Clarence House Dental Health Centre

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Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 23rd February 2017

to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Clarence House Dental Health Centre is located in the centre of Gloucester and provides private treatment to adults and NHS treatment to children. The practice consists of four treatment rooms, toilet facilities for patients and staff, a reception area, waiting areas, a consulting room, a staff room and an office.

The practice offers routine examinations and treatment. There are two dentists, two dental therapists/hygienists, one hygienist, eight dental nurses, two receptionists and a practice manager.

The practice's opening hours are

8.00 to 19.00 on Monday

8.00 to 17.00 on Tuesday

8.00 to 17.00 on Wednesday

8.00 to 19.00 on Thursday

8.00 to 15.45 on Friday

They also open on the first Saturday in the month for half a day.

The practice is part of an independent group of dentists who run an on-call rota. Out of hours patients were directed to phone the dentist on-call.

Summary of findings

We carried out an announced, comprehensive inspection on 23rd February 2017. The inspection was led by a CQC inspector who was accompanied by a specialist dental advisor.

For this inspection 49 people provided feedback to us about the service. Patients were positive about the care they received from the practice. They were complimentary about the service offered' which they said was very good and excellent. They told us that staff were professional, welcoming, helpful, caring and friendly and the practice was clean and hygienic.

Our key findings were:

• Safe systems and processes were in place, including a lead for safeguarding but there was no lead for infection control.

• Staff recruitment policies were appropriate and most of the relevant checks were completed. Staff received relevant training.

• The practice had ensured that risk assessments were in place.

• The clinical equipment in the practice was appropriately maintained. The practice appeared visibly clean throughout although some surgeries and the decontamination room were cluttered.

•The process for decontamination of instruments followed relevant guidance.

• The practice maintained appropriate dental care records and patients' clinical details were updated.

• Patients were provided with health promotion advice to promote good oral care.

• Consent was obtained for dental treatment.

• The dentists were aware of the process to follow when a person lacked capacity to give consent to treatment.

• All feedback that we received from patients was positive; they reported that it was a professional, caring and friendly service.

• There were arrangements for governance at the practice such as systems for auditing patient records and radiographs.

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

- Review the procedures for reporting accidents to include written information for staff about the process for reporting accidents and incidents.
- Review the system of team meetings to make sure practice based subjects such as health and safety, learning from accidents and incidents and learning from complaints are included as a regular agenda item.
- Develop policies and procedures about the duty of candour, to support a culture of openness and transparency.
- Review the recruitment procedures to ensure that written references are obtained before new staff start work in the practice in line with current guidance.
- Review the arrangements for support to staff to make sure all staff receive regular appraisals and personal development plans at least once a year.
- Review the arrangements for storing items in the surgeries and the decontamination room to make surfaces easier to clean.
- Review the arrangements for communication to include a hearing loop for patients with a hearing impairment and access to a translation service for people whose first language is not English.
- Review the arrangements for infection control to make sure a member of staff takes lead responsibility for infection control.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

There were systems for reporting incidents and for learning from incidents but these could be improved. Staff had received training about safeguarding adults and children. There were policies about safeguarding and whistleblowing and staff knew how to report any concerns.

There were also arrangements for dealing with foreseeable emergencies, for fire safety and for managing risks to patients and to staff. There was a business continuity plan. Hazardous substances were managed safely.

Most of the appropriate checks were being made to make sure staff were suitable to work with people. However, references were not always obtained before staff started to work in the practice. Emergency medicines were in place. Equipment was regularly serviced and X-rays were dealt with safely.

The surgeries were fresh and clean and guidance about decontamination of instruments was being followed to reduce the risk of the spread of infection.

Are services effective?

No action

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

The dentists took X-rays at appropriate intervals. The practice was checking the condition of the gums for every patient and they were checking for oral cancers. Patients completed medical history questionnaires and these were updated at each visit. The practice kept up to date with current guidelines and research. They promoted the maintenance of good oral health through information about effective tooth brushing. The dentists discussed health promotion with individual patients according to their needs.

