White Peak Dental Limited

White Peak Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 16 July 2015 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.

White Peak Dental Practice is located close to the centre of Ashbourne in Derbyshire, near the bus station. There are good public transport links with car parking at the bus station, and nearby street parking.

The practice treats only private patients, mostly from Ashbourne or the surrounding area. Patients are across the whole range of ages from children to older people.

The practice has two dentists who are directors of the practice and two associate dentists. Two dental therapists and six dental nurses plus one trainee dental nurse. There was one reception co-ordinator and a team of receptionists and administrative staff to provide support to the dental team.

The practice opening hours are: Monday: 8:00 am to 5:30 pm; Tuesday, Thursday 9:00 am to 5:30 pm; Wednesday: 9:00 am to 8:00 pm and Friday 9:00 am to 5:00 pm. The practice was closes 1:00 pm to 2:00 pm each day for lunch although reception is usually kept open during lunch.

One of the partners is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) 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.

Summary of findings

We viewed 59 CQC comment cards that had been completed by patients, about the services provided. All 59 comment cards had positive comments about the staff and the services provided. Many comment cards using words such as: “excellent”,“very good” and “professional” in their description of the service. In addition we spoke with three patients who also provided positive feedback about the practice and the dental treatment they had received. Comments particularly focussed on the caring nature of the staff, and how well the practice met patient’s needs.

Our key findings were:

- The practice recorded and analysed significant events and complaints and shared learning with staff.
- Staff had received safeguarding and whistle blowing training and knew the procedures to follow to raise any concerns.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment were readily available.
- Infection control procedures were in place and the practice followed the related guidance.
- Patient’s care and treatment was planned and delivered in line with evidence based guidelines, best practice and current legislation.
- Patients received clear explanations about their proposed treatment, costs, options and risks and were involved in making decisions about it.
- Patients were treated with dignity and respect and confidentiality was maintained.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- The practice was well-led and staff worked as a team.
- Governance systems were effective and there was a range of clinical and non-clinical audits to monitor the quality of services.
- The practice sought feedback from staff and patients about the services they provided

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had effective systems and processes in place to ensure that care and treatment was carried out safely. Significant events, complaints and accidents were recorded appropriately, investigated and analysed then improvement measures were implemented, and learning shared with staff members.

Patients were informed if mistakes had been made and given suitable apologies. Staff had received training in safeguarding and whistle blowing and knew the signs of abuse and who to report concerns to should the need arise. There were robust recruitment procedures in place and staff were trained and skilled to meet patients' needs. There were sufficient numbers of staff available at all times, with a backup system in times of emergency. Induction procedures were in place and completed for all new members of staff.

The practice had robust infection control procedures and staff had received training. Radiation equipment was suitably sited and used only by trained staff. Local rules were displayed clearly where X-rays were carried out. Emergency medicines in use at the practice were stored safely and securely. They were checked to ensure they did not go beyond their expiry dates. Sufficient quantities of equipment were in use at the practice and serviced and maintained at regular intervals.

Are services effective?

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

Patients received an assessment of their dental needs including taking or updating a medical history at each visit.

Explanations were given to patients in a way they understood and risks, benefits, options and costs were explained. Staff were supported through training, appraisals and opportunities for development. Patients were referred to other services in a timely manner if needed.

Patients were monitored through follow-up appointments in line with National Institute for Health and Care Excellence (NICE) guidelines.

Staff had received training in the Mental Capacity Act 2005 and its relevance to dental practice had been explained.

Staff were aware of Gillick competency in relation to children under the age of 16.

Are services caring?

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

Patients had provided positive feedback through comment cards and in person.

Staff at the practice treated patients with dignity and respect and maintained their privacy. The practice was accessible to patients with restricted mobility, with level access and ground floor surgeries if needed.

Patients said they were able to ask questions, and staff explained treatment options to them. The cost of any treatment was identified and explained before treatment began.

Are services responsive to people's needs?

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

Summary of findings

Information was readily available to patients.

Staff used the Public Health England document: 'Delivering better oral health: an evidence based toolkit for prevention.' This allowed staff to develop their role in health promotion, and to take steps to prevent tooth decay.

Patients were able to access treatment quickly in an emergency, and there were arrangements in place for patients to receive alternative emergency treatment when the practice was closed.

