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Warrington House Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 26 July 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

Warrington House Dental Practice is located in Brislington, a residential area of Bristol, and provides NHS and private treatment to patients of all ages. The practice consists of three treatment rooms, toilet facilities for patients and staff, a reception/ waiting area and a staff room.

The practice treats both adults and children. The practice offers routine examinations and treatment. There are five dentists.

The practice's opening hours are

8.00 to 17.00 on Monday

8.00 to 19.00 on Tuesday

8.00 to 17.45 on Wednesday

8.00 to 17.30 on Thursday

8.45 to 15.00 on Friday

The dentists operate an on-call system out of hours.

We carried out an announced, comprehensive inspection on 26 July 2016. The inspection was led by a CQC inspector accompanied by a dental specialist advisor.

Summary of findings

Before the inspection we looked at the NHS Choices website but there were no reviews.

For this inspection 36 people provided feedback to us about the service. Patients were positive about the care they received from the practice. They were complimentary about the service offered which they said was good or excellent. They told us that staff were professional, efficient, helpful, polite, caring and friendly and the practice was clean and hygienic. We received one negative comment about the reception staff sometimes being abrupt.

Our key findings were:

• Safe systems and processes were in place, including a lead for safeguarding and infection control.

• When recruiting staff the relevant checks were completed but not within timescales identified in current guidance. Staff received relevant training.

• The practice had ensured that risk assessments were in place and that they were regularly reviewed.

• The clinical equipment in the practice was appropriately maintained. The practice appeared visibly clean throughout.

•The process for decontamination of instruments followed relevant guidance.

• The practice maintained appropriate dental care records and patients' clinical details were updated.

• Patients were provided with health promotion advice to promote good oral care.

• Consent was obtained for dental treatment.

• The dentists were aware of the process to follow when a person lacked capacity to give consent to treatment.

• All feedback that we received from patients was positive; they reported that it was a professional, helpful, caring and friendly service.

• There were arrangements for governance at the practice such as systems for auditing patient records, infection control and radiographs.

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

- Review the recruitment procedures to ensure Disclosure and Barring checks and two written references are obtained before new staff start work in the practice.
- Review the training for medical emergencies to include role play to give staff the opportunity to learn how to work together in the event of an emergency.
- Review the process for checking the fire safety measures to include routine checks to ensure all the safety measures are working properly.
- Review the arrangements for checking the fridge temperatures to make sure they are kept at the correct level for the storage of medicines.
- Review the arrangements for keeping prescriptions to introduce a process of checking to ensure none are missing.
- Review the procedure for taking X-rays so that they are always graded to assess the quality.
- Review the training and development for dentists about the Mental Capacity Act 2005 and capacity and consent so that all dentists understand about adults' and children's capacity to consent.

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.

There were appropriate systems for reporting incidents and for learning from incidents. Staff had received training about safeguarding adults and children. There were policies about safeguarding and whistleblowing and staff knew how to report any concerns.

There were also arrangements for dealing with foreseeable emergencies, for fire safety and for managing risks to patients and to staff. However, routine checking of the fire safety measures was not taking place. There was a business continuity plan. Hazardous substances were managed safely.

Most of the appropriate checks were being made to make sure staff were suitable to work with vulnerable people. However, references and Disclosure and Barring checks were not always obtained before staff started to work in the practice. The necessary medicines were in place. Equipment was regularly serviced. X-rays were dealt with safely.

The surgeries were fresh and clean and guidance about decontamination of instruments was being followed to reduce the risk of the spread of infection.

Are services effective?

No action

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

The dentists took X-rays at appropriate intervals. The practice checked the condition of the gums for every patient and they checked for signs of oral cancers. Patients completed medical history questionnaires and these were updated at each visit. The practice kept up to date with current guidelines and research. They promoted the maintenance of good oral health through information about effective tooth brushing. The dentists discussed health promotion with individual patients according to their needs.

The practice had sufficient staff to support the dentists. Staff received appropriate professional development and all of the expected training.