The practice had sufficient staff to support the dentists. Staff received appropriate professional development and all of the expected training.

The practice had suitable arrangements for working with other health professionals and making appropriate referrals to ensure quality of care for their patients. Patients were asked for consent to treatment. Patients told us that the dentists discussed options for treatment with them. The patient records recorded options for treatment to help patients to make decisions about their care. The dentists showed understanding about the Mental Capacity Act 2005 (MCA) and what they would do if an adult lacked the capacity to make particular decisions for themself.

Are services caring?

No action

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

Summary of findings

Staff in the practice were polite and respectful when speaking to patients. Patients' privacy was respected and treatment room doors were closed during consultations. The practice used an electronic record system and the computer screens in reception were shielded so that they could not be seen by patients.

Patients were positive about the care they received from the practice. They reported that staff were professional, helpful, caring and friendly. Patients told us that they were involved in decisions about their care and gave consent to treatment.

Are services responsive to people's needs?

No action ✓

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

The practice had a system to schedule enough time to assess and meet patients' needs. Patients said that they could get an appointment easily. Emergencies were usually fitted in on the day the patient contacted the practice. The practice actively sought feedback from patients on the care being delivered. There was a procedure about how to make a complaint and the process for investigation. We saw evidence that the practice responded to feedback made direct to the practice and made changes when necessary.

There was an equality and diversity policy and staff had received training about equality and diversity. There was a stair lift to the surgeries and there was a toilet with disabled access. However, there was no hearing loop system for patients who had a hearing impairment and there was no information about translation services for people whose first language was not English.

Are services well-led?

No action ✓

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

The practice had set up systems for clinical governance such as audits of the infection control, record keeping and radiographs. There were checks of equipment. The autoclave and compressor were serviced and there were daily checks of the autoclave.

The practice had a range of policies which were made available to staff.

The practice manager was the lead for the practice one of the dentists was the lead for safeguarding and the other dentist was the lead for medical emergencies. However, there was no infection control lead. There was a whistleblowing policy but there was no information for staff about the duty of candour and the need to be open if an incident occurred where a patient suffered harm. So far there had been no such incidents.

The practice manager held team meetings once a month, there were monthly nurses' meetings and weekly management meetings. Staff were responsible for their own continuing professional development and kept this up to date.

The practice was seeking feedback from patients through patient satisfaction questionnaires and the NHS friends and family test. They made improvements in response to the feedback.

Clarence House Dental Health Centre

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 23rd February 2017. The inspection was led by a CQC inspector who was accompanied by a dental specialist advisor.

We reviewed information received from the provider before the inspection. During our inspection visit, we met with the practice manager, two nurses, and two dentists, one of whom was also the registered manager for the practice. Like registered providers, a registered manager is a 'registered person'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Before the inspection we looked at the NHS Choices website but there had been no reviews in the past year.

We also contacted NHS England and Healthwatch. We received information form NHS England about the NHS contract with the practice for children's dental care but we received no information from Healthwatch.

We reviewed policy documents and dental care records. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We observed a dental nurse carrying out decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area.

Forty nine people provided feedback about the service. Patients, who completed comment cards, were positive about the care they received from the practice. They were complimentary about the professional, 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 a system for reporting and learning from incidents but this could be improved. There was an accident book and information about reporting to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) if applicable.

There was no written accident or incident procedure. The practice manager told us that any accidents would be reported to the first aider for the practice or one of the dentists. Staff would report any incidents to the practice manager. There had been no accidents or incidents in the last twelve months. The practice manager told us that learning from accidents and incidents would be discussed in team meetings. There were monthly staff meetings, nurses' meetings and management meetings. We looked at two sets of staff meeting minutes and saw that learning from accidents and incidents was not a regular agenda item to make sure that any accidents and incidents were discussed. We also noticed that the meetings concentrated on business aspects of the service such as marketing rather than practice.

