

Northgate Practice Limited

# Northgate Dental Practice

## Inspection Report

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### Overall summary

We carried out an announced comprehensive inspection on 4 October 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**

Northgate Dental Practice is situated in Cleckheaton, West Yorkshire. It offers mainly NHS dental treatment to patients of all ages but also offers private dental treatments. The services include preventative advice and treatment and routine restorative dental care.

The practice has four surgeries, a decontamination room, a waiting area and a reception area. All of the facilities are on the ground floor of the premises. There are accessible toilet facilities.

There are five dentists (one of whom is currently on maternity leave), six dental nurses (one of whom is currently on maternity leave) and a practice manager.

The opening hours are Monday from 8-50am to 5-00pm, Tuesday, Thursday and Friday from 8-30am to 5-00pm and Wednesday from 9-00am to 5-00pm.

The principal 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.

During the inspection received feedback from 50 patients. The patients were positive about the care and treatment they received at the practice. Comments included staff

# Summary of findings

were pleasant, helpful and caring. Patients also commented that the practice was clean and hygienic, their needs were responded to and they received the right care and treatment.

## **Our key findings were:**

- The practice was visibly clean and uncluttered.
- The practice had systems in place to assess and manage risks to patients and staff including 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.
- Dental care records showed that treatment was planned in line with current best practice guidelines.
- 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.
- Patients were able to make routine and emergency appointments when needed.
- The governance systems were effective.
- There were clearly defined leadership roles within the practice and staff told us that they felt supported, appreciated and comfortable to raise concerns or make suggestions.
- Instruments were sterilised in line with guidance in 'Health Technical Memorandum 01-05 -Decontamination in primary care dental practices'. We found some inconsistencies in the awareness of staff in the manual scrubbing of instruments.
- Medical emergency medicines and equipment were in line with guidance from the British National Formulary and the Resuscitation Council UK. We noted that the automated external defibrillator and emergency oxygen cylinder were only checked on a monthly basis.

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

- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as, Public Health England (PHE).
- Review the practice's protocols for the checking of the automated external defibrillator and emergency oxygen cylinder.
- Review staff awareness of the practice's infection control procedures and protocols with regards to the manual scrubbing of instruments.
- Review its X-ray audit protocols to ensure that the audits are practitioner specific.

# 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 the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). The practice did not receive alerts from the Medicines and Healthcare products Regulatory Agency (MHRA).

Staff had received training in safeguarding at the appropriate level and knew the signs of abuse and who to report them to.

Staff were trained to respond to 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 saw that the automated external defibrillator and emergency oxygen cylinder were only checked on a monthly basis. The resuscitation council UK suggests that this should be at least weekly.

We found the equipment used in the practice, including the compressor and radiography equipment was well maintained and tested at regular intervals.

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. We saw when contaminated instruments were manually scrubbed, the practice protocol was not followed by staff.

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 comprehensive 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 practice followed 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).

The practice provided preventative advice and treatment in line with the 'Delivering Better Oral Health' toolkit (DBOH). This included fluoride application, oral hygiene advice and smoking cessation advice.

Staff had completed training relevant to their roles and this was monitored by the practice manager. 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



# Summary of findings

## 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 50 patients. Patients commented that staff were pleasant, helpful and caring. They also commented that their needs were met and any problems were discussed.

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.

No action



## 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. 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 had made reasonable adjustments to enable patients in a wheelchair or with limited mobility to access treatment. These included a movable ramp to access the premises and an accessible ground floor toilet.

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 staff felt supported and appreciated in their own particular roles. The practice manager was responsible for the administrative procedures and the principal dentist was the clinical lead.

There was a range of policies, procedures and protocols to guide staff in undertaking tasks. We saw these were regularly reviewed.

Effective arrangements were in place to share information with staff by means of monthly practice meetings which were minuted for those staff unable to attend. This gave everybody an opportunity to openly share information and discuss any concerns or issues.

The practice regularly audited clinical and non-clinical areas as part of a system of continuous improvement and learning.

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

No action



# Northgate 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 50 patients. We also spoke with two dentists, two 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. Staff were familiar with the importance of reporting significant events. We reviewed the significant events which had occurred. These had been documented, analysed and action taken to prevent reoccurrence. Any accidents or incidents would be reported to the practice manager and would also be discussed at staff meetings in order to disseminate learning.

Staff understood the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

The practice did not receive national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA). We highlighted this on the day of inspection and were told that this would be actioned.

### Reliable safety systems and processes (including safeguarding)

The practice had child and 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 manager and the principal dentist were the safeguarding leads for the practice and all staff had undertaken level two safeguarding training. Staff had a good understanding of the signs and symptoms of abuse and felt confident to report any concerns to the safeguarding leads or the local safeguarding teams.

The practice had systems in place to help ensure the safety of staff and patients. These included the use of a needle re-sheathing device, a protocol whereby only the dentists 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 reason is recorded in the patient's dental care records giving details as to how the patient's safety was assured.