The practice had suitable arrangements for working with other health professionals and making appropriate referrals to ensure quality of care for their patients. Patients were asked for consent to treatment. Patients told us that the dentists discussed options for treatment with them. The patient notes showed that options for treatment were discussed to help patients to make decisions about their care.

Some of the dentists showed understanding about the Mental Capacity Act 2005 (MCA) and what they would do if an adult lacked the capacity to make particular decisions for themselves. They also understood that some children were competent to be involved in decision making and consent to treatment.

Summary of findings

Are services caring?

No action

We found that this practice was providing caring services in accordance with the relevant regulations. Staff in the practice were polite and respectful when speaking to patients. Patients' privacy was respected and treatment room doors were closed during consultations. The practice used an electronic record system and the computer screens in reception were shielded so that they could not be seen by patients.

Patients were positive about the care they received from the practice. They reported that staff were professional, helpful, caring and friendly. The dentists discussed different treatment options with patients to help them to decide on the best treatment for them.

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 a system to schedule enough time to assess and meet patients' needs. Patients said that they could get an appointment easily. Emergencies were usually fitted in on the day the patient contacted the practice. The practice actively sought feedback from patients on the care being delivered. There was a procedure about how to make a complaint and the process for investigation. We saw evidence that the practice responded to feedback made direct to the practice and made changes when necessary.

There was an equality and diversity policy and staff had received training about equality and diversity. The dentists spoke different languages and one of the nurses had knowledge of British sign language. There was information about translation services for people whose first language was not English. There was level access for wheelchair users to one of the surgeries. There was a hearing loop system for patients who had a hearing impairment.

Are services well-led?

No action

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

The practice had set up systems for clinical governance such as audits of the infection control, record keeping and radiographs. There were checks of equipment. The autoclave and compressor were serviced and there were daily checks of the autoclave.

The practice had a range of policies which were made available to staff.

The practice manager and the provider were the lead professionals for the practice. There was a whistleblowing policy and information for staff about the duty of candour and the need to be open if an incident occurred where a patient suffered harm. So far there had been no such incidents.

The practice manager and the provider held team meetings. Staff were responsible for their own continuing professional development and kept this up to date.

The practice was sought feedback from patients through patient satisfaction feedback forms. They analysed these and made improvements in response to the feedback.

Warrington House Dental Practice

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 26th July 2016. The inspection was led by a CQC inspector accompanied by a dental specialist advisor.

We reviewed information received from the provider before the inspection. We also informed the local Healthwatch and NHS England. We did not receive any information from either organisation.

During our inspection visit, we met with, the practice manager who had been the registered manager for the previous provider and applied to CQC to continue as the registered manager. The new provider was not present at the time of the visit. Registered providers and registered managers are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

We reviewed policy documents and dental care records. We spoke with the practice manager, four dental nurses and three dentists. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We observed dental nurses carrying out decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area.

Thirty six people provided feedback about the service. Patients, who completed comment cards, were positive about the care they received from the practice. They were complimentary about the professional, helpful, friendly and caring attitude of the dental staff.

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

There was a system for reporting and learning from incidents. There was an accident book and information about when an accident needed to be reported to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). All accidents were reported to the manager. There had been no serious accidents only minor cuts. There was a policy about incidents and significant events which included information about analysing events so that staff could learn from them. The policy differentiated between significant events and accidents. There were templates to record incidents and significant events but there had been none to record.

Reliable safety systems and processes (including safeguarding)

There was a procedure about what to do if a member of staff had a sharps injury. A sharps injury occurs when a person is injured by a needle or other sharp object. There had been no such incidents. There were systems to reduce the risk of a sharps injury including the use of single use syringes. Other sharp instruments were handled safely. There were sharps bins in each surgery. We saw evidence that staff were immunised against blood borne viruses (Hepatitis B) to ensure the safety of patients and staff.

The practice had policies and procedures for child protection and safeguarding adults. This included information about how to report a concern to the local safeguarding teams. The practice manager was the safeguarding lead for the protection of vulnerable children and adults. We saw certificates to show that staff had received training about safeguarding adults and children. There were plans to update this training. There had been no safeguarding issues reported by the practice to the local safeguarding team.

