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Priory Park Dental Practice - St Neots

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 19 January 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

Priory Park Dental Practice provides primary dental care and treatment to patients whose care is funded through the NHS and to a small number of patients who pay privately. The service is jointly owned by Dr Jaco Craig and another principal dentist. The practice employs five associate dentists, two hygiene therapists, five dental nurses and two trainee dental nurses. There is also a practice manager and five reception and administrative staff. In addition, the practice employs the services of a management advisor. The practice opens 8am to 5.30 pm on Mondays, 8am to 8pm Tuesday to Thursday and closes at 4.30 on a Friday.

We received feedback from 43 patients either in person or via CQC comments cards from patients who had visited the practice in the two weeks before our inspection. The cards were all positive showing that patients valued the service they received and several said they would or had recommended it to friends or members of their family. Patients said that staff put them at their ease, were caring, involved them in decisions and provided good treatment outcomes.

Our key findings were:

Summary of findings

- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained
- The practice had access to emergency equipment and this included an automated external defibrillator and medical oxygen. Emergency medicines were in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- The training, learning and development needs of staff members were assessed and staff were supported to receive professional development.
- Governance arrangements were in place for the smooth running of the practice although some improvements were needed to strengthen quality improvements in relation to incidents, radiology audits and patient feedback.
- Staff worked well as a team and had clearly identified roles and responsibilities.
- A complaints process was in place and this was managed effectively so that learning and improvement took place.

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

- Review the storage and signage of the emergency equipment and the oxygen cylinders.
- Review the process used by staff for reporting incidents and accidents so that potential risks to patient safety can be minimised and learning shared with staff.
- Review the availability of equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK).
- Review the recruitment policy so that guidelines are clear in relation to obtaining employee references.
- Consider installing a hearing loop at the premises.
- Consider adding information about obtaining emergency care out of hours on the practice website.
- Strengthen the audit process for radiography so that the results are analysed and used to identify learning and improve practice.
- Review the process used for patient surveys and questionnaires to ensure that the results are used to improve the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had appropriate systems in place to manage the service in a safe way although the policy for managing and reporting incidents required improvement to ensure that staff were familiar with identifying incidents and recording actions. Patients were informed if mistakes had been made and given suitable apologies. Staff had received relevant training and were suitably skilled to meet patient's needs. Safeguarding procedures were in place and staff were able to demonstrate knowledge of the training they had received. The practice followed national guidelines for infection control and radiation equipment. Regular checks and maintenance of equipment ensured that all items were safe and fit for use. This included emergency equipment and medicines.

Are services effective?

We found that 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 which took into account their current medical history. Explanations were given to patients in a way they understood so that they could make informed choices about their care and treatment and provide their consent to treatment in accordance with national guidelines. This also included timely referrals to other services. Risks, benefits, options and costs of treatments were explained. Staff were supported through training and opportunities for development.

Are services caring?

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

Staff treated patients with dignity and respect and ensured their privacy was maintained. Patients told us that staff were welcoming, caring, and always had time to listen to them. Treatment was clearly explained and patients were provided with treatment plans and costs. Staff ensured that 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 that this practice was providing responsive care in accordance with the relevant regulations.

Appointment times met the needs of patients and waiting times were kept to a minimum. Information about emergency treatment was made available to patients. The practice had made reasonable adjustments to accommodate patients with a disability or to respond to their individual needs and preferences. Patients who had difficulty understanding care and treatment options were supported. The practice had a complaints policy that outlined the process to deal with complaints in an open and transparent way and apologise when things went wrong.

Are services well-led?

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

The practice followed a clear leadership structure and staff were confident in fulfilling their roles and responsibilities. Regular staff meetings took place and these were recorded and shared. Staff told us they felt supported by the management team and they received support to maintain their professional development and skills. Governance procedures were in place and policies and procedures were regularly updated. A system of quality monitoring checks

Summary of findings

had been established although further improvement was needed to ensure that the radiography audit and patient feedback results were interpreted and any improvements actioned. In addition staff were not familiar with the policy for managing incidents and near miss events and a clear process was not being followed and recorded. There was candour, openness and transparency amongst all staff we spoke with.