We saw that patients' clinical records were computerised, backed up to secure storage and password protected to keep personal details safe. Any paper documentation relating to patients' records was locked away. We saw that the room used to store paper dental care records was not fire proof. This was highlighted on the day of inspection and we were told these would be relocated to another room in fire proof cabinets.

### Medical emergencies

The practice had procedures in place which provided staff with clear guidance about how to deal with medical emergencies. 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. There was a flow chart in each surgery which detailed the process to be followed by staff in the event of a medical emergency. Staff told us of a recent medical emergency which had occurred and this had been dealt with well.

The practice kept an emergency resuscitation kit, medical emergency oxygen and emergency medicines. Staff knew where the emergency kit was kept. We checked the emergency equipment and medicines and found them to be in date and in line with the Resuscitation Council UK guidelines and the BNF.

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 monthly checks were carried out on the AED, emergency medicines and the oxygen cylinder. These checks ensured that the oxygen cylinder was in good working order, the AED battery was fully charged and the emergency medicines were in date. The resuscitation council UK states that emergency resuscitation equipment (the AED and emergency oxygen cylinder) should be checked on a weekly basis. This was highlighted on the day of inspection and we were told that this would be implemented.

# Are services safe?

## 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 recruitment files and found the recruitment procedure had been followed. The practice manager told us they carried out Disclosure 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 assessments were in place at the practice. These 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. We saw that an annual health and safety risk assessment was carried out on the premises.

There were policies and procedures in place to manage risks at the practice. These included pregnant workers, non-responders to Hepatitis B, work experience and trainee dental nurses.

The practice maintained a file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including details of substances such as disinfectants, and dental materials in use in the practice. The practice identified how they managed hazardous substances in its health and safety and infection control policies and in specific guidelines for staff, for example in its blood spillage and waste disposal procedures. The practice manager was responsible for adding any new substances when they were introduced to the practice.

## Infection control

There was an infection 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)'. The practice manager was the infection control lead and was responsible for overseeing the infection control procedures within the practice.

Staff had 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 maintain infection control standards. There was a cleaning schedule which identified and monitored areas to be cleaned. 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.

One of the dental nurses showed us the procedures involved in disinfecting, inspecting and sterilising dirty 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 (a device for sterilising dental and medical instruments). We noted that if instruments required manual scrubbing then this was done under running water. HTM 01-05 states that instrument scrubbing should be

# Are services safe?

carried out beneath the surface of temperature controlled solution. We also noted that the gloves used for manual scrubbing were not changed on a weekly basis. This was highlighted on the day of inspection and we were told that staff would be informed of this and further training would be carried out.

Instruments were appropriately bagged and stamped with a use by date one year from the day of sterilisation. 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.

We saw the practice used a data logger to download the data relating to each sterilisation cycle. We were told that this data was not downloaded on a regular basis. HTM 01-05 states that this should be done on a weekly basis.

The practice had carried out an Infection Prevention Society (IPS) self- assessment audit every six months relating to the Department of Health's guidance on decontamination in dental services (HTM01-05). 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 and any improvements were actioned.

Records showed a risk assessment process for Legionella had been carried out in October 2015 (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 and the use of a water conditioning system.

## Equipment and medicines

The practice had maintenance contracts for essential equipment such as X-ray sets, the autoclaves and the compressor. The practice manager maintained a comprehensive list of all equipment including dates when equipment required servicing. We saw evidence of validation of the autoclaves and the compressor. Portable appliance testing (PAT) had been completed in September 2016 (PAT confirms that portable electrical appliances are routinely checked for safety).

We saw that the practice was storing NHS prescription pads securely in accordance with current guidance and operated a system for checking deliveries of blank NHS prescription pads. Prescriptions were stamped only at the point of issue.

## 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 and serviced 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 surgeries 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.

X-ray audits were carried out every year. This included assessing the quality of the 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 detailed electronic and 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 National Institute for Health and Care Excellence (NICE) guidance to determine a suitable recall interval for the patients. This takes into account the likelihood of the patient experiencing dental disease.

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. 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 every time patients attended for treatment and entered in to their electronic dental care record. This included an update on their health conditions, current medicines being taken and whether they had any allergies.

The practice used current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, following clinical assessment, the dentist followed the guidance from the FGDP before taking X-rays to ensure they were required and necessary. Justification for the taking of an X-ray, quality assurance of each x-ray and a detailed report was recorded in the patient's care record.

### 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 dentists applied fluoride varnish to children's teeth who attended for an examination. Fissure sealants were also applied to

children's teeth where they were at high risk of dental decay. High fluoride toothpastes were recommended for patients at high risk of dental decay. We were shown models of teeth which the dentist used to demonstrate tooth brushing techniques to patients.

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 dentist and saw in dental care records that smoking cessation advice and alcohol awareness advice was given to patients where appropriate. Patients were made aware of the ill effects of smoking on their gum health and the synergistic effects of smoking and alcohol with regards to 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 included the fire evacuation process, the location of the emergency medicines and equipment, the infection control procedures and confidentiality. 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 and infection control. This was paid for by the provider. Records showed professional registration with the GDC was up to date for all staff and we saw evidence of on-going CPD.