There was a whistleblowing policy which staff could follow if they had concerns about another member of staff's performance. We also saw a policy about raising concerns which stated that any concerns should be raised with the manager or provider.

We saw a protocol for responding to patient safety alerts. The manager received safety alerts by email from the Medicines and Healthcare Regulatory Agency (MHRA) and NHS England. The manager or one of the nurses would act upon them if they were relevant to the practice. Any alerts which would affect the ordering of materials were passed to the nurse who was responsible for ordering. When staff needed to know about an alert this would be circulated to all staff.

Staffing and Recruitment

The practice staffing consisted of five dentists, eight dental nurses, some of whom worked on reception, a trainee nurse, a business manager and a practice manager. We looked at the recruitment records of a trainee nurse who had been recruited to the new practice and one nurse who had transferred from the previous practice. Each member of staff had completed a curriculum vitae (CV). They each had a copy of their passport as proof of identity and information about their right to work in the UK. The nurse who had transferred from the previous practice had one written reference and a record of a verbal reference and a Disclosure and Barring Service (DBS) check. We noted that they started work on the 6 July 2015 but their DBS check was not issued until 12 August 2015. Two references and a DBS check had been requested for the trainee nurse. The practice manager said that they applied for the DBS check once a new staff member had started work. They also said that the trainee nurse always shadowed a qualified nurse so never worked unsupervised. There was a record of the immunisation status of the nurses and dentists. We saw that appropriate checks of registration with the General Dental Council (GDC) had been carried out for the qualified staff. There were certificates of qualifications.

A system of appraisals had been developed for staff and appraisals took place annually. Appraisals for dentists were planned. New staff had a probationary period.

Medical emergencies

The practice had arrangements to deal with medical emergencies. Staff had received training in emergency resuscitation and basic life support and this was refreshed every year. We saw certificates for this training. The staff we spoke with were aware of the practice procedures for responding to an emergency. However, we noted that staff did not practice emergency procedures as a team. The practice had emergency equipment in accordance with guidance issued by the Resuscitation Council UK. This included relevant emergency medicines and oxygen and an

automated external defibrillator (AED). (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). There were defibrillator pads for both adults and children. The oxygen cylinder and resuscitation mask were in date. The oxygen cylinder was being routinely checked for effectiveness and we saw records for these daily tests. We reviewed the contents of the emergency medicines kit. We saw records of weekly checks of the medicines and equipment and all the emergency medicines were in date. The glucagon injections were being kept in the fridge and the temperature of the fridge was checked daily. New staff had an induction and probationary staff had an induction an s

Monitoring Health and Safety and responding to Risk

There were arrangements to deal with foreseeable emergencies. We saw that there was a health and safety risk assessment for the general risks in the practice. These included the action to be taken to manage risk. There were additional risk assessments for a trainee nurse, and for pregnant staff. The practice had a fire risk assessment and there were certificates showing that the fire alarm and emergency lighting had been serviced quarterly. Fire extinguishers were serviced annually. The practice manager conducted an annual inspection of the fire safety measures but there were no regular checks such as fire alarm tests. The practice had a business continuity plan to ensure continuity of care in the event that the practice's premises could not be used for any reason.

There were arrangements to meet the Control of Substances Hazardous to Health 2002 (COSHH) Regulations. We saw a folder which contained a policy about COSHH, COSHH risk assessments and safety data sheets. One of the nurses kept the folder up to date and provided information to other staff when there was a new product. When new products were introduced a representative came to talk to staff about the new materials.

The practice followed national guidelines on patient safety. For example, two of the dentists we spoke with told us that they routinely used a rubber dam when providing root canal treatment to patients in line with guidance from the British Endodontic Society. The third did not conduct root canal treatment. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use a rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured.

