Mr. David Tehrani Yeganeh

Christchurch Orthodontics

Inspection Report

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Date of inspection visit: 17/11/2016
Date of publication: 18/01/2017

Overall summary

We carried out an announced comprehensive inspection on 17 November 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

Christchurch orthodontics is a dental practice providing NHS and private orthodontic treatment for both adults and children. The practice is based in a former domestic dwelling in Christchurch, a town situated in Dorset.

The practice has four dental treatment rooms; one of which is based on the ground floor and a separate decontamination room used for cleaning, sterilising and packing dental instruments. The ground floor is accessible to wheelchair users, prams and patients with limited mobility.

The practice employs four orthodontic practitioners, one orthodontic therapist, five dental nurses, one decontamination room assistant, two reception staff and a practice manager.

The practice's opening hours are between 8.30am and 6pm Monday to Wednesday, 8.30am and 5pm Thursday and 8.30am and 4pm Friday.

There are arrangements in place to ensure patients receive urgent medical assistance when the practice is closed. This is provided by an out-of-hours service.

The provider, Mr David Tehrani Yeganeh, shares the practice facilities with another dentist who is separately registered with CQC. Facilities are shared and patients can register with either of the dentists. The dental nurses and support staff are employed jointly by both dentists.

Summary of findings

Mr David Tehrani Yeganeh is registered as an individual and is legally responsible for making sure that the practice meets the requirements relating to safety and quality of care, as specified in the regulations associated with the Health and Social Care Act 2008.

We obtained the views of 15 patients on the day of our inspection.

Our key findings were:

- We found that the practice ethos was to provide high quality patient centred orthodontic care in a relaxed and friendly environment.
- Effective leadership was provided by senior clinicians and an empowered practice manager.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice appeared clean and well maintained.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- Infection control procedures were robust and the practice followed published guidance.
- The practice had a safeguarding lead with effective processes in place for safeguarding adults and children living in vulnerable circumstances.
- There was a process in place for the reporting and shared learning when untoward incidents occurred in the practice.
- The orthodontist provided orthodontic care in accordance with current professional and National Institute for Care Excellence (NICE) guidelines.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Patients could access treatment and urgent and emergency care when required.
- Staff received training appropriate to their roles and were supported in their continued professional development (CPD) by the company.
- Staff we spoke with felt well supported by the senior clinicians and practice manager and were committed to providing a quality service to their patients.
- Information from 42 completed Care Quality Commission (CQC) comment cards gave us a positive picture of a friendly, caring, professional and high quality service.

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

- Review the practice fire safety risk assessment and the requirements of the Regulatory Reform (Fire Safety) Order 2005. Ensure all practice fire safety checks are carried out in accordance with legal requirements
- Review its responsibilities to the needs of disabled people and the requirements of the Equality Act 2010 and the Disability Discrimination Act audit undertaken for the premises. Specifically, the provision of a foot operated bin in the disabled toilet and the availability of hearing loops for patients who are hard of hearing.
- Consider the addition of General Dental Council (GDC) registration numbers of dentists working at the practice on the external name plate in accordance with GDC guidance issued in March 2012.
- Review all dentists and clinician personnel recruitment files and ensure that documentation is obtained and retained in relation to Schedule 3, Health and Social Care Act 2008.
- Review the recommendations of the January 2016 gas safety check provided in accordance with the Specifically the installation of a carbon monoxide detector.

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 robust arrangements for essential areas such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found that all the equipment used in the dental practice was well maintained.

The practice took its responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents.

Staff received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

No action ✓

Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the British Orthodontic Society and National Institute for Health and Care Excellence (NICE) to guide their practice.

We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals. The staff received professional training and development appropriate to their roles and learning needs.

No action ✓

Are services caring?

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

We obtained the views of 15 patients on 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 orthodontic care was very good. Patients commented on friendliness and helpfulness of the staff and orthodontic practitioners were good at explaining the treatment that was proposed.

No action ✓

Are services responsive to people's needs?

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 into account in how the practice was run.

Patients could access treatment and urgent and emergency care when required. The practice provided patients with access to telephone interpreter services when required.

The practice had one ground floor treatment room and level access into the building for patients with mobility difficulties and families with prams and pushchairs.

No action ✓

Summary of findings

Are services well-led?

No action

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

Effective leadership was provided by senior clinicians and an empowered practice manager. The clinicians and practice manager 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.

We saw evidence of systems to identify staff learning needs which were underpinned by an appraisal system and a programme of clinical audit. Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council.

