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# Churchview Dental Practice

## Inspection Report

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## Overall summary

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

Churchview Dental Practice is situated in Doncaster, South Yorkshire. It offers mainly private dental treatment to patients of all ages but also holds a small NHS contract for children. The services include preventative advice and treatment and routine restorative dental care.

The practice has two surgeries, a decontamination room, a waiting area and a reception area. All of the facilities are on the ground floor of the premises along with toilets.

There is one dentist, one dental hygiene therapist, two dental nurses (one of whom is a trainee), one receptionists and a practice manager.

The opening hours are Monday, Tuesday, Thursday and Friday from 8-00am to 5-30pm, Wednesday from 8-00am to 12-30pm and Saturday by appointment only.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. 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 we spoke with five patients who used the service and reviewed 65 completed CQC comment cards. The patients were positive about the care and treatment they received at the practice. Comments included that the practice had a very caring

# Summary of findings

ethos and that staff were helpful and friendly and supportive. They also commented that the practice was always clean and hygienic and the dentist explained treatments clearly.

**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.
- The dentist was passionate about providing the best care for patients.
- 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.
- There was a warm and welcoming feel to the practice.
- Staff ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood.
- The practice had a complaints system in place and there was an openness and transparency in how these were dealt with.
- Patients were able to make routine and emergency appointments when needed.
- The governance systems were effective.

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

- Review the current legionella risk assessment and implement the required actions including the monitoring and recording of water temperatures, giving due regard to the guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and the Health and Safety Executive –Approved Code of Practice L8: Legionnaires' disease "The control of legionella bacteria in water systems".

# 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.

Staff told us they felt confident about reporting incidents, accidents and the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

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

Staff were suitably qualified for their roles and the practice had undertaken the relevant recruitment checks to ensure patient safety.

Patients' medical histories were obtained before any treatment took place. The dentists were aware of any health or medication issues which could affect the planning of treatment. Staff were trained to deal with medical emergencies. All emergency equipment and medicines were in date and in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines.

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.

**Are services effective?**

No action

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 focused strongly on prevention and the dentists were aware of the 'Delivering Better Oral Health' toolkit (DBOH) with regards to fluoride application and oral hygiene 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.

**Are services caring?**

No action

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

# Summary of findings

During the inspection we spoke with five patients who used the service and reviewed 65 completed CQC comment cards. Comments included that the practice had a very caring ethos and that staff were helpful, friendly and supportive. They also commented that the dentist explained treatments clearly.

The practice had a warm and welcoming feel. We observed staff to be friendly and caring towards the patients.

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection.

Staff explained that enough time was allocated in order to ensure that the treatment and care was fully explained to patients in a way which they understood.

**Are services responsive to people's needs?**

**No action** 

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

The practice had an efficient appointment system in place to respond to patients' needs. There were vacant appointments slots for urgent or emergency appointments each day.

Patients commented they could access treatment for urgent and emergency care when required. There were clear instructions for patients requiring urgent care when the practice was closed.

There was a procedure in place for responding to patients' complaints. This involved acknowledging, investigating and responding to individual complaints or concerns. Staff were familiar with the complaints procedure.

The practice had made reasonable adjustments to enable patients in a wheelchair or with limited mobility to access treatment.

**Are services well-led?**

**No action** 

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 day to day running of the practice.

Effective arrangements were in place to share information with staff by means of monthly practice meetings which were well minuted for those staff unable to attend.

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 were currently undertaking the NHS Friends and Family Test (FFT).

# Churchview 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 spoke with five patients who used the service and reviewed 65 completed CQC comment cards. We also spoke with the dentist, two dental nurses, the receptionist 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 in the last 12 months. These had been well documented and analysed. Any accidents or incidents would be reported to the practice manager and would also be discussed at staff meetings in order to disseminate learning.

The practice manager understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR).

The practice received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) that affected the dental profession. These were actioned if necessary and were the stored for future reference.

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

The practice had child and vulnerable adult safeguarding policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff. Staff had access to contact details for both child protection and adult safeguarding teams. The dentist was the safeguarding lead for the practice and all staff had undertaken level two safeguarding training.

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 dentist handles sharps and guidelines about responding to a sharps injury (needles and sharp instruments).

The dentist 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.

We saw that patients' clinical records were computerised and password protected to keep personal details safe. Any paper documentation relating to patients' records were stored in lockable 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. We saw that there was a notice in the decontamination room which detailed what information the ambulance team would need in the case of a medical emergency. This also included directions to the practice and local landmarks which would help the paramedics find the practice.