Infection control

There were systems to reduce the risk and spread of infection. One of the nurses was the infection control lead for the practice. There was a comprehensive infection control policy. Clinical staff were required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. There were good supplies of protective equipment for patients and staff members including gloves, masks, eye protection and aprons. There were hand washing facilities in the treatment rooms and the toilet. The dentists, nurses and hygienist wore uniforms in the clinical areas and they were responsible for laundering these.

There was a Legionella risk assessment (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). We saw a log book of monthly checks of the temperatures at the cold and hot water outlets. The nurse showed us how they flushed the dental water lines in accordance with current guidance in order to prevent the growth of Legionella.

We examined the facilities for cleaning and decontaminating dental instruments in the surgeries. The practice had followed the guidance on 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)' when setting up their decontamination arrangements.

There was a clear flow from 'dirty' to 'clean.' In each surgery there was one sink with two bowls, one for pre-soaking the instruments and one for rinsing. The nurse showed us the process for decontamination of instruments. They put on personal protective equipment (PPE) including domestic style rubber gloves. They placed the instruments into an ultrasonic bath for six minutes before rinsing them in the rinsing sink. They inspected them for debris under an illuminated magnifying glass, placed them on trays and put them into the autoclave to sterilise. After the sterilisation cycle was complete they took the instruments out of the

steriliser and placed the tray, covered with a cloth, on top of the autoclave to cool. The autoclave was sufficient distance from the dental chair to prevent contamination. After they were cool they put them into date stamped bags and put them away in a drawer. The nurses also showed us how they cleaned down the surgeries between patients.

The autoclaves were checked daily for performance, for example, in terms of temperature and pressure. There were daily and weekly checks of the ultrasonic baths. Logs were kept of the results demonstrating that the equipment was working well. The autoclaves were serviced annually.

The practice followed relevant guidance about cleaning and infection control. Cleaning schedules were completed and the practice looked clean throughout. There was a cleaner who cleaned the practice daily. The nurses cleaned the surgeries. One patient we spoke with and 35 people who completed comment cards confirmed that the environment was always clean and hygienic. Ten people who completed comment cards said that he environment was safe an

Procedures to control the risk of infection were monitored as part of the daily check. The practice had an on-going contract with a clinical waste contractor. Waste was appropriately stored and segregated. This included clinical waste and safe disposal of sharps.

Equipment and medicines

We found that the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor, fire equipment and X-ray equipment had all been inspected and serviced. Portable appliance testing (PAT) for electrical items took place and we saw the certificate for the check on 6 May 2016.

Medicines were stored securely in a cupboard and a designated fridge. However, we saw no records of daily checks to show that the fridge temperature was appropriate for the storage of medicines. Prescription pads were locked away. There was no audit of prescriptions to ensure that none went missing. The defibrillator was kept in reception. There was an oxygen cylinder with an up to date certificate. Staff said that there were sufficient dental instruments.

Radiography (X-rays)

There was an X–ray unit in each of the four surgeries. There were suitable arrangements in place to ensure the safety of the equipment. We saw a log to show that the machines were maintained. The name of an external radiation protection adviser (RPA) was made available and the provider was the radiation protection supervisor (RPS). X-rays were graded as they were taken. The provider audited the radiographs. Are services safe

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We reviewed five patient records relating to four dentists. The dentists took X-rays at appropriate intervals, as informed by guidance issued by the Faculty of General Dental Practice (FGDP). They also recorded the justification and findings of x-rays. Two out of the four dentists had also graded their X-rays for quality assurance purposes. The records showed that an assessment of periodontal tissues was always undertaken using the basic periodontal examination (BPE) screening tool. (The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to a patient's gums.) Patients' BPE scores were recorded in the dental care records we read.

We saw that information about medical history was entered in people's records and the records showed that this was reviewed and updated at every visit. This information was kept up to date so that the dentists were informed of any changes in people's physical health which might affect the type of care they received.

We saw evidence that the practice kept up to date with the current guidelines and research in order continually to develop and improve their system of clinical risk management. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to prescribing antibiotics. They conducted risk assessments for patients to help them to decide appropriate intervals for recalling patients. The dentists were aware of the guidance issued in the DH publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Health promotion & prevention

The dentists discussed health promotion with individual patients as part of the routine examination process. This included discussions around smoking and sensible alcohol use. We saw records of examinations of soft tissue to check for the early signs of oral cancer.