There was no information for staff about the duty of candour, which means being open and honest with people when they have been harmed as a result of their care. The practice manager was not aware of the need for this. There had been no such incidents but we saw that the practice had been open and given an apology as a result of a complaint.

Reliable safety systems and processes (including safeguarding)

There was a written procedure to follow if a member of staff had a sharps injury. A sharps injury is when a person is injured by a needle or other sharp object. There had been no such incidents in the last two years. There were systems to reduce the risk of a sharps injury including sharps bins in each surgery and a safe sharps risk assessment. We saw that the practice was using a safety system for re-sheathing needles. We saw evidence that staff were immunised against Hepatitis B to ensure the safety of patients and staff.

The practice had policies and procedures for child protection and safeguarding adults. This included contact details for the local authority social services. One of the dentists was the safeguarding lead for the protection of vulnerable children and adults. We saw certificates to show that staff had received training about safeguarding adults and children. Staff would raise concerns with the safeguarding lead. There had been no safeguarding issues reported by the practice to the local safeguarding team. There was a whistleblowing policy, which staff could follow if they had concerns about another member of staff's performance. There was information for staff about safeguarding and whistleblowing in the individual staff files and on the practice computer shared drive.

The practice manager received safety alerts from the Medicines and Healthcare Regulatory Agency (MHRA) and NHS England. They said that they would print off information about any relevant alerts and share it with staff.

Staffing and Recruitment

The practice staffing consisted of two dentists, two dental therapists/hygienists, one hygienist, eight dental nurses, two receptionists and a practice manager. We looked at the recruitment records of two dental nurses and a hygienist who had been recruited to the practice. Each member of staff had completed a curriculum vitae (CV). They each had a Disclosure and Barring Service (DBS) check and had a copy of their passport as proof of identity and information about their right to work in the UK. The practice had received no references for the dental nurses before they started work and only one reference was received for the dental hygienist. There was a record of the immunisation status of the clinical staff. We saw that appropriate checks of registration with the General Dental Council (GDC) had been carried out for the qualified staff. There were certificates of qualifications.

A system of appraisals had been developed for staff but appraisals had not taken place within the last year. The practice manager had planned in appraisals for the forthcoming year. Examples of previous appraisals were seen and there were examples where poor performance was identified and improvements were made. New staff had an induction and a probationary period.

Medical emergencies

Are services safe?

The practice had arrangements to deal with medical emergencies. Staff had received training in emergency resuscitation and basic life support and this was refreshed every year. We saw certificates for this training. The staff we spoke with were aware of the practice procedures for responding to an emergency. The practice had emergency equipment in accordance with guidance issued by the Resuscitation Council UK. This included relevant emergency medicines and oxygen and 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). There were defibrillator pads for both adults and children. The oxygen cylinder and resuscitation mask were in date. The oxygen cylinder was being routinely checked for effectiveness and we saw records for these daily tests. We reviewed the contents of the emergency medicines kit. We saw records of weekly and monthly audits of the medicines and equipment and all the emergency medicines were in date. induction an s

Monitoring Health and Safety and responding to Risk

There were arrangements to deal with foreseeable emergencies. We saw that there was a health and safety risk assessment for the general risks in the practice. There were also risk assessments for each room in the practice and for other risks such as blood borne viruses, display screen equipment and dental radiography. These included the action to be taken to manage risk. The practice had a fire risk assessment and there were certificates showing that the smoke detectors and emergency lighting had been serviced. There was a fire log book to record weekly and monthly fire safety checks. The records showed that fire evacuation practices took place every six months. There were arrangements to meet the Control of Substances Hazardous to Health 2002 (COSHH) Regulations. There were safety data sheets for all the products used within the practice.

The practice followed national guidelines on patient safety. For example, the dentists 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 a 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.

The practice had a business continuity plan 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 to reduce the risk and spread of infection. There was no identified infection control lead for the practice. There was a comprehensive infection control policy. Clinical 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. 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 and the toilet. The clinical staff wore uniforms in the clinical areas and they were responsible for laundering these.

