Cranleigh Practice Ltd

# Cranleigh Practice Limited

## Inspection Report

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## Overall summary

We carried out an announced comprehensive inspection on 26 April 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**

Cranleigh Dental Practice has three dentists, a dental hygienist, five dental nurses and a receptionist and practice manager. Four of the dental nurses are qualified and registered with the General Dental Council (GDC) and one is a student nurse. The practice opens at 9am from Monday to Thursday and closes at 6pm. On Fridays the practice is open 9am to 1pm.

Cranleigh Dental Practice provides both NHS and private treatment for adults and children. The practice is situated in a converted residential property. There are three dental treatment rooms; and a separate decontamination room for cleaning, sterilising and packing dental instruments. There is also a reception and waiting area.

The practice manager 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.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice, we also spoke with patients following the inspection. We received feedback from seven patients who provided an overall positive view of the services the practice provides. Three

# Summary of findings

patients commented that there could occasionally be a wait to see the dentist after their appointment time but also praised the practice. All of the patients commented that the quality of care was good.

**Our key findings were:**

- The practice had mechanisms in place to record significant events and accidents.
- The practice had effective safeguarding processes and staff understood their responsibilities for safeguarding adults and children
- The practice had enough staff to deliver the service.
- Infection prevention and control systems were in place and audits were completed on a six monthly basis
- Patients were treated with dignity and respect and confidentiality was maintained.
- The practice kept up to date with current guidelines when considering the care and treatment needs of patient's
- Health promotion advice was given to patients appropriate to their individual needs such as smoking cessation or dietary advice.
- Patients felt involved in all treatment decisions and were given sufficient information, including details of costs to enable them to make an informed choice.
- The appointment system met the needs of patients and waiting times were kept to a minimum
- Feedback from seven patients gave us a completely positive picture of a friendly, caring and professional service.
- The practice had implemented clear procedures for managing comments, concerns or complaints.

# 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 operated systems for recording and reporting significant events and accidents and staff were aware of who to report incidents and accidents to within the practice.

A member of staff had recently been identified as the safeguarding lead and staff understood their responsibilities for reporting any suspected abuse.

Medicines and equipment available for use in a medical emergency were being checked for effectiveness. Medicines for use in an emergency were available on the premises as detailed in the Guidance on Emergency Medicines set out in the British National Formulary (BNF).

Infection control audits were being undertaken, on a six monthly basis. The practice had systems

for waste disposal and on the day of inspection the practice was visibly clean and clutter free.

**No action** 

**Are services effective?**

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

The practice demonstrated that they followed professional guidance, for example, issued by the National Institute for Health and Care Excellence (NICE). The practice monitored patients' oral health and gave appropriate health promotion advice. Staff were registered with the General Dental Council (GDC). Staff records were complete in relation to recruitment and continuous professional development (CPD) and staff monitored CPD to ensure that it was kept up to date.

Patients told us that staff explained treatment options to ensure that they could make informed decisions about any treatment they received and records seen confirmed this.

**No action** 

**Are services caring?**

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

We observed staff being welcoming and friendly when patients came in to book an appointment. We received feedback from seven patients. Patients praised all staff and gave a positive view of the service; three patients who confirmed that they were happy with the service also said that occasionally there was an extended wait to see the dentist.

Patients commented that treatment was explained clearly and staff said that dentists always took their time

to explain treatment to patients. Patient records were stored securely and patient confidentiality was well maintained.

**No action** 

# Summary of findings

**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 service was aware of the needs of the local population and took these needs into account in how the practice was run. Patients had good access to appointments, including emergency appointments, which were available on the same day. Staff had access to translation services, if required. Patients were invited to provide feedback via the 'Friends and Family' Test and the test results had been reviewed by the practice and an action plan developed.

There was a clear complaints procedure and information about how to make a complaint was available for patients to see.

**Are services well-led?**

No action 

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

Strong and effective leadership was provided by the principal dentist. The principal dentist and other staff had an open approach to their work and shared a commitment to continually improving the service they provided. There was a no blame culture in the practice. The practice had robust clinical governance and risk management structures in place. Staff told us that they felt well supported and could raise any concerns with the principal dentist. All the staff we met said that they were happy in their work and the practice was a good place to work.