Staff told us that they felt well supported and could raise any concerns with the senior clinicians and practice manager. All the staff we met said that they were happy in their work and the practice was a good place to work.

Christchurch Orthodontics

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 17 November 2016. Our inspection was carried out by a lead inspector, a second inspector and a dental specialist adviser.

During our inspection visit, we reviewed policy documents and staff training and recruitment records. We obtained the views of 11 members of staff.

We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the systems that supported the patient dental care records. We obtained the views of 15 patients on the day of our inspection.

Patients gave positive feedback about their experience 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

A practice manager we spoke with demonstrated a good awareness of RIDDOR 2013 (reporting of injuries, diseases and dangerous occurrences regulations). 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.

Records showed that no such accidents occurred during 2015-16. The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA). Where relevant, these alerts were shared with all members of staff by the practice manager.

Reliable safety systems and processes (including safeguarding)

We spoke to a dental nurse about the prevention of needle stick and orthodontic sharps 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. Although used rarely, the practice used a system whereby needles were not manually re-sheathed using the hands following administration of a local anaesthetic to a patient. The practice used the 'scoop method' to prevent needle stick injuries from occurring. 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.

The practice had a safeguarding lead who was the 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 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.

The practice carried out checks in relation to fire safety and had a current fire risk assessment. Whilst the practice did weekly testing of fire call points, the location of the fire call point tested was not recorded and should be. In addition, although the emergency lighting was tested twice a year by a Fire Protection company, a monthly test should be undertaken by the Practice. We spoke with the Practice Manager who assured us this shortfall would be rectified as soon as practicably possible.

Medical emergencies

The practice had arrangements in place 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 in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had access to medical 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

All of the orthodontic practitioners, orthodontic therapist and 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.

We looked at four staff recruitment files and records confirmed three had been recruited in accordance with the practice's recruitment policy. The records for dentists and clinicians recruitment files did not match the content of

other practice staff files which were recruited in line with practice policy. We spoke with the practice owner who assured us this shortfall would be addressed as soon as practicably possible.

Staff recruitment records were stored securely 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 in place 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 in place a well maintained 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.

The practice had a gas safety check carried out in January 2016. Included in that report was a recommendation to install a carbon monoxide detector. We were told by the practice manager this was planned but on the day of our inspection it had not yet been completed.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The practice had in place 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 and control in dental practices) Essential Quality Requirements for infection control was being exceeded. It was observed that audit of infection control processes carried out in November 2015 and July 2016 confirmed compliance with HTM 01 05 guidelines.

We found the practice had produced an annual statement in relation to infection prevention control required under The Health and Social Care Act 2008: Code of Practice about the prevention and control of infections and related guidance.

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

The drawers of one treatment room 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 and visors.

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 August 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 cleaning, sterilisation and the packaging of processed instruments. 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 an automated washer disinfector 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 autoclaves 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 complete and up to date. All recommended tests utilised as part of the validation of the automated washer disinfector were carried out in accordance with current guidelines, the results of which were recorded in an appropriate log file.

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 in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. This was stored in a separate secure location adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection.

We saw that general environmental cleaning was carried out according to a cleaning plan developed by the practice. Cleaning materials and equipment were stored in accordance with current national guidelines.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclaves had been serviced and calibrated in November 2016 and other equipment used in the decontamination processes had been serviced in March 2016. The practice's X-ray machine had been serviced and calibrated as specified under current national regulations in November 2015 and were due to be tested again in 2018.

Portable appliance testing (PAT) had been carried out in October 2015.

Although local anaesthesia was used very rarely these medicines were stored securely for the protection of patients. We found that the practice stored prescription pads in a safe overnight to prevent loss due to theft.

We observed that the practice had equipment to deal with minor first aid problems such as minor eye problems and 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 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 three yearly maintenance logs and a copy of the local rules. The local rules must contain the name of the appointed Radiation Protection Advisor, the identification and description of each controlled area and a summary of the arrangements for restriction access. Additionally, they must summarise the working instructions, any contingency arrangements and the dose investigation level.

We were shown that a radiological audit for each dentist had been carried out on an ongoing basis during 2016. 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 the practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. We saw training records that showed staff where appropriate had received training for core radiological knowledge under IRMER 2000 Regulations.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The orthodontist we spoke with carried out consultations, assessments and treatment in line with recognised general professional guidelines and the guidance provided by the British Orthodontic Society. The orthodontist described to us how they carried out their assessment of patients for a course of orthodontic treatment. 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 of the patient's jaw and tooth relationships and the factors that affected these relationships. Following the clinical assessment, the diagnosis was then discussed with the patient, their parents, guardians or carers and treatment options explained in detail.