Staff had annual appraisals where training requirements, general wellbeing and if the staff member wished to pursue any further training were discussed. We saw evidence of completed appraisal documents and associated personal development plans. Staff told us they felt well supported within the practice and could get help when required.

### 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 and in line with current guidance. For example, referrals were made to hospitals and specialist dental

# Are services effective?

(for example, treatment is effective)

services for further investigations or specialist treatment including orthodontics, oral surgery and sedation. Patients would be given a choice of where they could be referred and the option of being referred privately for treatment.

The dentist 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 dentist to see if any action was required and then stored in the patient's dental care records.

The practice had a procedure for the referral of a suspected malignancy. This involved sending an e-mail the same day and a telephone call to confirm the e-mail had arrived.

The practice maintained a log of all referrals which had been sent. This allowed them to actively monitor their referrals.

## **Consent to care and treatment**

Patients were given appropriate verbal and written 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. The dentists 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 an 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. The principal dentist had completed a course on the MCA.

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. Patients were given a treatment plan which outlined the treatments which had been proposed and the associated costs. We saw evidence within the dental care records of a robust process for consent was followed. Patients were given time to consider and make informed decisions about which option they preferred. The dentists were aware that a patient could withdraw consent at any time.

# 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. This included ensuring dental care records were not visible to patients, keeping surgery doors shut during consultations and treatment and ensuring the blinds in the waiting room were closed so passers-by could not see in. We were told that no personal details were discussed at the reception desk. We were told that if any such discussions needed to be made outside the surgery an empty room would be found to speak with the patient.

We were told that anxious patients were supported with care, explanations, gentleness and proceeding at the patient's pace whilst delivering treatment.

### **Involvement in decisions about care and treatment**

The practice provided patients with information to enable them to make informed choices. 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. We were shown a model which demonstrated the process involved in the preparation for a crown. They felt that this enabled patients to more fully understand the proposed treatment.

We saw an extensive range of information leaflets relating to the different treatments available in the practice in the waiting area.

# 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. We were told that the reception staff took into account the most appropriate time of day for patients to attend. This would include after school appointments for children. They would also ensure the most accessible surgery was available for patients who attended in a wheelchair.

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 for each dentist. 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 a movable ramp to access the premises and a ground floor accessible toilet. Two of the surgeries were large enough to accommodate a wheelchair or a pram. We were told that when patients in a wheelchair had appointments then these surgeries were made available. The registered provider had installed dental chairs which were easier for patients who had mobility difficulties to sit on.

### Access to the service

The practice displayed its opening hours on the premises. The opening hours are Monday from 8-50am to 5-00pm, Tuesday, Thursday and Friday from 8-30am to 5-00pm and Wednesday from 9-00am to 5-00pm.

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 NHS 111 service. Information about the out of hours emergency dental service was available on the telephone answering service and displayed in the waiting area and in the window of the practice.

### Concerns & complaints

The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. There were details of how patients could make a complaint displayed in the waiting room. The practice manager was responsible for 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. There had not been any complaints in the last 12 months. We saw historically that complaints had been dealt with in line with the practice's policy. We saw that as a result of one complaint the practice had taken steps to prevent the issue from reoccurring.

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. This included acknowledging the complaint within three working days and providing a formal response within 10 working days. If the practice was unable to provide a response within 10 working days then the patient would be made aware of this.

# Are services well-led?

## Our findings

### **Governance arrangements**

The practice manager was responsible for the administrative part of the practice and the principal dentist was the clinical lead providing support for the other dentists. There was a range of policies and procedures in use at the practice. These policies were reviewed on an annual basis. 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 pregnant workers, non-responders to Hepatitis B, work experience and trainee dental nurses.

There was an effective management structure in place to ensure that responsibilities of staff were clear. For example one member of staff was responsible for checking the emergency medicines and equipment and another was responsible for carrying out the weekly and quarterly tests on the decontamination equipment.

### **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. We saw evidence of this in dental care records and through discussions with the dentists. We were told that if something had gone wrong then the patient would be informed, an apology given and a plan to rectify the issue would be made.

Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. These would be 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 monthly staff meetings. These meetings were minuted for those who were unable to attend. During these staff meetings topics such as health and safety, infection control, continuous professional development and patient feedback were discussed.

### **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 audits such as dental care records, X-rays and infection control. We looked at the audits and saw that the practice was performing well. We saw that where improvements could be made they were discussed at staff meetings and actioned as necessary.

The practice organised in house training on medical emergencies, basic life support and infection control. The practice manager did not actively monitor staff training but we were told that they would look into doing this to ensure all staff were up to date with 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 including carrying out patient satisfaction surveys and a comment book in the waiting room. The practice amalgamated a question with 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. Each month the question was changed so at the end of each year they were able to cover 12 questions. They felt by doing this patients were not overwhelmed by too many questions in one go. The questions asked included whether the dentist discussed treatment options, was the dentist thorough and if they were able to ask any questions. We saw that each month they received over 100 responses and the feedback was positive. The latest results of the FFT showed that 100% of patients asked said that they would recommend the practice to friends and family.