There was a Legionella risk assessment (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). We saw a log book of monthly checks of the temperatures at the cold and hot water outlets. The dental nurse showed us how they flushed the dental water lines in accordance with current guidance in order to prevent the growth of Legionella. They said that the dental water lines were cleaned once a week.

We examined the facilities for cleaning and decontaminating dental instruments in the decontamination room. 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)' when setting up their decontamination room. However, we noted that was some clutter in the decontamination room and some of the surgeries, which could make some areas difficult to clean.

In accordance with HTM 01-05 guidance dirty instruments were carried from the surgery to the decontamination room in a designated sealed box to ensure the risk of the spread of infection was minimised. The box was white and clear plastic with the name of the Dentist written in red to

Are services safe?

denote dirty There was an identical separate box with the name written in green to show it was for clean instruments. There was a possibility that the names could wear off leading to a risk of cross infection.

There was a clear flow from 'dirty' to 'clean.' There were two sinks, one for washing and one for rinsing. The dental nurse showed us the process for decontamination of instruments. They put on personal protective equipment (PPE) including domestic style rubber gloves. They scrubbed the instruments with a long handled brush before rinsing them in the rinsing sink. Following this they placed them in the washer disinfector. They inspected them for debris under an illuminated magnifying glass, placed them on trays and put the trays of washed instruments into the autoclave to sterilise. After the sterilisation cycle was complete they took the instruments out of the steriliser to the clean area of the room, put them into date stamped bags. The dental nurses used a clean container to take the sterilised instruments back to the surgeries. The dental nurses also showed us how they cleaned down the surgeries between patients.

There autoclave and washer disinfector were checked daily and weekly for performance, for example, in terms of temperature and pressure. A log was kept of the results demonstrating that the equipment was working well. We saw certificates to show the autoclave and washer disinfector were serviced annually.

The practice was following relevant guidance about cleaning and infection control. Cleaning schedules were completed and the practice looked clean throughout. The practice used a colour coding system for cleaning equipment to reduce the risk of cross contamination. The dental nurses cleaned the surgeries. Patients confirmed that the environment was always clean and hygienic. Ten people who completed comment cards said that he environment was safe and hygienic

Procedures to control the risk of infection were monitored as part of the daily checks and the practice had carried out cross infection audits. The practice had an on-going contract with a clinical waste contractor. Waste was being appropriately stored and segregated. This included clinical waste and safe disposal of sharps.

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) for electrical items took place and the next test is due in September 2017. There was a current fixed electrical wiring certificate.

Medicines were stored securely in a cupboard and a designated fridge. Prescription pads were locked in the medication cabinet. The defibrillator was kept in reception. There was an oxygen cylinder with an up to date certificate. Staff said that there were sufficient dental instruments.

Radiography (X-rays)

There was an X–ray unit in each of the surgeries. There were suitable arrangements in place to ensure the safety of the equipment. We saw a log to show that the X-ray machines were maintained and we saw the certificates for the most recent examination in May 2016. We saw a radiation protection file which contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisors and the necessary records relating to the X-ray equipment. There was a critical examination pack for each X-ray set along with maintenance logs and a copy of the local rules. The local rules describe the operating procedures for the area where X-rays are taken and the amount of radiation required to achieve a good image. Each practice must compile their own local rules for each X-ray set on the premises. The local rules set out the dimensions of the controlled area around the dental chair/ patient and state the lowest X-ray dose possible to use. Applying the local rules to each x-ray taken means that X-rays are carried out safely.

There was no evidence of a Health and Safety Executive (HSE) notification and the practice manager said that she would make sure a notification was made. The service had a system of digital X-rays and X-rays were graded as they were taken. We saw records of audits of the radiographs.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We reviewed dental care records with the dentists and found that the 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 always 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 needed in relation to a patient's gums.) Patients' BPE scores were recorded in the dental care records we read.