# Cranleigh Practice Limited

**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 practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008

The inspection was carried out on 26 April 2016 by a CQC inspector who was supported by a specialist dental adviser. 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, and the details of their staff members including proof of registration with their professional bodies.

We informed NHS England area team that we were inspecting the practice and they asked us to look at infection control at the practice. We also told local Healthwatch on 15 February 2016 that we were inspecting the practice; however, we did not receive any information of concern from them.

During the inspection, we spoke with the principal dentist, dental nurses/practice manager and reviewed policies, procedures and other documents. We also obtained the views of seven patients following the day of our visit. We reviewed five comment cards that we had left prior to the inspection, for patients to comment about the services provided at the practice.

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

Staff demonstrated a good awareness of RIDDOR (The reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). The practice had an incident reporting system in place when something went wrong; this system also included the reporting of minor injuries to patients and staff. The practice reported that there had been 14 incidents over the last 12 months that required investigation. The records we saw demonstrated that the reporting forms were available and staff knew how to complete these with the purpose to prevent incidents. We looked at three in detail which demonstrated analysis, shared learning and a reduction in risk o prevent such an event happening again.

The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA). Where relevant these incidents were sent to all members of staff by the practice manager. Staff could explain that relevant alerts would also be discussed during staff meetings to facilitate shared learning these meetings occurred weekly. Minutes from practice meetings confirmed this.

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

We spoke to a dental nurse about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current EU Directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne diseases. The practice used a system whereby needles were not manually re-sheathed using the hands following administration of a local anaesthetic to a patient. Dentists were also responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps.

We asked the principal dentist how they treated the use of instruments used during root canal treatment. They explained that these instruments were single patient use only. They also explained that root canal treatment was carried out where practically possible using a rubber dam. This was confirmed by the dental nurses we spoke with. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work. Patients can be assured that the practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam.

The principal dentist and practice manager acted as the safeguarding leads and as a point of referral should members of staff encounter a child or adult safeguarding issue. A policy and protocol was in place for staff to refer to in relation to children and adults who may be the victim of abuse or neglect. Training records showed that all staff had received appropriate safeguarding training for both vulnerable adults and children. Information was available in the practice that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities.

### Medical emergencies

The practice had arrangements to deal with medical emergencies at the practice. The practice had an

automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Staff had received training in how to use this equipment. The practice had emergency medicines as set out in the British National Formulary guidance for dealing with medical emergencies in a dental practice. The practice had access to oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines.

The emergency medicines and oxygen we saw were all in date and stored in a central location known to all staff. The practice held training sessions each year for the whole team so that they could maintain their competence in dealing with medical emergencies. Staff we spoke with demonstrated they knew how to respond if a person suddenly became unwell.

### Staff recruitment

# Are services safe?

All of the dentists, the dental hygienist and four of the five dental nurses had current registration with the General Dental Council, the dental professionals' regulatory body. The practice had a recruitment policy that detailed the checks required to be undertaken before a person started work. For example, proof of identity, a full employment history, evidence of relevant qualifications, adequate medical indemnity cover, immunisation status and references.

The systems and processes we saw were in line with the regulations. Staff recruitment records were stored securely in a locked cabinet to protect the confidentiality of staff personal information. We saw that all staff had received appropriate checks from the Disclosure and Baring Service (DBS). These are checks to 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.

## Monitoring health & safety and responding to risks

The practice had arrangements to monitor health and safety and deal with foreseeable emergencies. The practice maintained a comprehensive system of policies and risk assessments which included radiation, fire safety, general health and safety and those pertaining to all the equipment used in the practice. The practice had a business continuity plan to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service.

The practice had a well-maintained comprehensive Control of Substances Hazardous to Health (COSHH) file. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients.

## Infection control

There were effective systems to reduce the risk and spread of infection within the practice. The practice had a robust infection control policy that was regularly reviewed. It was demonstrated through direct observation of the cleaning process and a review of practice protocols that HTM 01 05 (national guidance for infection prevention control in dental practices') Essential Quality Requirements

for infection control were being exceeded. It was observed that an audit of infection control processes carried out in February 2016 confirmed compliance with HTM 01 05 guidelines.