The practice promoted the maintenance of good oral health through information about effective tooth brushing. We observed that there was information about tooth brushing and health promotion displayed in the waiting area. This could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition.

Staff skills and experience

The practice staffing consisted of five dentists, eight dental nurses, some of whom worked on reception, a trainee nurse, a business manager and a practice manager. The practice manager told us that all staff received professional development and training. Courses for all staff included safeguarding, cardio pulmonary resuscitation, medical emergencies, infection control, health and safety, equality and diversity and the Mental Capacity Act 2005 (MCA.) The dentists and the nurses were responsible for their own continuing professional development (CPD.) They logged all their training hours online with the General Dental Council (GDC.) We saw evidence that the nurses and dentists were keeping their CPD up to date. We spoke with a trainee nurse who said that they were in the process of their induction and were registered for a college course in dental nursing the following year.

Annual appraisals and personal development plans were planned for all staff. We saw four personal development plans for nurses and the appraisals were planned annually. The trainee nurse told us that they had a training plan. The provider was planning to appraise the dentists.

Working with other services

The practice had suitable arrangements for working with other health professionals to ensure quality of care for their patients. We saw copies of letters which showed that the dentists used a system of onward referral to other providers, for example, for oral surgery and orthodontics. Where there was a concern about oral cancer a referral was made to the local hospital. Referral information was sent to the specialist service about each patient, including their medical history and X-rays.

Consent to care and treatment

The practice ensured that valid consent was obtained for all care and treatment. The dentists discussed treatment options, including risks and benefits, as well as costs, with each patient. We saw records of these discussions and of

Are services effective?

(for example, treatment is effective)

verbal and written consent in the patient notes. One of the dentists told us that consent was mainly verbal. We spoke with three dentists who said that they always discussed treatment options with their patients. They said that when a patient was undecided they printed out the treatment options and gave them to the patient to consider. People who completed comment cards said that they were always asked their views about treatment and the dentists explained. The patient we spoke with said that the dentist always discussed treatment options and always obtained their consent.

We found that staff had training about the Mental Capacity Act 2005 (MCA). We spoke with two dentists who demonstrated knowledge about the MCA and capacity to consent. One of these dentists told us that they conducted assessments of capacity to consent. The two dentists also demonstrated understanding about the ability of children under the age of 18 to be involved in their treatment planning and consent to their treatment. The third dentist showed a lack of understanding about the adults' capacity to consent and said they would discuss treatment options with the person who came with the patient. They also showed a lack of understanding about some children's ability to consent and said that they only considered consent was valid if the young person was over the age of 18.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patient confidentiality was respected. The practice had an electronic record system. Electronic records were password protected and staff had training about protecting information. The computer screens in reception could not be seen by patients. Patients were afforded appropriate privacy as the treatment room doors were closed during consultations. The waiting room was away from the consulting rooms so that conversations could not be heard from the other side of the door. If a patient wished to discuss something with the receptionist in private they were requested to come into the office. If staff received a confidential telephone call in reception they would phone the person back from the office. We observed that staff in the practice were polite and respectful when speaking to patients. Patients told us that they were treated with respect.

Patients who completed comment cards, were positive about the care they received from the practice. Patients reported that staff were professional, approachable, caring, helpful, polite and friendly. They said that they provided a very good service. We had only one negative comment. One patient stated that the reception staff could be abrupt and not receptive to patients. One patient we spoke with said that the dentist and nurse always respected their privacy and took a personal interest in them.

Involvement in decisions about care and treatment

The practice provided treatment plans for patients including costs. Verbal consent was obtained for treatment. One patient we spoke with said that the dentist explained treatment to them very clearly so that they could make decisions and the dentist always asked their opinion. They said that they were having several appointments over time and they expected to receive a treatment plan at the next visit. They told us that they gave verbal consent to treatment. Patients who completed comment cards said that the dentists always explained the treatment to them, listened to what they had to say and took account of their views.