We found evidence that record keeping was audited. We saw that information about medical history was entered in patients' dental records and the records showed that this was reviewed and updated at every visit. This information was kept up to date so that the dentists were informed of any changes in patients' physical health which might affect the type of care they received. Patients told us that they had completed a medical history questionnaire and they were asked about any changes at each visit.

We saw evidence that the practice kept up to date with the current guidelines and research in order continually to 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 referring patients for removal of wisdom teeth and prescribing antibiotics. They conducted risk assessments for patients to help them to decide appropriate intervals for recalling patients. The dentists were not aware of the Department of Health Delivering Better Oral Health Toolkit when considering care and advice for patients. This was discussed with dentists who agreed to familiarise themselves with this guidance.

Health promotion & prevention

The dentists discussed health promotion with individual patients as part of the routine examination process. This included discussions around smoking and sensible alcohol use. We saw records of examinations of soft tissue to check for the early signs of oral cancer.

The practice promoted the maintenance of good oral health through information about effective tooth brushing. We observed that there was information about tooth brushing and health promotion displayed in the waiting area. This could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition.

Staff skills and experience

The practice manager told us that all staff received professional development and training. Courses for all staff included safeguarding, cardio pulmonary resuscitation, medical emergencies, infection control, health and safety, equality and diversity and the Mental Capacity Act 2005 (MCA.) There was also training about data protection, deaf awareness, fire safety, Legionella and first aid at work. The clinical staff were responsible for their own continuing professional development (CPD.) They logged all their training hours online with the General Dental Council (GDC.) We saw evidence that the dental nurses and dentists were keeping their CPD up to date.

The practice manager had planned annual appraisals and personal development plans for all staff for the forthcoming year. We saw records for three staff which confirmed that they had previously had an appraisal and personal development plan. There were action pans in the personal development plans with dates for completing the actions to help the staff to develop.

Working with other services

The practice had suitable arrangements for working with other health professionals to ensure quality of care for their patients. The dentists used a system of onward referral to other providers, for example, for oral surgery and orthodontics. Where there was a concern about oral cancer a referral was made to a local hospital. Referral information was sent to the specialist service about each patient, including their medical history and X-rays.

Consent to care and treatment

The practice ensured that valid consent was obtained for all care and treatment. The dentists discussed treatment options, including risks and benefits, as well as costs, with each patient. We saw records of verbal and written consent in the patient notes. We spoke with two dentists who told us that they discussed options for treatment with patients. We saw entries in the patient notes which recorded when

Are services effective?

(for example, treatment is effective)

treatment options were discussed with patients. When treatment was needed for children the dentist obtained consent from their parents, or if a child was older and able to decide they obtained consent from the young person. The dentists told us how they involved children in decision making about their treatment through explaining and showing them what was going to happen using pictures.

We found that staff had training about the Mental Capacity Act 2005 (MCA) as part of safeguarding training. We spoke with two dentists who demonstrated knowledge about the MCA and capacity to consent. They said that they would always assume a person had capacity to consent to treatment and would explain to the person in simple terms. If the person had a relative with Power of Attorney they would involve them in decision making about treatment. They would always consider what was in the patient's best interests.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patient confidentiality was respected. The practice had an electronic system of patient records. Electronic records were password protected. The computer screens in reception could not be seen by patients. Patients were afforded appropriate privacy as the treatment room doors were closed during consultations. If a patient wished to discuss something with the receptionist in private they were invited into a consultation room. We observed that staff in the practice were polite and respectful when speaking to patients. Patients told us that they had sufficient privacy when treatment was carried out and staff were polite and respectful.

Patients who completed comment cards, were positive about the care they received from the practice. Patients reported that staff were professional, helpful, caring and friendly. They said that they provided a very good service.

Involvement in decisions about care and treatment

The practice provided treatment plans for patients including costs. Verbal consent was obtained for the dentist's treatment plans. Patients said that the dentist explained treatment to them very clearly and listened to their views so that they could make decisions.