Priory Park Dental Practice - St Neots

Detailed findings

Background to this inspection

The inspection took place on 19 January 2016 and was carried out by a CQC inspector and a dental specialist advisor.

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 NHS England area team and Healthwatch; however we did not receive any information of concern from them.

The methods that were used during the inspection included talking to people using the service, interviewing staff, making observations of the environment and staff actions and a review of documents.

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 a process in place for reporting accidents and this required improvement. There had been two reported accidents in the last two years. Records held by the manager detailed minimal information however, a report of the accident was held in the staff member's file. This did not include information about the actions taken although the manager was able to confirm that appropriate treatment and support had been provided.

We found the practice had an adverse event and near miss policy in place with supporting investigation documents. This was not used by staff who were unfamiliar with it's content. When we spoke with staff they described a recent incident where a patient had fainted after treatment. This was not reported or recorded as an incident to ensure that any learning or improvement could take place. Staff were encouraged to be open and report any issues of concern or raise comments to the practice manager.

The manager was familiar with the requirement to report work related accidents or near miss incidents in line with Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR).

We spoke with staff who told us they followed steps to ensure there were no errors with wrong site surgery. For example they ensured they checked with the patient, referred to X-rays and records.

We looked at a complaints policy which clearly outlined the practice would apologise if things had gone wrong. Records we reviewed showed us that when things went wrong, patients were given an apology and informed of any actions taken as a result.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding adults. This included contact details for the local authority's safeguarding team, social services and other agencies including the Care Quality Commission. Staff had completed safeguarding training and demonstrated to us their knowledge of how to recognise the signs and symptoms of abuse and neglect.

There was a named staff member with overall responsibility for safeguarding and staff were clear about reporting arrangements. No safeguarding issues had been reported.

A risk assessment had been undertaken for the safe use of sharps (needles and sharp instruments) in January 2015. Safe syringe systems were used to minimise risks to staff from inoculation injuries.

We spoke with the principle dentist who was available during the inspection. They told us they did not use rubber dam during root canal treatments but used other materials to protect the patients airway. A rubber dam is usually made of latex rubber, used in dentistry to isolate the operative site from the rest of the mouth.

Medical emergencies

The practice had access to an automated external defibrillator. (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). Additional equipment to assist a patient to maintain their airway was available for adult's but not for children. There was no portable suction unit available. The emergency equipment was stored in a cupboard on the ground floor with other items that could make rapid access difficult. We also noted the signs locating emergency equipment were small and could be improved.

Emergency medicines were available at the practice in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice. We checked the emergency medicines and saw that the appropriate medicines were available and within their expiry dates. We saw records to show that the drugs were checked monthly and replaced before they expired.

A suitable portable oxygen cylinder was available and equipped to use with adults and children in an emergency situation. It was stored in an accessible area but there was no sign on the door to identify that compressed gas was stored there.

Staff recruitment

We reviewed the recruitment records for three members of staff who had been recruited by the practice within the last year. There was evidence of a full recruitment process although there was no record of references sought for one member of staff and another had one limited reference on

Are services safe?

file. The practice manager told us these had been requested but she had been unable to obtain alternative referees. The recruitment policy did not contain guidance on what to do in this situation. The provider has recently decided to complete Disclosure and Barring Service (DBS) checks for all staff and some were in progress for reception staff. Other records we reviewed demonstrated DBS checks for other staff were in place.

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies. We found the practice had completed a fire risk assessment, had a fire evacuation procedure in place and completed regular checks of fire fighting equipment and the fire alarm. A member of staff had completed training as a fire warden and staff were aware of who took this role. Staff completed a daily sign in/out log which showed at a glance who was in the premises should a fire or other emergency occur.

The practice had a health and safety risk management process in place which enabled them to assess, mitigate and monitor risks to patients, staff and visitors to the practice. The manager was responsible for health and safety. There were plans for her to be supported by another member of staff once they had completed a training course. There was an appropriate business continuity plan in place.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. We looked at the COSHH file and found risks (to patients, staff and visitors) associated with substances hazardous to health had been identified. Information about the action to be taken in the event of an exposure was accessible to staff.