The practice kept an emergency resuscitation kit, medical emergency oxygen and emergency medicines. Staff knew where the emergency kits 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 Advisory 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 regular checks were carried out on the AED, emergency medicines and the oxygen cylinder. These checks ensured that the oxygen cylinder was full, the AED battery was fully charged and the emergency medicines were in date. We saw that the oxygen cylinder was serviced on an annual basis.

**Staff recruitment**

The practice had a policy and a set of procedures for the safe recruitment of staff which included seeking references, proof of identity, checking relevant qualifications and professional registration. We reviewed a sample of staff files and found the recruitment procedure had been followed. The practice manager told us they carried out Disclosure and Barring Service (DBS) checks for all newly employed staff. These checks identify whether a person has a criminal record or is on an official list of people barred from working

in roles where they may have contact with children or adults who may be vulnerable. We reviewed records of staff recruitment and these showed that all checks were in place.

All clinical staff at this practice were qualified and registered with the General Dental Council (GDC). There were copies of current registration certificates and personal indemnity insurance (insurance professionals are required to have in place to cover their working practice).

**Monitoring health & safety and responding to risks**

A health and safety policy and risk assessment was in place at the practice. This identified the risks to patients and staff who attended the practice. The risks had been identified and control measures put in place to reduce them.

There were policies and procedures in place to manage risks at the practice. These included fire, wet floors, hot instruments, pregnant workers and risks associated with Hepatitis B.

The practice maintained a file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including substances such as disinfectants, and dental materials in use in the practice. 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 COSHH folder was well laid out by where the substances were kept in the practice, for example, the surgeries, decontamination room or staff room.

**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)'. One of the dental nurses 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 help 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). 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.

# Are services safe?

The practice had systems in place for daily and weekly quality testing the decontamination equipment and we saw records which confirmed these had taken place. There were sufficient instruments available to ensure the services provided to patients were uninterrupted.

The practice had carried out an Infection Prevention Society (IPS) self- assessment audit in April 2016 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.

Records showed a risk assessment process for Legionella had been carried out in December 2010 and had been reviewed on an annual basis to ensure it was still valid (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, the use of a water conditioning agent in the water lines and bi-annual tests on the on the water quality to ensure that Legionella was not developing. We did not see any evidence that water temperature testing was carried out. We raised this issue with the practice manager and we were told that they were unaware that this was required. We saw evidence on the day of inspection that the practice manager took the decision to get a new Legionella risk assessment done which included on-site training for all staff.

**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 April 2016 (PAT confirms that portable electrical appliances are routinely checked for safety).

The practice also dispensed antibiotics for private patients. These were kept locked away and a log of which antibiotics had been dispensed was kept. All of these antibiotics were in date and a stock control system was in place to ensure medicines did not go out of date. NHS prescriptions were stamped only at the point of issue and were kept locked away when not needed to ensure their safe use.

**Radiography (X-rays)**

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. Records we viewed demonstrated that the X-ray equipment was regularly tested, serviced and repairs undertaken when necessary. A Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure that the equipment was operated safely and by qualified staff only. We found there were suitable arrangements in place to ensure the safety of the equipment. Local rules were available in both 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 dentist 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 dentist used 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. If the patient had more advanced gum disease then a more detailed inspection of the gums was undertaken. During the inspection we noted that the dentist used dental loupes during examinations and whilst providing treatment. Dental loupes provide a dentist with a degree magnification which aids visual acuity and aids correct diagnosis and treatment of dental conditions.

Medical history checks were updated every time they 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 dentist used markers on patients noted to alert them if there were any medical conditions which could affect treatment, for example, if they were on blood thinning medicines.

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.

The dentist spoke passionately about dentistry and the work which he did. It was clearly evident the providing the best possible treatment was paramount to the practice's ethos. The dentist had attended numerous training courses in order to continuously improve his skills in different areas of dentistry.

**Health promotion & prevention**

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

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 covered topics such as health and safety, fire evacuation procedures, the location of emergency equipment and the sterilisation process. We saw evidence of completed induction checklists in the personnel files.

Staff had good access to on-going training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). The practice organised in house training for medical emergencies to help staff keep up to date with current guidance on treatment of medical emergencies in the

# Are services effective?

## (for example, treatment is effective)

dental environment. The practice owner paid for all courses which staff are required to attend. Records showed professional registration with the GDC was up to date for all staff and we saw evidence of on-going CPD.

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

We saw that staff had annual appraisals and training requirements were discussed at these. We saw evidence of completed appraisal documents. New members of staff had quarterly appraisals until they got familiar with the way the practice works and were up to date with all their mandatory training.

**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 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 urgent letter the same day and a telephone call to confirm the letter 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 dentist 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. The dentist was clear about involving children in decision making and ensuring their wishes were respected regarding treatment.