Support to patients

The practice manager told us that staff asked all patients if they had any particular needs and they often said that they were nervous. Staff would then book extra time or extra staff to be with them. The practice had a system of prompts in the patient records to help the dentists identify when they had a nervous patient. The receptionists scheduled longer appointment when a patient was nervous. Patients who required urgent treatment were usually fitted in on the day they requested an appointment. One patient we spoke with and patients who completed comment cards said that the dentists always listened to what they had to say.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system to schedule enough time to assess and meet patients' needs. The practice fitted emergencies into the appointment schedule. Patients commented that the staff provided a good service. The practice actively sought feedback from patients on the care being delivered through satisfaction surveys. We saw evidence that the practice responded to feedback that they received. For example, one patient said that it would be useful to have a cycle rack so the practice provided a cycle rack. They had also introduced a water cooler in reception. The service provided off the shelf reading glasses in case someone forgot their spectacles. The reception staff reminded people of their appointments by phone and they were introducing text reminders because more patients preferred to be contacted by text.

Tackling inequity and promoting equality

There was an equality and diversity policy and there was training for staff about equality and diversity. The practice manager said that the population served by the practice was becoming more diverse and they were seeing more patients who did not have English as their first language. There was information about translation services. Two dentists spoke French, one spoke Norwegian and one member of staff knew British sign language. There was a loop system for patients with a hearing impairment. One of the surgeries was downstairs with level access for people who used wheelchairs. There was a ramp up to the door which had been installed with advice from a patient who used a wheelchair. There was a toilet on the ground floor but this was not large enough to accommodate a wheelchair.

Access to the service

The opening hours were displayed in reception and the website. Patients told us that they had no difficulty getting appointments. Emergencies were usually fitted in on the day the patient contacted the practice. Reception was manned from 7.30am so people would be seen promptly if they phoned in. The earliest appointment was 8.00am and staff would stay on if treatment was needed later in the day. The dentists provided an on-call system for out of hours care.

Concerns & complaints

There was information in reception about how to make a complaint to the practice manager and there was a patient leaflet about the procedure for making a complaint. There was also a more detailed complaints procedure including timescales for responding to complaints and the process for investigation. One patient we spoke with knew how to make a complaint. Information about concerns and complaints would be recorded on a patient complaint form. We saw a template for a complaints review report. However, there had been no complaints.

Are services well-led?

Our findings

Governance arrangements

The practice had set up systems for clinical governance. There were audits of infection control, records, radiographs and waiting times for patients.

There were checks of equipment. We saw evidence that the autoclave and compressor were serviced. The nurse told us that they conducted daily checks of the autoclave and we saw records of these tests. We saw that there was a range of policies which were made available to staff. Appropriate records were kept.

Leadership, openness and transparency

The practice manager was the lead professional for the practice and they were also the lead for safeguarding and infection control and medical emergencies. The registered provider was the clinical lead professional. We saw information for staff about the duty of candour. There was a Being Open policy which included the procedure to follow if a patient was harmed as a result of their care. So far there had been no incidents where patients had suffered harm. We saw a whistleblowing policy which was made available to staff.

Management lead through learning and improvement

The practice manager told us that the provider had meetings with the dentists and had two meetings with the whole team since taking over the practice. The practice manager said that they held meetings with dentists but these were not always recorded. They said that they had informal discussions with staff each morning to plan the day. One of the nurses told us that there were team meetings and staff could raise issues for the agenda and express their views. The nurses told us that they were responsible for their own continuing professional development and kept this up to date. They said that they also had training within the practice and we saw records to show that relevant training was taking place, for example for safeguarding and health and safety. Appraisals and personal development plans for staff had been started.

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

There were feedback forms in reception for patient satisfaction and for the NHS friends and family test. The practice manager had analysed 125 patient satisfaction forms in February 2016. Improvements in response to feedback and suggestions included providing tissues and a water cooler in reception and providing a cycle rack.