to other practices or specialists if the treatment required was not provided at their location. We saw evidence of records containing valid consent. Patient leaflets were available with up to date British Dental Association (BDA) advice sheets. The care and treatment required was explained to the patient and they were given a choice of other dentists who were experienced in undertaking the type of treatment required. A referral letter was then prepared with full details of the consultation and the type of treatment required. This was then sent to the practice that was to provide the treatment so they were aware of the details of the treatment required. When the patient had received their treatment they would be discharged back to the practice for further follow-up and monitoring.Where patients had complex dental issues, such as oral cancer, the practice referred them to other healthcare professionals using their referral process. This involved supporting the patient to access the 'choose and book' system and select a specialist of their choice.

Consent to care and treatment

The practice had a consent policy to support staff in understanding the different types of consent a patient could give and whether it could be taken verbally or in writing. Staff we spoke with told us they had read the policy and they had access to it. Staff we spoke with had a clear understanding of consent issues, they understood that consent could be withdrawn by a patient at any time. Clinical and reception staff were aware of consent in relation to children under the age of 16 who attended for treatment without a parent or guardian. They told us that children of this age could be seen without their parent/ guardian and the dentist told us that they would ask them questions to ensure they understood the care and treatment proposed before providing it. This is known as the Gillick competency test. The dentist we spoke with also explained how they would take consent from a patient if their mental capacity was reduced. This followed the guidelines of the Mental Capacity Act 2005 and included involving any carer to ensure that procedures were explained in a way the patient could understand. We spoke with a patient and asked them about their care, they said they felt fully involved in their care and options for treatment. They were able to show the places where costs were advertised and we found these on notice boards in the waiting area, as well as the website and patient leaflet.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patients we spoke to felt that practice staff were kind, caring and that they were treated with dignity, respect and staff were helpful. One comment card told us they were nervous about seeing the dentist but had been reassured on each occasion, making their experience less stressful. This patient had transferred from another practice and stated they had not worried about their treatment since arriving. The remainder of CQC comment cards we viewed reflected that patients were very satisfied with the way staff treated them at the practice; patients stated they did not feel rushed and the dentist always gave them time. A data protection and confidentiality policy was in place of which staff were aware. We looked at this policy and found it up to date and regularly reviewed. This covered disclosure of patient information and the secure handling of patient information. We observed the interaction between staff and patients, finding that confidentiality was being maintained. Records were held securely. We observed that staff at the practice treated patients with dignity, respect and maintained their privacy. The reception area was open plan but we were told by staff that when a confidential matter arose, a private room just outside the waiting area was available for use. We saw that when any consultation took place this was always in a consultation room with the door shut, it was not possible to hear conversations outside these rooms. We saw that patients who had an uncomfortable experience were reviewed by the clinical team in order to provide relief from pain and discomfort.

Involvement in decisions about care and treatment

The patient we spoke with told us that the dentist listened to them and they felt involved with the decisions about their care and treatment. They told us that consultations and treatment were explained to them in a way they understood; they felt that they had options regarding their treatment. We looked at care plans and examined comment cards, all of which showed evidence that the patients were valued and their wishes considered. For example one comment card stated that the patient had always been listened to and treated with dignity and respect. We found clear evidence that pricing plans and overall costs were explained to patients.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice information leaflet and practice booklet described the range of services offered to patients, the complaints procedure, information about patient confidentiality and record keeping. The practice offered both NHS and private treatment and the costs of each were clearly displayed in the booklet and on boards in the waiting room. Appointment times and availability met the needs of patients. The practice was open from 9.00am to 5.00pm three days a week. Patients with emergencies were seen on the day of requesting an appointment with the dentist providing a mobile telephone number for contact when the practice was closed. The consultation room was on the ground floor, allowing access for patients with limited mobility; we saw arrangements for wheelchair access with the main entrance wide enough to accommodate a wheelchair. The practice was undertaking patient survey and monitored the results and comments from patents.

Tackling inequity and promoting equality

The practice was accessible for those patients with mobility issues, using wheelchairs or mobility scooters. We saw arrangements for wheelchair access with the main entrance wide enough to accommodate a wheelchair. The practice was located within a house in a residential road; there was a surgery on the ground floor. There was a waiting area, patient toilet, and a dentist surgery on the ground floor which meant patients could be accommodated according to their needs.Appointments were available at various times of the day and all emergency patients or those with specific needs could be met.