The practice had a complaints procedure that explained to patients the process to follow, the timescales involved for investigation and the person responsible for handling the issue. The practice was following this policy and procedure.

Are services well-led?

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

The practice had arrangements in place for monitoring and improving the services provided for patients. Regular checks and audits were completed to ensure the practice was safe and patient's needs were being met.

The practice had a full range of policies and procedures to ensure the practice was safe and met patient's needs. Responses to patients concerns or complaints had been recorded, and showed an open no blame approach.

White Peak Dental Practice

Detailed findings

Background to this inspection

The inspection took place on 16 July 2015 and was conducted by a CQC inspector and a Dentist specialist advisor.

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.

Prior to the inspection we asked the practice to send us some information which we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, the details of their staff members, their qualifications and proof of registration with their professional bodies.

We also reviewed the information we held about the practice and found there were no areas of concern.

During the inspection we spoke with two dentists, and two dental nurses. We reviewed policies, procedures and other documents. We reviewed 59 comment cards that we had left prior to the inspection, for patients to complete, about the services provided at the practice. We also spoke with three patients.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had procedures in place to investigate, respond to and learn from significant events and complaints. Staff were aware of the reporting procedures in place and encouraged to bring safety issues to the attention of the registered provider. Significant events were discussed at practice meetings, and learning was shared with the staff team. We saw minutes of practice meetings to provide evidence of this. A dentist described an incident involving a patient who had been referred to secondary care. It was evident that communication with the patient before making the referral had not been clear. The dentist explained that this was discussed within the practice and steps had been taken to ensure that in the future patients fully understood what a referral to secondary care involved. An apology had been given to the patient.

The practice had procedures in place to assess the risks in relation to the control of substances hazardous to health (COSHH). This included cleaning materials and other hazardous substances used within the practice. Each type of substance that had a potential risk was recorded and graded as to the risk to staff and patients. Measures were clearly identified to reduce such risks. These included the provision of personal protective equipment for staff (gloves, aprons, masks and visors to protect the eyes) and patients. Hazardous materials were stored safely. The practice kept data sheets from the manufacturers to inform staff what action to take in the event of a spillage or contact with the skin.

During the inspection the registered manager said that the practice did not receive Medicines and Healthcare products Regulatory Agency (MHRA) alerts. These alerts identify any problems or concerns relating to a medicine or piece of medical equipment, including those used in dentistry. By not receiving the alerts the practice might have missed out on important safety information. Following the inspection the registered manager made us aware the practice had signed up to receive MHRA alerts.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for responding to concerns about the safety and welfare of vulnerable patients. These policies were in date, and been reviewed in September 2014 (children) and February 2015 (vulnerable adults). Staff were aware of these policies and who to contact and how to refer concerns to agencies outside of the practice should they need to raise concerns. They were also able to demonstrate that they understood the different forms of abuse that may occur and how to raise concerns. The practice had a designated member of staff who took the lead with regard to safeguarding both children and vulnerable adults. Training records showed that all staff at the practice were trained in safeguarding adults and children. Staff said they had attended a classroom based training session in Burton within the last year, and the training records supported this.

The practice had a whistle blowing policy for staff to raise concerns in confidence. The policy had been reviewed and updated on 3 July 2015. Staff told us that they felt confident that they could raise concerns and knew the procedure for whistleblowing and who they could speak with about those concerns. The whistle blowing policy was part of the staff handbook which had been given to every member of staff.

Medical emergencies

The practice had procedures in place for medical emergencies. Training records showed all staff had received basic life support training including the use of the 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).

Staff were able to describe how they would deal with a number of medical emergencies including anaphylaxis (allergic reaction) and cardiac arrest.

Emergency medicines, a defibrillator and oxygen were available if required. This was in line with the Resuscitation Council UK guidelines. We checked the emergency medicines and found that they were as recommended in the British National Formulary (BNF) guidance. and all medicines were in date. The room where the compressed gases were held were clearly marked with a warning sign. Staff told us that they checked medicines and equipment to monitor stock levels, expiry dates and to make sure that equipment was in working order. These checks were recorded.

Are services safe?

The practice had a code red protocol in place. This was to be used if, for example a patient collapsed. Staff members trained in first aid and a dentist would respond to such an emergency. A staff member said they would dial 999 if there was any doubt, or if the situation required.