Infection control

There were effective systems in place to reduce the risk and spread of infection. The practice had an appropriate infection control policy in place to guide practice and several other infection control manuals were available for staff reference.

We examined the facilities for cleaning and decontaminating dental instruments. The practice had two dedicated decontamination rooms on separate floors of the building. These were set out according to the Department of Health's guidance, Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices. The lead dental nurse showed us how reusable instruments were decontaminated and demonstrated their knowledge and competence of the guidelines. Both decontamination rooms had separate zones for clean and dirty instruments to prevent cross contamination of instruments and staff wore appropriate personal protective equipment (including heavy duty gloves and a mask) while instruments were being decontaminated. Staff used an ultrasonic cleaner, an illuminated magnifying lens and an autoclave machine to complete the decontamination process. An autoclave is a device used for sterilising dental and medical instruments. Once sterilised, instruments were placed in pouches and dated to indicate when they should be reprocessed if left unused. Staff confirmed to us their knowledge and understanding of single use items and how they should be used and disposed of which was in line with guidance.

Records we reviewed showed that daily, weekly and monthly tests were performed to check that the decontamination equipment was working efficiently and correctly maintained. Records were kept of the results to support this.

We found that there were adequate supplies of liquid soaps and hand towels throughout the premises and hand washing techniques were displayed in the toilet facilities. Most sharps bins with the exception of one, were properly located, signed, dated and not overfilled. The practice had an on-going contract with a clinical waste contractor. Staff segregated and stored waste appropriately and this included clinical waste and the safe disposal of sharp instruments.

The treatment rooms and equipment were visibly clean and tidy. Hand washing posters were displayed next to each dedicated hand wash sink to ensure effective decontamination. Patients were given a protective bib and safety glasses to wear each time they attended for treatment. There were good supplies of protective equipment for patients and staff members.

Records showed a risk assessment for Legionella had been completed in 2013 and this had been reviewed regularly, most recently in June 2015. This process ensures the risks of Legionella bacteria developing in water systems within the premises had been identified and preventive measures taken to minimise the risk of patients and staff developing Legionnaires' disease. (Legionella is a bacterium found in

Are services safe?

the environment which can contaminate water systems in buildings). We also found staff conducted and recorded regular tests on the water supply which included checking the hot and cold water temperatures. A member of staff had designated responsibility for completing the checks and in their absence, this was delegated to another named member of staff.

The last infection control audit had been carried out in September 2015 and we found the audits were completed regularly. Where areas for improvement had been identified, these had been recorded then actioned.

Equipment and medicines

There were systems in place to ensure that items of equipment were serviced regularly, including the dental air compressor, autoclaves, dental chairs, fire extinguishers and the X-ray equipment. We were shown the annual servicing certificates.

An effective system was in place for the prescribing, dispensing, use and stock control of the medicines used in clinical practice such as antibiotics and local anaesthetics. These medicines were stored safely for the protection of patients.

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 in the treatment rooms.

X-ray machines were the subject of regular visible checks and records were maintained to support this. A specialist company attended at regular intervals to calibrate all X-ray equipment and 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 and completed regular training in the safe use of radilology equipment. This meant that patients were protected against the risks associated with taking X-rays as the staff were all competent in the safe use of the equipment.

We saw records that indicated the practice completed regular X-ray audits to monitor their practice although there was no documented interpretation of the audit against national guidelines. We also saw new audit forms that contained a clear process to interpret the quality of the audit findings against national guidelines. The practice manager confirmed these were ready to use as the practice had identified this improvement was required.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice asked new patients to supply them with information about their medical history, current health, medication being taken and any allergies. This was reviewed at appropriate intervals to ensure that any potential health issues were considered as part of their dental assessment and treatment plan.

The dentists completed a dental assessment for each patient in line with recognised guidance from the National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC) guidelines. This 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 their 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 dietary advice 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.