S**upport to patients**

The receptionists scheduled longer appointment when a patient was nervous. The dentists said that they put people at their ease by chatting and explaining their treatment in simple terms and by showing them what was going to happen. If necessary they offered sedation but the practice manager told us that this was only used about once or twice a year. Patients who required urgent treatment were usually fitted in on the day they requested an appointment. An emergency appointment slot was kept every morning and afternoon for each dentist.

Patients told us that the dentists always listened to what they had to say. Patients who said that they or their children were nervous patients told us that the dentists were always caring and supportive and reassured them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system to schedule enough time to assess and meet patients' needs. Emergencies were usually fitted in on the day the patient contacted the practice. The practice kept two designated emergency appointments a day for each dentist. Patients commented that the staff provided a good service. They told us that when they had had an emergency they were seen the day that they contacted the practice and it was easy to make an appointment. The practice actively sought feedback from patients on the care being delivered through feedback questionnaires in the surgery and requests for feedback on the practice website. We saw evidence that the practice responded to feedback that they received. For example, the practice had changed the décor in the practice, changed the music in the waiting areas and provided air conditioning in the surgeries.

Tackling inequity and promoting equality

There was an equality and diversity policy and there was training about equality and diversity. There were some reasonable adjustments in place. The practice had conducted a Disability Access Audit and monitored issues in relation to disability access. There was a disabled access toilet for patients and there was a stair lift so that people who could not manage stairs could access the surgeries.

We found that there was no loop system for deaf people. There was also no access to a translation service for people whose first language was not English. The practice manager told us that patients were asked to bring an interpreter with them if required.

Access to the service

The opening hours were displayed in reception and on the website. Patients told us that they had no difficulty getting appointments. Emergencies were usually fitted in on the day the patient contacted the practice. For out of hours care patients were advised to contact an on-call dentist.

Concerns & complaints

There was a procedure for making a complaint, including timescales for responding to complaints and the process for investigation. Information about how to make a complaint was displayed on the website and was given to patients on request. Two patients we spoke with were not aware of the complaints procedure but they knew how to make a complaint. Information about concerns and complaints would be recorded and there was a complaints log. There had been five formal complaints in the last year. These had been investigated and followed up with the complainant. Some changes had been made in response to complaints. For example changes were made to reception procedures to make sure that the correct fees were charged and patients were informed when appointments were running late. However, we saw team meeting minutes which showed that complaints were not a regular agenda item to make sure that learning from complaints was shared with all staff.

Are services well-led?

Our findings

Governance arrangements

The practice had set up systems for clinical governance. There were audits of infection control, records and radiographs. There were checks of equipment. We saw evidence that the autoclave and compressor and X-ray machines were serviced. The nurse told us that they conducted daily checks of the autoclave and we saw records of these tests. We saw that there was a range of policies which were made available to staff. Appropriate records were kept.

Leadership, openness and transparency

The practice manager was the lead for the practice and one of the dentists was the lead for safeguarding and the other dentist was the lead for medical emergencies. There was no infection control lead and the manager told us that this was because all the nurses worked part time and they needed someone who was there all the time. There were dedicated fire wardens and a first aider for the workplace. We saw that there was no information for staff about the duty of candour and the need to be open if an incident occurred where a patient suffered harm. So far there had been no incidents where patients had suffered harm as a result of their treatment. We saw a whistleblowing policy which was made available to staff.

Management lead through learning and improvement

The practice manager told us that there were team meetings once a month. There were also monthly nurses' meetings and weekly management meetings. The nurses told us that they were responsible for their own continuing professional development and kept this up to date. They said that they also had training within the practice and we saw records to show that relevant training was taking place, for example for safeguarding and health and safety. There was a system of appraisals and personal development plans for staff.

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

The practice used the NHS friends and family test and patients said that they would recommend the practice. Patient satisfaction questionnaires were in reception and the manager went through these once a month. Patients were asked to put feedback on the practice website and on the practice social media page. As a result of feedback the practice had improved the décor of the building, changes the music in reception and provided air conditioning in the surgeries. Patients said that they had not been asked for their views but they would give feedback to the manager or dentist and they had no suggestions for improvements.