We saw that the three dental treatment rooms, decontamination room, waiting area, reception and toilets were very clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms and the decontamination room. Hand washing facilities were available including liquid soap and paper towel dispensers in each of the treatment rooms, decontamination room and toilet. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

The drawers of a treatment rooms were inspected and these were clean, ordered and free from clutter. Each treatment room had the appropriate routine personal protective equipment available for staff use; this included protective gloves, masks and eye protection.

The dental nurse we spoke with described to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. They demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines. The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a

term for particular bacteria which can contaminate water systems in buildings). They described the method they used which was in line with current HTM 01 05 guidelines.

We saw that a Legionella risk assessment had been carried out at the practice by a competent person in January 2016. The recommended procedures contained in the report were carried out and logged appropriately. These measures ensured that patients' and staff were protected from the risk of infection due to Legionella.

The practice had a separate decontamination room for instrument processing. The dental nurse we spoke with demonstrated the process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean. The practice used a system of manual scrubbing for the initial cleaning process, following inspection with an illuminated magnifier the instruments were placed in an autoclave (a device for

sterilising dental and medical instruments). When the instruments had been sterilised, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines.

We were shown the systems in place to ensure that the autoclave used in the decontamination process were working effectively. It was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were always complete and up to date.

All recommended tests utilised as part of the validation of the ultra-sonic cleaning bath were carried out in accordance with current guidelines, the results of which were recorded in an appropriate log book.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained and was in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. This was stored in a separate locked location adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection. Patients' could be assured that they were protected from the risk of infection from contaminated dental waste.

Environment cleaning was carried out by the nurses and receptionist. We saw an extensive file that contained detailed cleaning plans for each treatment room and other areas of the practice. We saw that the practice carried out a regular audit of these procedures, the audits contained action plans for staff to follow to maintain the standard of environmental cleaning.

### Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclave had been serviced and calibrated in August 2015. The practices' X-ray machines had been serviced and calibrated as specified under current national regulations. Portable appliance testing (PAT) had been carried out.

The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored securely for the protection of patients. All of the local anaesthetic cartridges had not been removed from their blister packs. We found that the practice stored prescription pads securely overnight to prevent loss due to theft. The practice also had a prescription logging system to account for the prescriptions issued to prevent inappropriate prescribing or loss of prescriptions. We observed that the practice had equipment to deal with minor first aid problems such as minor eye problems and spill kits to deal with body fluid and mercury spillage.

### Radiography (X-rays)

We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 (IRR99) and Ionising Radiation Medical Exposure Regulations 2000

(IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for each X-ray set along with the maintenance logs, Health and Safety Executive (HSE) notification and a copy of the local rules.

We saw that a radiological audit for each dentist had been carried out in November 2015. Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured. These findings showed that practice was acting in accordance with national radiological law and patients and staff were protected from unnecessary exposure to radiation.

We saw training records that showed all staff where appropriate had received training for core radiological knowledge under IRMER 2000 and IRR 99 Regulations.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Monitoring and improving outcomes for patients

The dentists we spoke with carried out consultations, assessments and treatment in line with recognised general professional guidelines. The dentists described to us how they carried out their assessment of patients for routine care. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by 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 the last appointment. Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained in detail. Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Dental care records we reviewed demonstrated that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums).This was carried out where appropriate during a dental health assessment.

### Health promotion & prevention

The practice was very focussed on the prevention of dental disease and the maintenance of good oral health. To facilitate this aim the practice appointed dental hygienists to work alongside of the dentists in delivering preventative dental care. The dentist we spoke with explained that patients at high risk of tooth decay were identified and were offered fluoride varnish applications or the prescription of high concentrated fluoride tooth paste to keep their teeth in a healthy condition.

They also placed fissure sealants (thin coatings on the biting surfaces of permanent back teeth) on patients who were particularly vulnerable to dental decay. Other preventative advice included tooth brushing techniques explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. Dental care records we reviewed demonstrated that dentists and hygienist had given oral health advice to patients.

The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area. Underpinning this was a range of leaflets explaining how patients could maintain good oral health.