Staff recruitment

The practice had a recruitment policy for the employment of new staff. This included obtaining proof of identity, checking skills and qualifications, registration with professional bodies where relevant, references and whether a Disclosure and Barring Service (DBS) check was necessary. We looked at the files for six staff employed at the practice and found that the practice policy had been followed. Discussions with the registered manager identified exactly what information should be held at the practice in staff files.

The practice had an induction system for new staff; this was individually tailored for the job role. We saw that there was an induction checklist in place. We reviewed the induction documentation for the newest member of staff and saw that the documentation was complete and detailed.

There were sufficient numbers of suitably qualified and skilled staff working at the practice. A system was in place to ensure that where absences occurred staff would cover for their colleagues.

Monitoring health & safety and responding to risks

The practice had a health and safety policy and environmental risk assessments in place. The risks to staff and patients had been identified and measures had been put in place to reduce those risks.

The practice had other policies and procedures to manage risks. These included infection control, a legionella risk assessment, and fire evacuation procedures. Processes were in place to monitor and reduce these risks so that staff and patients were safe. Staff told us that fire detection and fire fighting equipment such as fire alarms and emergency lighting were regularly tested, and records in respect of these checks were completed consistently.

Infection control

The practice was visibly clean, tidy and organised. An infection control policy was in place, which was scheduled for six monthly review. The last review of the policy having been completed in January 2015. The policy described how cleaning was to be undertaken at the premises including the surgeries and the general areas of the practice. The level and frequency of cleaning was detailed and checklists were available for staff to follow. The registered manager told us that the practice employed a cleaner but dental nurses had set cleaning responsibilities in each surgery. The practice had systems for testing and auditing the infection control procedures. The last infection control audit by the infection Prevention Society was dated 25 March 2015. The practice scored 95% on this audit, an action plan to address the 5% was produced on 13 May 2015. We saw that action had been taken to address the audit action plan.

We found that there were adequate supplies of liquid soaps and hand towels throughout the premises. Sharps bins were suitably located, signed and dated and not overfilled. A clinical waste contract was in place and waste matter was appropriately sorted, and stored securely in locked containers until collection.

We looked at the procedures in place for the decontamination of used dental instruments. The practice had a specific decontamination room that had been arranged according to the

Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05):

Decontamination in primary care dental practices.' Within the decontamination room there were clearly defined dirty and clean areas to reduce the risk of cross contamination and infection. Staff wore appropriate personal protective equipment during the process and these included heavy duty gloves, aprons and protective eye wear.

We found that instruments were being cleaned and sterilised in line with the published guidance (HTM01-05). During our inspection, a dental nurse demonstrated the decontamination process, and we saw the correct procedures were used. The practice cleaned their instruments manually and using an ultrasonic bath. An ultrasonic bath is a piece of equipment specifically designed to clean dental instruments through the use of ultrasound and water. Instruments were then rinsed and examined visually with an illuminated magnifying glass and sterilised in an autoclave (a device for sterilising dental and medical instruments).

The practice had two non-vacuum autoclaves designed to sterilise non wrapped or solid instruments. At the end of

the sterilising procedure the instruments were dried on racks, packaged, sealed, stored and dated with an expiry date. We looked at the sealed instruments in the surgeries and found that they all had an expiry date that met the recommendations from the Department of Health.

The equipment used for cleaning and sterilising was maintained and serviced in line with the manufacturer's instructions. Daily, weekly and monthly records were kept of decontamination cycles to ensure that equipment was functioning properly. This allowed the clinical staff (the dentists and dental nurses) to have confidence that equipment was sterile and there was no risk of cross contamination between patients. Records showed that the equipment was in good working order and being effectively maintained.

Staff were well presented and told us they wore clean uniforms daily. They also told us that they wore personal protective equipment when cleaning instruments and treating people who used the service. Staff files reflected that staff had received inoculations against Hepatitis B and received regular blood tests to check the effectiveness of that inoculation. People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections. The needle stick injury policy was displayed in the decontamination room. A member of staff was able to describe what action they would take if they had a needle stick injury and this reflected the practice policy.

Records showed a risk assessment process for Legionella was in place. This process ensured the risks of Legionella bacteria developing in water systems within the premises had been identified and preventive measures taken to minimise risk of patients and staff developing Legionnaires' disease. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings).