Access to the service

Patients could access care and treatment in a timely way and the appointment system met the needs of patients. Where treatment was urgent patients would be seen the same day if necessary. The practice manager told us there was always enough time for the dentist to see urgent cases and if necessary the dentist stayed late to ensure all patients were treated.We saw no evidence that patients were kept waiting and most were seen within 10 minutes of arriving for their appointment. The comment cards we received showed the patients had no problems obtaining an appointment of their choice. The practice had started telephoning their patients to remind them they were due for a scheduled check-up. The arrangements for obtaining emergency dental treatment were clearly displayed in the waiting room area and in the practice booklet.

Concerns & complaints

The practice had a complaint procedure and policy which we saw was regularly reviewed. Staff we spoke with were aware of the procedure to follow if they received a complaint and forms were available for the purpose. The procedure explained to patients the process to follow, the timescales involved for investigation, the person responsible for handling the matter and details of other external organisations that a complainant could contact. There was material readily available to read that explained the complaints procedure for private patients. There was a notice board in the waiting room that also outlined the procedures and practice policy. We looked at complaints that had been received in the last 12 months and found none recorded. We spoke to the practice manager who understood how to record a complaint and what constituted one.

We saw a policy and recording system in place to deal with complaints if they arose.

Are services well-led?

Our findings

Governance arrangements

The practice had a small number of staff and governance arrangements were not robust; for example, some staff members' indemnity insurance was out of date and there was no programme of required audit in radiography and infection control. There was one dentist at the practice and two dental nurses, one of which was the practice manager.

We spoke at length with the practice manager who had a clear understanding of governance and their role and responsibilities. They told us they had been supported by the dentist and that standards had been set for them to follow.

There was a full range of policies and procedures in use at the practice. These included health and safety, infection prevention control, patient confidentiality and recruitment.

Staff were aware of the policies and they were readily available for them to access. Staff we spoke with were able to discuss many of the policies and this indicated to us that they had read and understood them.

We found that there was a lack of audit for dental radiation and infection control taking place at the practice. We spoke to the dentist about these who undertook a series of tests after our visit and provided evidence to us that these had been done. These included infection control, patient records, oral health assessments and X-ray quality. The latter was carried out by the dentists qualified to do so and this involved grading the quality of the X-rays to ensure they had been taken correctly. Where areas for improvement had been identified action had been taken.

The practice also used a dental patient computerised record system and all staff had been trained to use it. This enabled dental staff to monitor their systems and processes and to improve performance.

Between September 2014 and our visit we saw that the practice had carried out six procedures which included conscious sedation techniques. Conscious sedation is a technique in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation. The drugs and techniques used to provide conscious sedation for dental treatment should carry a margin of safety wide enough to render loss of consciousness unlikely. In order to carry out these procedures the practice employed a doctor experienced in this area of medicine but we were not provided with evidence the practice had obtained assurance that this practitioner fulfilled all recent guidelines. These guidelines are contained in a document titled "Standards or Conscious Sedation in the Provision of Dental Care" and issued by the dental faculties of the Royal College of Surgeons and the Royal College of Anaesthetists. In particular the section covering transitional arrangements for practitioners, continuing professional development and team completion were not being complied with. The doctor providing the procedure only demonstrated six hours of continuing professional development (CPD) when the minimum was 12 hours and the dental nurse assisting had not completed mandatory training. We spoke to the dentist and practice manager about this and they have stated that no conscious sedation will take place at the practice until they are assured of compliance with all necessary guidelines.

Leadership, openness and transparency

The culture of the practice encouraged candour, openness and honesty.

All staff were aware of whom to raise any issue with and told us that the practice manager and dentist 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 ethos.

Management lead through learning and improvement

The practice had a practice manager who had been in place since 2014. The practice manager was proactive in their approach to improvement and had made changes to the policies to ensure they were kept up to date and accurate with current staff. Staff meetings took place and all relevant information was cascaded to them. Prior to meetings staff were encouraged to consider items for the agenda and meetings were used positively to identify learning and improvement measures. The meetings were used to share experience; there was a standing agenda that included opportunities to learn. Staff appraisals were used to identify training and development needs. These would provide staff with additional skills and to improve the experience of patients at the practice.

Are services well-led?

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

We were shown completed feedback forms where patients had the opportunity to discuss their treatment and experience of the practice. The data from these forms provided an opportunity for the practice to learn from their patients' experiences and these were discussed at staff meetings.

There was a staff meeting that took place during which all staff attended and we were told that there was an open agenda where anything concerning staff could be discussed. We saw minutes of these meetings.

The practice was a very small rural practice but CQC comment cards we received indicated patients were very satisfied with the services they provided.