The practice offered treatment under sedation for nervous adult patients who paid privately for their treatment. This involved the administration of a medicine (a sedative) through a vein in their arm to help them to relax during their dental procedure. The patient remains awake during the whole procedure. We spoke with one principal dentist who offered this treatment for patients having implants who requested sedation. The dentist told us each patient was risk assessed prior to the procedure and their informed consent was recorded in accordance with national guidelines. The procedure was always completed in an appropriate room with an dental nurse trained and familiar with the technique. The patient's condition was monitored closely during and after the procedure. Patient's were given verbal advice about aftercare post procedure and were not supplied with written information as advised in the Standards for Conscious Sedation in the Provision of Dental Care (2015).

Records we reviewed supported these findings.

Patients spoken with and comments received on CQC comment cards reflected that patients were satisfied with the assessments, information they received and the quality of the dental care they received.

Health promotion & prevention

The practice promoted the maintenance of good oral health as part of their overall philosophy and had considered the Department of Health publication 'Delivering Better Oral Health; a toolkit for prevention' when providing preventive oral health care and advice to patients. They employed two dental hygienists and the dentists referred appropriate patients to them for assessment and advice. This included treating and giving advice on the prevention of decay and gum disease, advice on tooth brushing techniques and oral hygiene products. The practice prescribed high fluoride toothpaste for adults at high risk of decay.

Information was available for patients about oral health on the practice website and information leaflets were provided to patients as required. Health promotion information was displayed in the waiting rooms. Information for parents and guardians of children to support good dental care was also available. Children received fluoride applications in line with national guidelines .

CQC comment cards that we received and patients we spoke with confirmed that they had received helpful health promotion advice.

Staffing

The dental team was led by two principal dentists. The practice employed five associate dentists, two hygiene therapists, five dental nurses, two trainee dental nurses, a practice manager and five reception and administrative staff. In addition, the practice employed the services of a management advisor.

Are services effective?

(for example, treatment is effective)

Staff leave was planned in advance to ensure that a minimum number of staff were away at one time. Cover, if required was sought from part time staff. If this was not possible agency staff were used from time to time. We saw the practice used a clear induction process for agency staff.

Records of staff training were held centrally by the practice manager and progress was monitored. We saw that this included safguarding training, the Mental Capacity Act and basic life support. Other forms of training were evident and this included peer review meetings and short training sessions held during staff meetings.

Individual members of staff were supported to develop their skills to support their role. For example a radiography course for two dental nurses and a health and safety course for a receptionist.

There was an appraisal system in place and staff received six monthly reviews to discuss their training and support needs. Staff told us they had found this to be a useful and worthwhile process; they felt well supported by the practice manager and principal dentists.

Working with other services

When required, patients were referred to other dental specialists for assessment and treatment. All referrals were checked and countersigned by the principal dentist and records were made of the referral. This included gaining the patient's consent to share their personal information. The system used ensured that patient's needs were followed up appropriately after their treatment and dental records were updated.

The dentist we spoke with referred patients to specialists within the local area if the treatment required was not provided by the practice. This was always completed following discussion with the patient so that informed choices could be made where possible. Staff told us the care and treatment required was fully explained to the patient and referrals were completed promptly.

Consent to care and treatment

The practice ensured valid consent was obtained from patients for all care and treatment. We observed a dentist discussing the results of one patient's Xray with them. They explained the findings and described the treatment options that were available to them. The patient chose to have an external referral and the process was clearly described to them including expected timescales.

Each patient received a treatment plan and an estimate of costs prior to treatment being completed. Consent to commence treatment was clearly recorded in the dental records. Patients we spoke with confirmed this.

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Two clinical staff we spoke with demonstrated an understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment. This included assessing a patient's capacity to consent and when making decisions in a patient's best interests. They were also familiar with the Gillick principles to ensure that children and young people were enabled to make their own decisions about their treatment if this was age appropriate.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Staff told us that if a patient required a confidential discussion about their care or treatment they were taken to a more private room so that information could not be overheard. We found that patients' electronic dental care records were stored securely at all times and observed that staff took care not to discuss patient's personal details so that they could be heard by others at the reception desk.