### Staffing

The practice had three dentists working over the course of a week and were supported by four dental nurses, a student nurse and a dental hygienist, a receptionist and the practice manager. We observed a friendly atmosphere at the practice. Staff we spoke with told us the staffing levels were suitable for the size of the service. The staff appeared to be a very effective and cohesive team; they told us they felt supported by the dentists. They told us they felt they had acquired the necessary skills to carry out their role and were encouraged to progress. We confirmed that the dental nurses received an annual appraisal. These appraisals were carried out by the principal dentist and the practice manager. There was effective use of skill mix in the practice. This enabled the dentists to concentrate on providing care to patients whose needs were more complex whilst the dental hygienists provided routine care and advice.

The principal dentist showed us their system for recording training that staff had completed. These contained details of continuing professional development (CPD), confirmation of current General Dental Council (GDC) registration, and current professional indemnity cover

# Are services effective?

## (for example, treatment is effective)

where applicable. All of the patients we spoke with said they had confidence and trust in the dentists. This was also reflected in the Care Quality Commission comment cards we received.

### Working with other services

One of the dentists explained how they would work with other services. Dentists were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as oral surgery, special care dentistry and orthodontic providers.

We noted the practice used a referral tracking system to monitor referrals from the practice. This ensured that patients were seen by the right person at the right time.

### Consent to care and treatment

We spoke with the dentists about how they implemented the principles of informed consent; all of the dentists had a very clear understanding of consent issues. They explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan and the patients dental care records. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options.

To underpin the consent process the practice had developed bespoke consent forms for more complex treatment including root canal treatment, surgical removal of teeth and dental implants. The dentists went onto explain how they would obtain consent from a patient who suffered with any mental impairment that may mean that they might be unable to fully understand the implications of their treatment. If there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed.

They added they would involve relatives and carers if appropriate to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005. Staff were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

# Are services caring?

## Our findings

### Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting areas and we saw that doors were closed at all times when patients were with dentists or the hygienist. Conversations between patients and clinicians could not be heard from outside the treatment rooms which protected patient's privacy.

Patients' clinical records were stored electronically and in paper form. Computers were password protected and regularly backed up to secure storage with paper records stored in lockable records storage cabinets at various points in the practice. Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality.

Before the inspection, we sent Care Quality Commission (CQC) comment cards so patients could tell us about their experience of the practice. We collected five completed CQC patient comment cards and obtained the views of two patients following the day of our visit. These provided a positive view of the service the practice provided. All of the patients commented that the quality of care was very good. Patients commented that treatment was explained clearly and the staff were caring and put them at ease. They also said that the reception staff were always helpful and efficient. During the inspection, we observed staff in the reception area. We observed that they were polite and helpful towards patients and that the general atmosphere was welcoming and friendly.

### Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. A poster detailing NHS fees was displayed in the waiting area. Booklets were also available in the waiting area and on the practice website that detailed the costs of both NHS and private treatment.

The dentists we spoke with paid particular attention to patient involvement when drawing up individual treatment plans. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them. This included information recorded on the standard NHS treatment planning forms for dentistry where applicable.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting patients' needs

During our inspection we looked at the examples of Information the practice had available for people. We saw that the practice waiting area displayed a wide variety of information including the practice patient information leaflet and leaflets about the services the practice offered, results of the family and friends test, how to make a complaint, fire procedures for patients to follow and the practices quality assurance policy.

The patient information leaflet explained opening hours, emergency 'out of hours' contact details and arrangements, staff details and how to make a complaint. The practice website also contained useful information to patients such as leaflets about different types of treatments which patients could down load and how to provide feedback on the services provided. We observed that the appointment diaries were not overbooked and that this provided capacity each day for patients with dental pain to be fitted into urgent slots for each dentist. The dentists decided how long a patient's appointment needed to be and took into account any special circumstances such as whether a patient was very nervous or the level of complexity of treatment. A patient waiting time audit had identified some delays in patients being seen. This was addressed by extending examinations and consultations for the dentists to get to know their patients better and to have time to discuss their needs and expectations.

### Tackling inequity and promoting equality

The practice had made reasonable adjustments to help prevent inequity for patients that experienced limited mobility or other issues that would hamper them from accessing services. Staff informed patients that the practice was on the first floor, accessed by a flight of stairs. Patients that identified the stairs would pose a problem were helped by the staff to access other practices with level access. The practice used a translation service, which they arranged if it was clear that a patient had difficulty in understanding information about their treatment.