Equipment and medicines

We viewed records which reflected that equipment in use at the practice was regularly maintained and serviced in line with manufacturers guidelines. Portable appliance testing (PAT) took place on all electrical equipment. With the last PAT tests having been completed in May 2015, the records were sent to the Care Quality Commission (CQC) for review.October 2013. Fire extinguishers were checked and serviced regularly by an external company and staff had been trained in the use of equipment and evacuation procedures. Fire fighting equipment had last been checked and tested in February 2015.

Medicines in use at the practice were stored and disposed of in line with published guidance. There were sufficient stocks available for use. Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities. Records of checks carried out were recorded for audit purposes.

Emergency medicines were available, and located centrally, but securely for ease of use in an emergency.

Radiography (X-rays)

X-ray equipment was situated in individual surgeries and X-rays were carried out in line with local rules that were relevant to the practice and equipment. The local rules documents were displayed in each area where X-rays were carried out.

A radiation protection advisor and a radiation protection supervisor had been appointed to ensure that the equipment was operated safely and by qualified staff only. Those authorised to carry out X-ray procedures were clearly identified. This protected people who required X-rays to be taken as part of their treatment. The practice's radiation protection file contained documentation to demonstrate the X-ray equipment had been maintained at the recommended intervals. Records we viewed demonstrated that the X-ray equipment was regularly tested and serviced with repairs undertaken when necessary.

The practice monitored the quality of its X-ray images on a regular basis and maintained appropriate records. This ensured that they were of the required standard and reduced the risk of patients being subjected to further unnecessary X-rays. Patients were required to complete medical history forms and the dentist considered each patient's individual circumstances to ensure it was safe for them to receive X-rays. This included identifying where patients might be pregnant. Patient's notes showed that information related to X-rays was well recorded and was in line with guidance from the Faculty of General Dental Practice (UK) (FGDP-UK). This included grading of the x-ray, views taken, justification for taking the X-ray and the clinical findings.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice had policies and procedures in place for assessing and treating patients. The assessment happened at the start of each consultation. The assessment included taking a medical history from new patients and updating information for returning patients. This included health conditions, current medicines being taken and whether the patient had any allergies.

Dentists tried to use rubber dams when completing root canal treatments in line with guidelines from the British Endodontic Society. A rubber dam is a device that isolates selected teeth and safeguards the rest of the patient's mouth during treatment.

The dentists we spoke with told us that each patient's diagnosis was discussed with them and treatment options and costs were explained. Where relevant, preventative dental advice was given in order to improve the outcome for the patient. The patient notes were updated with the proposed treatment after discussing the options with the patient. Patients were monitored through follow-up appointments in line with National Institute for Health and Care Excellence (NICE) guidelines.

Dentists were aware of NICE guidelines, particularly in respect of recalls of patients and anti-biotic prescribing.

We reviewed 59 comment cards. Feedback we received was positive with patients expressing their satisfaction with their treatment received, the staff, and the quality of the dentistry carried out.

Health promotion & prevention

The waiting room and reception area at the practice contained a range of literature that explained the services offered at the practice in addition to information about effective dental hygiene and how to reduce the risk of poor dental health. This included information on how to maintain good oral hygiene both for children and adults and the impact of diet, tobacco and alcohol consumption on oral health. Patients were advised of the importance to have regular dental check-ups as part of maintaining good oral health.

Two members of staff had qualifications in health promotion. One staff member told us that in the past children from a local primary school had visited the practice for dental health promotion sessions. These sessions involved talking about foods that were good for the teeth, and foods that were bad. How to clean your teeth properly, and good oral hygiene. The staff member said the sessions had been very productive and rewarding for the staff as well as the children.

Staffing

The practice had two dentists who were directors of the practice and two further associate dentists. There were also two dental therapists and six dental nurses plus one dental nurse trainee. There was one reception co-ordinator and a team of receptionists and administrative staff to provide support to the dental team.

Dental staff had appropriate professional qualifications and were registered with their professional body. Staff were encouraged to maintain their continuing professional development (CPD) to maintain their skill levels. CPD is a compulsory requirement of registration with the General Dental Council (GDC). CPD contributes to the staff members' professional development. Staff files showed details of the number of hours staff members had undertaken and training certificates were also in place in the files.