On the day of our inspection, we observed staff being polite, friendly and welcoming to patients.

We received a total of 40 CQC comments cards completed by patients during two weeks leading up to the inspection. The cards were all very positive showing that patients valued the service they received. Patients said that staff put them at ease, were welcoming and caring. They told us staff listened to their needs and gave good advice.

A member of staff told us about the level of support they had provided to a very anxious patient who was due to have some treatment. They arranged for the patient to have an evening appointment and spent time describing treatment, expectations and answering their questions. The treatment was completed the following day and the patient gave staff positive feedback about the helpful support they had received.

Involvement in decisions about care and treatment

We received comments on the CQC cards from patients who told us they received a good level of information about their treatment or general dental needs that enabled them to make choices about their treatment. They also felt able to ask their dentist questions about their treatment and told us they were happy with the outcomes of their treatment. Patients we spoke with confirmed they received information about their dental costs prior to any treatments taking place. We also found that information about treatment costs for NHS and any private dental care was displayed in the waiting room.

We spoke with staff who gave us examples of individualised care that enabled patients to make their own treatment decisions. For example a patient with dementia was seen by their dentists who provided them with relevant information to form an opinion and make their own decisions. The dentist, with permission from the patient then called in their next of kin to explain the treatment discussion to enable them to support the patient's own decision.

Records we checked showed that patients consent had been obtained before treatment plans were progressed.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice offered a range of treatments to patients which included regular check-ups, fillings, extractions, root canal, dentures, bridges and crowns. In addition a dental hygienist provides a childrens' club each month aimed at children who are not good at cleaning their teeth regularly. The service provided mainly NHS treatment. Some private treatments were available and this included sedation services. Information about treatment costs were available in the waiting rooms and were also explained to patients during their consultation. The practice's website contained limited information about the treatments offered.

The practice had a system in place to schedule enough time to assess and undertake patients' care and treatment. We reviewed this with reception staff who showed us that emergency appointment slots were held each day so that requests for urgent appointments could be met. On occasions when they could not provide a convenient appointment for an unregistered patient, the practice advised them to try another local dentist or the dental access centre. Alternatively patients could opt to be seen privately.

Staff told us they did not feel under pressure to complete procedures and always had enough time available to prepare for each patient.

Tackling inequity and promoting equality

We asked staff to explain how they communicated with people who had different communication needs such as those who spoke another language. Staff told us they treated everybody equally and welcomed patients from different backgrounds, cultures and religions. Staff also encouraged patients with limited English language skills to attend with a relative or friend who could translate for them. Alternatively, they could access a translation service. Staff told us a patient who was profoundly deaf communicated with them in writing. There was no hearing loop available at the practice.

The practice made a note on patient's dental records to indicate whether a patient had particular needs, for example if they had a medical condition such as diabetes or a heart condition. Staff also told us how they supported people with learning disabilities or mental health needs in accordance with their needs and preferences.

The practice had treatment rooms on the ground and first floors of the building with an entrance suitable for patients who used a wheelchair or for mothers with young children or babies using prams. A patient we spoke with told us that they were always able to see their dentist in a ground floor treatment room as they were no longer able to manage the stairs. The practice had accessible toilets for patients with a disability and baby changing facilities.

Access to the service

The practice offered a range of general dental services and opened weekdays from 8.00am until 8.00pm three days per week with earlier closing on Monday and Fridays. It provided treatment to NHS patients on the ground and first floors of the premises. The practice operated a system to remind patients of their appointment details by email or text messaging if the patient had given permission for this.

The interval in between routine check-ups was determined by each dentist in line with national guidelines. Patients we spoke with were satisfied with access to routine and emergency appointments.

Information about obtaining emergency care out of hours was available in the waiting rooms and if patients called when the practice was closed, an answerphone message explained what to do. This information was not on the practice website.

Out-of-hours cover was provided by the NHS 111 service.