### Access to the service

The practice was open 9am - 6pm Monday to Thursday and 9am to 1pm Friday. The practice used the NHS 111 service to give advice in case of a dental emergency when the practice was closed. This information was publicised in the practice information leaflet, practice website, at the entrance to the practice and on the telephone answering machine when the practice was closed.

### Concerns & complaint

The practice had a complaints policy and a procedure that set out how complaints would be addressed, who by, and the time frames for responding. Information for patients about how to make a complaint was seen in the patient leaflet, poster in the waiting area and practice website.

The practice had received four complaints during the last 12 months. We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was an effective system in place which ensured a timely response. Staff could explain how they would handle a complaint which was in line with the practice complaints policy.

# Are services well-led?

## Our findings

### Governance arrangements

The governance arrangements of the practice were developed through a process of continual learning and improvement. The governance arrangements for the practice was facilitated by the principal dentist and the practice manager who were responsible for the day to day running of the practice. The practice maintained a comprehensive system of policies and procedures. All of the staff we spoke with were aware of the policies and how to access them. We noted all policies and procedures were kept under review by the principal dentist on a regular basis.

### Leadership, openness and transparency

Effective leadership was provided by the principal dentist and practice manager. The practice ethos focussed on providing patient centred dental care in a relaxed and friendly environment. The comment cards we saw reflected this approach. The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said they felt comfortable about raising concerns with the principal dentist. There was a no blame culture within the practice. They felt they were listened to and responded to when they did raise a concern however minor. We found staff to be hard working, caring and committed to the work they did. All of the staff we spoke with demonstrated a firm understanding of the principles of clinical governance in dentistry and the standards for dental professionals and were happy with the practice facilities. Staff reported that the principal dentist was proactive and resolved problems very quickly. As a result, staff were motivated and enjoyed working at the practice and were proud of the service they provided to patients.

### Learning and improvement

We saw evidence of systems to identify staff learning needs which were underpinned by an appraisal system and a programme of clinical audit. For example, we observed that the dental nurses and receptionists received an annual appraisal; these appraisals were carried out by the principal dentist and practice manager and were followed up by a review to check if the staff were on course to meet their appraisal objectives. There was a system of peer review in place to facilitate the learning and development needs of the dentists. These were held informally on a weekly basis. Subjects discussed at recent meetings included fire drills, testing of the ultrasonic bath, fire safety and infection control training.

The practice used the principle of the 'daily chats' which were carried out by the staff to increase their awareness of the particular needs and risks of patients, including issues around their medical, social and clinical needs.

We found there was a rolling programme of clinical and non-clinical audits taking place at the practice. These included infection control, clinical record keeping and X-ray quality. The audits demonstrated a comprehensive process where the practice had analysed the results to discuss and identify where improvement actions may be needed.

Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. Staff told us that the practice ethos was that all staff should receive appropriate training and development. The principle dentist encouraged staff to carry out professional development wherever possible. The practice used a variety of ways to ensure staff development including internal training and staff meetings as well as attendance at external courses and conferences. The practice ensured that all staff underwent regular mandatory training in cardio pulmonary resuscitation (CPR), infection control, child protection and adult safeguarding, dental radiography (X-rays). We saw that the practice maintained a record of all staff's training records.

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

The practice had gathered feedback from patients through the NHS Friends and Family test (FFT), NHS Choices, compliments and complaints. We saw that there was a robust complaints procedure in place, with details available for patients in the waiting area, practice leaflet and on the website. Results of the Family and Friends Test (FFT) we saw indicated that 100% of patients who completed the survey were happy with the quality of care provided by the practice and patients were either highly likely or likely to recommend the practice to family and friends.

Staff told us that the principal dentist was very approachable and they felt they could share their views about how things were done at the practice. Staff confirmed that they had daily chats every morning; and

# Are services well-led?

staff who were absent were informed of these meetings when they were next on shift. Staff described the meetings as good with the opportunity to discuss successes, changes and improvements. Staff we spoke with said they felt listened to and included in all aspects of the running of the practice.