The Tooth Spa Limited

The Tooth Spa

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 21 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

The Tooth Spa is situated in the Chapel Allerton area of Leeds, West Yorkshire. It offers only private dental treatments to both adults and children. The services include preventative advice and treatment, general and cosmetic dentistry, domiciliary visits, orthodontics and emergency access for non-registered patients. They also offer direct access for dental hygiene services. Direct access means giving patients the option to see a dental care professional (DCP) without having first seen a dentist and without a prescription from a dentist.

The practice opened in 2014 and is currently building up a patient list. They also accept referrals from other practices.

The practice has two surgeries, a decontamination room, one waiting area and a reception area. All facilities are on the ground floor of the premises and there are accessible toilet facilities. The practice is fully accessible for those in a wheelchair.

There are three dentists, a dental hygiene/therapist, a receptionist and a practice manager/owner. Both the receptionist and the practice manager/owner are qualified dental nurses. They also have access to other dental nurses through the locum agency owned by the practice owner.

Summary of findings

The opening hours are Monday to Saturday 9-00am to 5-30pm. Apoointments are also available in the evening and Sundays by appointment only.

The practice owner 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.

On the day of inspection, 19 patients provided feedback. The patients were positive about the care and treatment they received at the practice. They told us they were treated with dignity and respect in a clean and tidy environment. Patients also commented that the staff are helpful, extremely professional and that it was easy to get an appointment at a time which suited them.

Our key findings were:

- The practice was clean and hygienic.
- The practice had systems in place to assess and manage risks to patients and staff including infection prevention, control and health and safety and the management of medical emergencies.
- Staff were suitably 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.
- 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 practice had a complaints system in place which was easily accessible to patients.

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

- Make the X-ray audit practitioner specific.
- Make the sharps injury procedure more visible in the surgery.
- Make the clean and dirty zones in the surgery easier to identify.
- Document when policies have been reviewed.

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 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?

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 made referrals for specialist treatment or investigations where indicated.

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 dentists were aware of 'The Delivering Better Oral Health' toolkit (DBOH) with regards to fluoride application and oral hygiene advice.

Staff were encouraged to complete training relevant to their roles and this was monitored by the practice owner. The clinical staff were up to date with their continuing their professional development (CPD).

Referrals were made to secondary care services if the treatment required was not provided by the practice.

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 19 patients. Patients commented that staff were polite, friendly, and helpful and that they were made to feel at ease. Patients also commented that they were involved in treatment options and everything was explained thoroughly.

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.

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.

Summary of findings

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 and they also offered emergency appointments out of normal working hours for both registered and non-registered patients. Patients commented they could access treatment for urgent and emergency care when required

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 and it was displayed in the waiting room for patients to reference if needed.

The practice was fully accessible for patients with a disability or limited mobility to access dental treatment.

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 all staff felt supported and appreciated in their own particular roles. The practice manager was responsible for the day to day running of the practice.

There were effective clinical governance arrangements in place which helped with the smooth running of the practice.

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

The Tooth Spa

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.

During the inspection we received feedback from 19 patients. We also spoke with one dentist, the receptionist and the practice owner/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. There had not been any significant events within the past 12 months. However, staff were familiar with the need to report any incident or accident and to implement processes to prevent them from occurring again. We were told that any incidents would be discussed at staff meetings in order to disseminate learning or discuss ideas for preventative measures.

The registered provider understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR) and provided guidance to staff within the practice's health and safety policy.

The registered provider received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) that affected the dental profession. These were received via e-mail from the MHRA. These would then be discussed with staff and actioned if applicable to the practice.

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 practice manager was the safeguarding lead for the practice and all staff had undertaken safeguarding training. There had not been any referrals to the local safeguarding team; however staff were confident about when to do so. Staff told us they were confident about raising any concerns with the safeguarding lead or the local safeguarding team.

The practice had systems in place to help ensure the safety of staff and patients. These included the use of a safe sharps system and guidelines about responding to a sharps injury (needles and sharp instruments). However, we noted that the guidelines for dealing with a sharps injury were not clearly displayed in the surgery for staff to reference. This was brought to the attention of the practice owner and we were told that this would be addressed.

Rubber dam (this is a square sheet of latex used by dentists for effective isolation of the root canal and operating field and airway) was used in root canal treatment in line with guidance from the British Endodontic Society. Both latex and non-latex rubber dam sheets were available in the event a patient might be allergic to latex.

We saw that patients' clinical records were mainly computerised and password protected to keep people safe and protect them from abuse. Any paper documentation relating to dental care records were also securely 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. This was in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). 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.

The emergency resuscitation kits, oxygen and emergency medicines were stored in the staff room. Staff knew where the emergency kits were kept. On the day of inspection the practice did not have an Automated External Defibrillator (AED). An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. However, we saw evidence that one had been ordered previously and they were awaiting delivery. Staff had already received training on the use of an AED.

Records showed daily checks were carried out on the emergency medicines and the oxygen cylinder. These checks ensured that the oxygen cylinder was full and the emergency medicines were in date. We were told that once the AED had been delivered it would also be checked on a daily basis.