Concerns & complaints

The practice had an appropriate complaints policy in place and the practice manager was responsible for dealing with any complaints received and sharing this information with the team. Information on how to raise a complaint and how it would be dealt with was available in written format in the waiting room. The website also included a link for patient to use if they wished to raise any concerns or provide feedback to the practice manager.

The practice last received a complaint in May 2014. Although this had taken some time to complete a formal

Are services responsive to people's needs?

(for example, to feedback?)

resolution, the practice were able to demonstrate records to indicate they had provided an appropriate apology and response to the patient. Learning from the complaint was shared with staff.

Are services well-led?

Our findings

Governance arrangements

The practice manager and principal dentists took the lead on governance and quality monitoring issues.

There was a full range of policies and procedures in use at the practice. These included health and safety, infection prevention and control, patient confidentiality and recruitment. Staff we spoke with were aware of the policies and how to access them. The policies we looked at were up to date. However, we found that staff were not familiar with the policy for managing incidents and near miss events and a clear process was not being followed and recorded.

The practice manager had established regular practice meetings to discuss internal quality issues and share staff knowledge and experience. Minutes of meetings supported this.

Systems were in place to ensure the safety of the environment and of equipment such as machinery used in the decontamination process and fire safety equipment. Risk assessments were in place although the storage of the emergency equipment required a review to ensure it's safety and accessibility in an emergency situation.

Records we reviewed demonstrated that regular audits took place for infection control and radiography. There were also systems in place to seek patient feedback on a regular basis. However we found that the data gathered for both of these quality checks was not interpreted so that areas for improvement could be identified and actioned.

Leadership, openness and transparency

There was a clear leadership structure in place that was well known to staff and they understood their roles and responsibilities within the practice. For example there was a lead dental nurse, a safeguarding lead and health and safety leads. The practice manager set standards and ensured they were maintained.

Staff were involved in regular team meetings and took turns to chair the meetings. Minutes of these were available for staff reference and for those who were unable to attend. The staff we spoke with told us they enjoyed their jobs, worked well as a team and were supported to raise any issues about the safety and quality of the service. We were told that there was a no blame culture at the practice and that the delivery of high quality care was a high priority.

All staff knew how to raise any issues or concerns and were confident that action would be taken by the practice manager without fear of discrimination. A policy was in place to support this process.

Learning and improvement

There were systems in place to promote learning and service improvements although some of these required further development. Staff recognised and acted on complaints and accidents although further development was needed to ensure that staff recognised incidents or significant events in accordance with the practice policy. Records were not fully completed to ensure that risks were identified, reviewed and changes were communicated to the staff team to ensure quality improvements were completed.

Staff had opportunities to receive mandatory training and additional clinical training through the NHS. The training was available through online courses as well as face to face training. We found that one nurse had been able to access training in radiography and sedation techniques and a receptionist was booked to attend a health and safety course.The practice manager monitored staff progress with training and development.

Dentists and dental nurses at the practice were registered with the GDC. The GDC registers all dental care professionals to make sure they are appropriately qualified and competent to work in the United Kingdom. The practice manager kept a record to evidence that staff were up to date with their professional registration.

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

The practice used the friends and family test to monitor patient satisfaction and address any comments or concerns. The results were very favourable although few contained additional comments that could be acted upon. The monthly results were not shared with patients at the time of the inspection visit. The practice manager informed us that there were plans to share this on the website in the future.

Are services well-led?

The practice used their own patient survey and patient questionnaire. The questionnaire was sent out to approximately 10 patients per month and the results were recorded into a spread sheet. A separate survey was also completed and this included more detailed questions about the patient experience. Although the results were summarised there was no evidence of an analysis to help inform learning and improve the patient experience. The practice manager agreed that this should be further developed.

The practice had reviewed the feedback from a patient complaint and identified learning to share with their staff. The complaints policy focused on resolving issues at the first point of contact when possible or referring to the practice manager.

Staff we spoke with told us their views were sought at team meetings and the practice manager and principal dentists were very approachable. They told us their views were listened to and they felt part of a team who worked well together.