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.

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 written treatment plan which outlined the treatments which had been proposed, the associated costs and any potential risks related to the treatment. Patients were given time to consider and make informed decisions about which option they preferred.

# 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. We observed staff to be helpful, discreet and respectful to patients. Staff told us that if a patient wished to speak in private an empty room would be found to speak with them.

The waiting area was separate from the reception area which reduced the chance of any patients overhearing an inadvertent breach of confidentiality. The waiting area had a warm, homely feel and there was plenty of reading material available for patients. We were told that it was rare for more than one or two patients ever to be in the waiting room at one time. This allowed the patients to relax in a quiet environment.

Patients' electronic care records were password protected and regularly backed up to secure storage. Any paper documentation relating to dental care records were securely stored in locked cabinets.

**Involvement in decisions about care and treatment**

The practice provided patients with information to enable them to make informed choices. The dentist 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. The dentist regularly used an intraoral camera before, during and after providing treatment. We were shown numerous examples of this. The use of photographs significantly aided patients in understanding what dental problems they had and what treatments were available.

Patients were also informed of the range of treatments available in the practice information leaflet, and on the practice website. The dentist had created some photo books which demonstrated the services which were available at the practice. These showed patients before and after photos of patients which they had treated over the years. We felt that these were a valuable tool to show patients what could be achieved by different treatment options.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting patients' needs**

We found the practice had an efficient appointment system in place to respond to patients' needs. Staff told us that patients who requested an urgent appointment would be seen the same day. We saw evidence in the appointment book that there were dedicated emergency slots available each day for each dentist. If the emergency slots had already been taken for the day then the patient would be booked at the end of a session to ensure they were seen on the same day. The dentist told us that plenty of time was allocated for each patient in order to provide the best treatment possible. 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 step free access to the premises, a ground floor toilet, on-site parking and a hearing loop. The surgeries were large enough to accommodate a wheelchair or a pushchair.

**Access to the service**

The practice displayed its opening hours on the premises, in the practice information leaflet and on the practice website. The opening hours are Monday, Tuesday, Thursday and Friday from 8-00am to 5-30pm, Wednesday from 8-00am to 12-30pm and Saturday by appointment only.

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. Private patients were provided with a mobile telephone number of the dentist who would either give advice or open the surgery to see the patient. NHS patients were signposted to the NHS 111 service. Information about the out of hours emergency dental service was available on the telephone answering service, displayed in the waiting area, on the practice website and in the practice information leaflet.

**Concerns & complaints**

The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. There was a flow chart within the practice manual for staff to reference about how to deal with complaints when they arose. 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. We reviewed the complaints which had been received in the past 12 months and found that they had been dealt with in line with the practices policy and to the patient's satisfaction. The practice kept a detailed log of any complaints which had been raised. This included the nature of the complaint, the date it had been acknowledged, the date a response had been provided and a conclusion including any actions taken as a result. Any complaints would be discussed at staff meetings in order to disseminate learning and prevent recurrence.

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 two 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 was a member of Denplan Excel. This is a certification programme for dentists to demonstrate excellence in quality assurance, patient care and communication.

The practice manager and one the principal dentist were in charge of the day to day running of the service. There was a range of policies and procedures in use at the practice. We saw they had systems in place to monitor the quality of the service and to make improvements. The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately.

The practice had an effective approach for identifying where quality or safety was being affected and addressing any issues**.** Health and safety and risk management policies were in place and we saw a risk management process to ensure the safety of patients and staff members. For example, we saw risk assessments relating to fire, wet floors, hot instruments, pregnant workers and risks associated with Hepatitis B.

There was an effective management structure in place to ensure that responsibilities of staff were clear. Staff told us that they felt supported and were clear about their roles and responsibilities.

**Leadership, openness and transparency**

The culture of the practice encouraged candour, openness and honesty to promote the delivery of high quality care and to challenge poor practice. This was evident when we looked at the complaints they had received in the last 12 months.

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, RIDDOR, safeguarding and COSHH 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 clinical audits such as dental care records, medical histories, X-rays and infection control. We looked at the audits and saw that the practice was performing well.

Staff told us they had access to training and this was monitored to ensure essential training was completed each year; this included medical emergencies and basic life support. Staff working at the practice were supported to maintain their continuous professional development as required by the General Dental Council. The practice paid for staff to attend training including CPD events organised by Denplan which covered much of the core CPD.

**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 annual patient satisfaction surveys. The most recent patient survey showed a high level of satisfaction with the quality of the service provided.

The practice also undertook the NHS Friends and Family Test (FFT). The FFT is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.