Staff training was monitored and training updates and refresher courses were provided. The practice had identified some training that was required and this included basic life support and safeguarding. Records we viewed showed that staff were up to date with this training. Staff told us that they were supported in their learning and development and to maintain their professional registration.

The practice had procedures in place for appraising staff performance. The records showed that appraisals had taken place. Staff said they felt supported and involved in discussions about their personal development. They told us that the dentists were supportive and always available for advice and guidance.

The practice had an induction system for new staff. Records showed that there was an induction checklist with induction to infection prevention and control. We saw that new staff had completed a full induction.

Working with other services

Are services effective?

(for example, treatment is effective)

The practice had systems in place to refer patients to other practices or specialists if the treatment required was not provided by the practice. This included referral for specialist treatments such as conscious sedation or referral to the dental hospital if the problem required more specialist attention.

Consent to care and treatment

The practice had a policy for consent to care and treatment with staff. On reviewing this policy we saw that it made no reference to the Mental Capacity Act 2005 (MCA). However, following the inspection visit we were sent a revised consent policy which contained reference to the MCA and how this affected the issue of consent. We saw evidence that patients were presented with treatment options and consent forms which were signed by the patient. The dentists were aware of and understood the use of Gillick competency in young persons. Gillick competence is used to decide whether a child (16 years or younger) is able to consent to their own medical or dental treatment without the need for parental permission or knowledge.

Documents within the practice demonstrated staff were aware of the need to obtain consent from patients and this included information regarding those who lacked capacity to make decisions. Staff had attended MCA training. MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We observed that staff at the practice treated patients with dignity and respect and maintained their privacy. The reception area was a large open plan area however, reception staff said they were aware of the need for confidentiality in this public area. Staff confirmed that should a confidential matter arise, a private area was available for use either the back office or an unused surgery. Staff members told us that they never asked patients questions related to personal information at reception.

A data protection and confidentiality policy was in place of which staff were aware. This covered disclosure of, and the secure handling of patient information. We observed the interaction between staff and patients and found that confidentiality was being maintained. We saw that patient records, both paper and electronic were held securely either under lock and key or password protected on the computer. One staff member showed a particular grasp of the responsibilities to both clinicians and patients when discussing consent.

We viewed 59 Care Quality Commission comment cards that had been completed by patients, about the services provided. All 59 comment cards had positive comments about the staff and the services provided. Patients said that practice staff were caring and that they were treated with dignity, respect and warmth.

Involvement in decisions about care and treatment

We spoke with three patients on the day of the visit. All the comments were positive, and included comments about the cleanliness of the practice, and how caring and friendly the staff were. All three patients said that treatment was explained clearly including the cost. One patient particularly praised their dentist who had gone to considerable lengths to help and treat the patient.

Comment cards completed by patients included comments about how treatment was always explained in a way the patients could understand. Eight comment cards made specific reference to staff always explaining treatment options.

The practice information leaflet, information displayed in the waiting area and on the practice website clearly described the range of services offered to patients, the complaints procedure and information about patient confidentiality. The practice offered private treatment and the costs were clearly displayed and fee information was also available on the practice website.

Within the practice welcome pack there was an information sheet about children's care plans. This gave information about treatment options and costs.

Staff were aware of and understood the Public Health England document: 'Delivering better oral health: an evidence based toolkit for prevention'. Staff said they had used this document when delivering health promotion information and guidance.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Patients could access care and treatment in a timely way and the appointment system met the needs of patients. Where treatment was urgent patients would be seen within 48 hours or sooner if possible. The patient leaflet informed patients about the importance of cancelling appointments should they be unable to attend so as to reduce wasted time and resources.

Tackling inequity and promoting equality

The practice had a range of anti-discrimination policies and promoted equality and diversity. Staff were aware of these. They had also considered the needs of patients who may have difficulty accessing services due to mobility or physical issues. The practice had a level access providing step free access to assist patients with mobility issues, using wheelchairs or mobility scooters and parents with prams or pushchairs. The premises also had an assisted toilet. The practice was located close to the bus station in the town centre. This gave good access by all forms of public transport. Car parking was in the nearby bus station or roadside parking.