We were told that when staff were undertaking domiciliary visits that the whole emergency kit was taken with them. These visits took place outside normal working hours so that there was never a patient being treated in the surgery when the emergency equipment and medicines were out on a domiciliary visit.

Staff recruitment

Are services safe?

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 owner 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). Copies of the dentists and dental hygiene therapist GDC certificates were also displayed in the waiting room.

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. We were told that as part of the evening cleaning done by the practice owner any issues with the premises would be picked up and appropriate control measures or maintenance would be done.

There were policies and procedures in place to manage risks at the practice. These included infection prevention and control 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.

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)'.

Staff 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 room and the decontamination room to be clean, hygienic and obviously well maintained. 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 in each surgery which identified and monitored areas to be cleaned. There were hand washing facilities in the surgeries and staff had access to supplies of personal protective equipment (PPE) for patients and staff members. Patients confirmed that staff used PPE during treatment and that the surgery was clean and hygienic. Posters promoting good hand hygiene and the decontamination procedures were clearly displayed to support staff in following practice procedures. However, we noted that the clean and dirty areas of the surgeries were not clearly marked out. However, staff were fully aware of the importance of zoning to prevent cross contamination. We discussed this with the practice owner and we were told signage would be put in the surgeries.

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.

The practice undertook domiciliary visits. We were told that instruments would be transported in solid lockable containers when these visits were being done. These containers were clearly marked as clean or dirty.

Are services safe?

We were showed 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. 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.

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 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. This audit was reviewed on a six monthly basis to ensure the appropriate standards were being adhered to.

Records showed a risk assessment process for Legionella had been carried out in March 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 agent. The practice had dental units which had an inbuilt water line flushing system. This ensured the water lines were flushed for the appropriate amount of time.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as X-ray sets, the autoclave and the compressor. The practice maintained a list of all equipment including dates when maintenance contracts which required renewal. We saw evidence of validation of the autoclave and the compressor. Portable appliance testing (PAT) had been completed in January 2014 (PAT confirms that portable electrical appliances are routinely checked for safety). Fire extinguishers were serviced on an annual basis.

We saw that local anaesthetics were appropriately stored and a log of batch numbers was recorded.

The practice dispensed antibiotics for patients. These were kept locked away and a log of prescriptions was kept. This log included which dentist had prescribed them, the type of antibiotic, the dose and the reason for the prescription.

Radiography (X-rays)

The practice had documentation relating to radiation protection and a record of all X-ray equipment including service and maintenance history. Records we viewed demonstrated the X-ray equipment was regularly tested and serviced. 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.

An X-ray audit had been carried out in August 2015. This was to assess whether the X-rays had been justified, reported on and whether they were of diagnostic quality. The audit results showed that the practice was generally performing well. However, we identified that this audit was done for the whole practice and was not practitioner specific. These audits should be conducted for each individual practitioner so that individual needs can be identified and action plans formulated for a specific practitioner. This was discussed with the practice owner and we were told that this would be done for the next X-ray audit.

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 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. This was documented and also discussed with the patient.

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. If the patient had more advanced gum disease then a more detailed inspection of the gums was undertaken.

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 by each patient 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 practice used markers in their electronic dental care records to highlight to other practitioners when there was a medical condition or if the patient was taking a medicine which could affect dental treatment.

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 dentists followed the guidance from the FGDP before taking X-rays to ensure they were required and necessary. We discussed with the dentist the FGDP guidelines and they spoke very knowledgably about the role of X-rays in assessing dental decay in patients. Justification for the taking of an X-ray, quality assurance grade of each X-ray and a detailed report was recorded in the patient's care record.

Health promotion & prevention

Staff were aware of the importance of 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 all children who attended for an examination. High fluoride toothpastes were prescribed for patients at high risk of dental decay.

We saw from dental care records that oral hygiene advice was provided to patients and this was tailored for a patient's individual needs. This was then followed up and reinforced at follow up appointments.

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 was given to patients who smoked. 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 getting the new member of staff aware of the practice's policies, the location of emergency medicines and the decontamination procedures. We saw evidence of completed induction checklists in the personnel files.

Staff told us they 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 dental environment. Records showed professional registration with the GDC was up to date for all staff and we saw evidence of on-going CPD.

Staff told us they had annual appraisals and training requirements were discussed at these. We saw evidence of completed appraisal documents. We also saw that staff had personal development plans which were formulated as a result of the appraisal.

Are services effective?

(for example, treatment is effective)

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. For example, referrals were made to hospitals and specialist dental services for further investigations or specialist treatment including community dental services and sedation. Patients were given a choice of which practice they were referred to and informed of possible waiting lists. The practice 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 referring dentist to see if any action was required and then stored in the patient's dental care records. The practice owner kept a log of all referrals which had been sent and also when a letter had been received back.

The practice also accepted referrals from other practices for treatment. If referrals were received then the patient would be contacted to book an initial assessment appointment. The patient would be made aware of any charges involved with the initial appointment. At the end of the treatment a letter would be sent back to the referring dentist to inform them of what treatment had been done and advice about on-going care.

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. Staff 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.