Where relevant, preventative dental information was given to improve the outcome of orthodontic treatment for the patient. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products specifically designed for orthodontic patients. 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 if private orthodontic treatment had been proposed. Patients were monitored through follow-up appointments and these typically lasted between 18 months to two years for a course of orthodontic treatment.

The practice used an orthodontic therapist to improve the outcomes for patients (Orthodontic therapists are registered dental professionals who carry out certain parts of orthodontic treatment under prescription from a dentist). They worked within their scope of practice to prescriptions provided by the orthodontist. We saw several examples of detailed treatment plans provided by the orthodontist which the therapist followed to complete each patient's treatment plan. Dental care records that were shown to us by the orthodontist demonstrated that the findings of the assessment and details of the treatment carried out were recorded appropriately. The records were comprehensive, detailed and well maintained.

To monitor the quality of the orthodontic treatment provided the practice used a system known as peer assessment rating or PAR scoring. The PAR index is a fast, simple and robust way of assessing the standard of orthodontic treatment that an individual provider is achieving. The orthodontist explained that the practice was achieving a high level of improved outcomes for patients.

Health promotion & prevention

The practice was very focussed on the prevention of dental disease and the maintenance of good oral health during the patients' course of orthodontic treatment. To facilitate this aim the practice used several strategies. For example, following the first treatment session the orthodontic practitioners, including the orthodontic therapist would provide intensive oral hygiene instruction and details on how to look after the orthodontic braces to prevent problems during orthodontic treatment. Patients would then be given details of dental hygiene products suitable for maintaining their orthodontic braces. Other preventative interventions included the prescription of high concentration fluoride tooth paste to help prevent dental decay during the duration of treatment. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. Underpinning these guidelines was a range of leaflets explaining how patients could maintain good oral health during their orthodontic treatment.

Staffing

We observed a friendly atmosphere at the practice. All clinical staff had current registration with their professional body, the General Dental Council.

All of the patients we asked told us they felt there was enough staff working at the practice. Staff told us there were enough staff. Staff we spoke with told us they felt supported by the dentist and practice manager. They told us they felt they had acquired the necessary skills to carry out their role and were encouraged to progress.

The practice employed four orthodontic practitioners, three of whom were on the General Dental Council specialist list for orthodontics, one orthodontic therapist, five dental nurses, one decontamination room assistant, two reception staff and a practice manager.

There was effective use of skill mix in the practice. The practice encouraged the development of the extended duty

Are services effective?

(for example, treatment is effective)

dental nurse role (EDDN). For example, we found that dental nurses had received additional training in the taking of dental X-rays, specialist orthodontic nursing, impression taking, dental photography and oral health education.

There was a structured induction programme in place for new members of staff. We were told the orthodontic therapist always worked with chairside support.

Working with other services

The practice was a specialist referral practice for orthodontics for practices across the Hampshire and Dorset area. Referring practices were required to complete a bespoke referral form for patients to access services. One orthodontist we spoke with explained how they would work with other services if patients required other specialist input such as that from consultant restorative and maxillo-facial services as part of the patient's orthodontic treatment.

Consent to care and treatment

We spoke with the orthodontist about how they implemented the principles of informed consent; they had a very clear understanding of consent issues. They explained how individual treatment options, risks, benefits and costs where appropriate were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they understood their treatment options. This included the extensive use of dental photography which was used as part of the initial patient assessment and throughout the course of the orthodontic treatment to provide a record of the progression of the treatment through to the final treatment outcome.

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. The orthodontists 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 went on to say 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.

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.

Conversations between patients and orthodontic practitioners could not be heard from outside the treatment rooms which protected patients' privacy. Patients' clinical records were stored securely. Computers which contained patient confidential information were password protected and regularly backed up to secure storage; with paper records stored in an area of the practice not accessible to unauthorised people.

Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff were aware of the importance of providing patients with privacy and maintaining confidentiality.

We obtained the views of 42 patients prior to the day of our visit and 15 patients on the day of our visit. These provided a completely positive view of the service the practice provided. All of the patients commented that the dentists were good at treating them with care and concern. 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 helpful and efficient. During the inspection, we observed staff in the reception area, they were polite and helpful towards patients and the general atmosphere was welcoming and friendly.