Staff members told us that longer appointment times were available for patients who required extra time or support, such as patients with learning disabilities, or who were particularly nervous or anxious. We saw an example of a patient who was anxious being given a longer appointment, so the dentist could take their time while reassuring the patient.

Access to the service

The arrangements for emergency dental treatment outside of normal working hours were through the Derby emergency rota. Weekends and Bank Holidays were covered by a rota organised amongst local practices. This information was displayed in the practice leaflet.

The practice normal opening hours were: Monday: 8:00 am to 5:30 pm; Tuesday, Thursday 9:00 am to 5:30 pm; Wednesday: 9:00 am to 8:00 pm and Friday 9:00 am to 5:00 pm. The practice was closes 1:00 pm to 2:00 pm each day for lunch although reception is usually kept open during lunch.

Concerns & complaints

The practice had a complaints procedure that explained to patients the process to follow, the timescales involved for investigation and the person responsible for handling the issue. It also included the details of other external organisations that a complainant could contact should they remain dissatisfied with the outcome of their complaint or feel that their concerns were not treated fairly. Details of how to raise complaints were included in the practice leaflet given to all new patients and accessible in the reception area and on the practice website. Staff we spoke with were aware of the procedure to follow if they received a complaint.

From information received prior to the inspection we saw that two complaints had been received since July 2014. The registered manager said that complaints were identified and analysed for any trends or concerns. We reviewed the complaints file and saw evidence of the analysis, and that complaints had been responded to in line with complaints policy.

The practice had also received many compliments, and these were displayed in the reception area.

Care Quality Commission comment cards reflected that patients were extremely satisfied with the services provided.

Are services well-led?

Our findings

Governance arrangements

The practice had arrangements in place for monitoring and improving the services provided for patients. For example minutes of staff meetings identified that issues of safety and quality were regularly discussed. Staff said that meetings were beneficial as learning could be shared and there was a consistent approach. There were robust governance arrangements in place. This was demonstrated by audits of patient's notes and regular review and updates of policies and procedures. Staff were aware of their roles and responsibilities within the practice.

There were systems in place for carrying out clinical and non-clinical audits within the practice. These included assessing the detail and quality of patient records, oral health assessments and X-ray quality. Health and safety related audits and risk assessments were in place to help ensure that patients received safe and appropriate treatments.

There was a full range of policies and procedures in use at the practice. These included health and safety, infection prevention and control, patient confidentiality and recruitment. Staff were aware of the policies and they were readily available for them to access. Staff were able to demonstrate many of the policies and this indicated they had read and understood them. The practice also used a dental patient computerised record system and all staff had been trained to use it. We reviewed a random sample of policies and procedures and found them to be in date and with review dates identified.

Leadership, openness and transparency

The dentists were friendly, welcoming and approachable. Staff said they were able to speak with the dentists and discuss any professional issues with them.

The culture of the practice encouraged candour, openness and honesty. Staff told us that they could speak with the principal dentists if they had any concerns. We were told that there was a no blame culture at the practice and that the delivery of high quality care was integral to the running of the practice. Responses to patients concerns or complaints had been recorded, and showed an open approach, with apologies for any distress given.

Staff told us that there were clear lines of responsibility and accountability within the practice and that they were encouraged to report any safety concerns.

We were told staff felt well cared for, respected and involved with monthly staff meetings.

Management lead through learning and improvement

In it's statement of purpose White Peak Dental Practice stated it's first aim was: "To promote good oral health to all patients attending our practice for care and advice." We found staff were aware of the practice values and ethos and demonstrated that they worked towards these. Several staff members said that the patient came first, and was at the heart of the practices' focus and activity.

We saw that dentists reviewed their practice and introduced changes to practice through their learning and peer review. This was demonstrated following analysis of one complaint received. This had raised awareness, and the dentists' approach had changed as a result.

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

Staff said that patients could give feedback at any time they visited. The practice had carried out a patient satisfaction survey during June 2015. The practice received 41 responses, which had been analysed and results shared with the staff team.

The practice had systems in place to review the feedback from patients who had complained. A system was in place to assess and analyse complaints and then learn from them if relevant, acting on feedback when appropriate.

The practice held regular staff meetings and staff appraisals had been undertaken. Staff told us that information was shared and that their views and comments were sought informally and generally listened to and their ideas adopted. Staff told us that they felt part of a team and well supported.