Staff ensured patients gave their consent before treatment began and this was signed by the patient. We were told that individual treatment options, risks, benefits and costs were discussed with each patient. Patients commented that risks, benefits and costs had been discussed prior to undertaking any treatment. These discussions were well documented in the dental care records. Patients would be provided with a written treatment plan which gave a breakdown of what treatments had been planned and their associated costs. If the patient was happy with the treatment plan then they were asked to sign it. Staff were also aware that consent could be removed at any time. Patients were also 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. Staff were fully aware of patient confidentiality issues and we were told that this was of the upmost importance to the practice in order to maintain patients' confidence whilst being treated there.

Dental care records were not visible on the reception desk to help maintain patient confidentiality. We observed staff were helpful, discreet and respectful to patients. Staff said that if a patient wished to speak in private, an empty room would be found to speak with them.

Patients' electronic dental care records were password protected and regularly backed up to secure storage. Any paper documentation was securely stored in locked cabinets when the practice was closed to ensure confidentiality.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients commented they felt involved in their treatment and it was fully explained to them. This included discussions about risks, benefits and any associated costs. Patients told us that they were never pushed into any particular treatment and felt that it was totally their decision about which treatment suited them the best.

We were told by the dentist that they used X-rays and special tests to assist when explaining treatments to patients and what is needed. For example, the dentist would show the patient an X-ray with a cavity on it which extends into the nerve of the tooth. This would then explain why the patient was experiencing tooth ache and that options for the treatment would be to clean out the nerve of the tooth or to extract the tooth.

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.

Patients were also informed of the range of treatments available (including the option of joining the Denplan monthly payment scheme) in the practice information leaflet and on notices in the waiting area. The practice's website also provides a great deal of information about the different treatments which are available and what is involved in each different treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We found the practice had a very flexible appointment system in place to respond to patients' needs. Staff told us that patients (both registered and un-registered) who requested an urgent appointment would be seen the same day. The practice offered evening appointments for emergencies. If a patient called up with an emergency then they would be booked in for an evening appointment and a dentist would be contacted to see the patient.

If the practice was closed then the phone line was redirected to the practice owner's mobile phone. We were told that if a patient rang out of hours then they would either be seen the same day if appropriate or at least within 24 hours.

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 ramp to access the premises and a ground floor accessible toilet. The ground floor surgeries were large enough to accommodate a wheelchair or a pram. The registered provider had installed dental chairs which had a reversible headrest which allowed patients in a wheelchair to be treated whilst still in the wheelchair.

The practice also offers domiciliary services for those unable to attend the surgery. These include home visits and for individuals in care homes.

We were also told that staff also spoke a variety of different languages including Urdu, Arabic, Greek and Spanish.

Access to the service

The practice displayed its opening hours in the premises and on the practice website. The opening hours are Monday to Saturday 9-00am to 5-30pm. Evening appointments were also available by appointment only.

Patients told us that they were rarely kept waiting for their appointment. 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. If the practice was closed then the phone line was redirected to the practice owner's mobile phone and an emergency appointment would be scheduled the same day and if not within 24 hours.

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 owner was in charge of dealing with complaints when they arose. Staff told us they would raise any formal or informal comments or concerns with the practice owner 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 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 five 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 owner was 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 staff had signed the policies to confirm that they had read and understood them. We were told these policies were reviewed on an annual basis. However, these reviews were not documented. This was discussed with the practice owner and we were told that these annual reviews would be documented from now on.

We saw the practice 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 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 the use of sharps, the use of equipment and infection control.

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. 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 were discussed openly at staff meetings where relevant and it was evident the practice worked as a team and dealt with any issue in a professional manner.

The practice had quarterly staff meetings involving all staff members. These meetings were minuted for those who were unable to attend.

All staff were aware of whom to raise any issue with and told us that the practice manager was approachable, would listen to their concerns and act appropriately. We were told there was a no blame culture at the practice and that the delivery of high quality care was part of the practice's ethos.

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, X-rays, oral cancer screening and infection control. We looked at the audits and saw that the practice was performing well. However, where improvements could be made these were identified and followed up by a repeat audit. For example, we noted that the clinical record audit identified that not all the patients had a basic periodontal examination (BPE) recorded in their electronic dental care records. We were told that this had actually been done; however, it had not been saved on the computer. This was because some of the practitioners had not clicked the correct button to save the record. This had led to the practice owner instructing the practitioner on how to save these examinations in the dental care records.

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 encouraged to maintain their continuous professional development as required by the General Dental Council.

All staff had annual appraisals at which learning needs, general wellbeing and aspirations were discussed. We saw evidence of completed appraisal forms in the staff folders and also completed personal development plans.

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

The practice had a system in place to involve, seek and act upon feedback from people using the service. This was by a comment box in the waiting room. The comment box was checked regularly by the practice owner. However, we were told very few comments about how to improve the service were received. There was reference to comments in the practice leaflet with regards to making comments directly

Are services well-led?

to the practice owner. Patients commented that they felt the practice owner was very approachable and would be happy to make comments on how to improve the service directly.

We were told by the practice owner that they would conduct a formal patient satisfaction survey within the next six months.