Involvement in decisions about care and treatment

Although the vast majority of orthodontic treatment provided to young people under the age of 18 is free of charge under NHS regulations, the practice provided details of the costs of private orthodontic treatment. These details were available in the waiting room and on the practice website. The orthodontist we spoke with paid particular attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the orthodontist recorded the information they had provided to patients about their treatment and the options open to them. This included information recorded on the standard orthodontic NHS treatment planning forms 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 examples of information available to patients. 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 and how to make a complaint. The patient information leaflet explained opening hours, emergency 'out of hours' contact details and arrangements and how to make a complaint. The practice website also contained useful information to patients such as details about different types of orthodontic treatments 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 orthodontist decided how long a patient's appointment needed to be and considered any special circumstances such as whether a patient was very nervous, had a disability and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to help prevent inequity for patients that experienced limited mobility or other barriers that may hamper them from accessing services. Adjustments were the introduction of ramp access, an automatic main door and a ground floor treatment room.

The practice used a translation service, which they arranged if it was clear that a patient had difficulty in understanding information about their treatment. It was noted that the practice had access to seven different languages through staff skills and abilities.

To improve access for patients who found steps a barrier, the practice had level access and one treatment room was on the ground floor. A wheelchair accessible toilet was available. The practice provided a 'foot operated' bin in the wheelchair accessible toilet, which may have been difficult for some patients to use.

The practice did not have access to a 'hearing loop' which would assist patients who were hearing aid users.

Access to the service

The practice's opening hours were between 8.30 and 6pm Monday to Wednesday, 8.30am and 5pm Thursday and 8.30am and 4pm Friday.

We asked 15 patients if they were satisfied with the hours the surgery was open; all but one patient said yes. This patient said they did not know when the surgery was open.

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 booklet kept in the waiting area, NHS Choices website and on the telephone answering machine when the practice was closed.

Concerns & complaints

There was a complaints policy which provided staff with information about handling formal complaints from patients. Staff told us the practice team viewed complaints as a learning opportunity and discussed those received in order to improve the quality of service provided,

Information for patients about how to make a complaint was available in the practice's waiting room. This included contact details of other agencies to contact if a patient was not satisfied with the outcome of the practice investigation into their complaint. We asked 15 patients if they knew how to make a complaint if they had an issue.

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.

For example, a complaint would be acknowledged within three working days and a full response would be given as soon as reasonably possible. We saw a complaints log which listed one complaint received over the previous year which records confirmed had been concluded satisfactorily.

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 this location consisted of the practice owners 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 the staff we spoke with were aware of the policies and how to access them. We noted management policies and procedures were kept under review by the orthodontic therapist, the lead for policy development, on a regular basis.

Leadership, openness and transparency

Effective leadership was provided by the provider and an empowered practice manager. The practice ethos focussed on providing high quality patient centred orthodontic 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 practice owner. There was a no blame culture within the practice. They felt they were listened to and responded to when they did raise a concern. 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 were happy with the practice facilities. Staff reported that the practice manager was proactive and aimed to resolve 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.

The practice placed signs and literature in the public domain which referred to individuals registered with the General Dental Council (GDC). The signs and public documents did not list all registered staff details or their GDC registration numbers.

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 all staff received an annual appraisal. There was a system of peer review in place to facilitate the learning and development needs of the dentists and dental nurses which took place on an annual basis.

We found there was a comprehensive rolling programme of clinical audit taking place at the practice. These included infection control, clinical record keeping and X-ray quality, an audit of referrals and orthodontic treatment planning. 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 practice owner 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.

The practice ensured that all staff underwent regular mandatory training in cardio pulmonary resuscitation (CPR), infection control, child protection and adult safeguarding and dental radiography (X-rays).

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

The practice gathered feedback from patients through surveys, compliments and complaints. We saw that there was a robust complaints procedure in place, with details available for patients in the waiting area.

The practice was listed on NHS Choices website and information was up to date and patient feedback was responded to. This was evidenced by the introduction of a water cooler and magazines as a result of patient feedback.

Results of the most recent practice survey carried indicated that 100% of patients, who responded, would recommend the practice to a family member or friend.

Staff told us that the dentists were very approachable and they felt they could give their views about how things were done at the practice. Staff told us that they had frequent meetings and described the meetings as good with the

Are services well-led?

opportunity to discuss successes, changes and improvements. For example, changes included provision of a whiteboard in the staff area to improve internal communications.