ARP Dental Care Ltd

Habashi Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 11 June 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.

Habashi Dental Practice is located in the London Borough of Greenwich. The premises consist of four treatment rooms, a dedicated decontamination room and an X-ray room. There are also toilet facilities, a waiting room, a reception area, an administrative office and a stock room.

The practice provides NHS and private dental services and treats both adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers, crowns and bridges, tooth whitening and oral hygiene.

The staff structure of the practice is comprised of a principal dentist (who is also the owner), four further dentists, a head nurse, a senior nurse, four other qualified dental nurses, two trainee dental nurses and two receptionists.

The practice is open Monday to Friday from 9.00am to 1.00pm and from 2.00pm to 5.00pm.

The principal dentist 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 carried out an announced, comprehensive inspection on 11 June 2015. The inspection took place over one day and was carried out by a CQC inspector and dentist specialist advisor.

We received 50 CQC comment cards completed by patients and spoke with two patients in the waiting area. Patients we spoke with, and those who completed comment cards, were positive about the care they received from the practice. They were complimentary about the friendly and helpful attitude of the staff.

Our key findings were:

- Patients' needs were assessed and care was planned in line with best practice guidance, such as from the National Institute for Health and Care Excellence (NICE).
- There were effective systems in place to reduce and minimise the risk and spread of infection.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, oxygen cylinder and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and patient practice team.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- The principal dentist had a clear vision for the practice and staff told us they were well supported by the management team.
- There were governance arrangements in place and the practice effectively used audits to monitor and improve the quality of care provided.

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

- Ensure that at least two references are sought for all new members of staff (clinical and non-clinical) during any recruitment process.

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 systems in place to minimise the risks associated with providing dental services. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse. There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. The practice had policies and protocols, which staff were following, for the management of infection control, medical emergencies and dental radiography. We found the equipment used in the practice was well maintained and checked for effectiveness.

Are services effective?

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

The practice provided evidence-based care in accordance with relevant, published guidance, for example, from the General Dental Council (GDC). The practice monitored patients' oral health and gave appropriate health promotion advice. Staff explained treatment options to ensure that patients could make informed decisions about any treatment. The practice worked well with other providers and followed up on the outcomes of referrals made to other providers. Staff engaged in continuous professional development (CPD) and were meeting the training requirements of the GDC.

Are services caring?

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

We received positive feedback from patients through comment cards and discussions on the day of the inspection. They felt that the staff were patient and caring; they told us that they were treated with dignity and respect at all times. We found that patient records were stored securely and patient confidentiality was well maintained.

Are services responsive to people's needs?

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

Patients had good access to appointments, including emergency appointments, which were available on the same day. The practice had access to telephone interpreting services to support people who did not have English as their first language. The needs of people with disabilities had been considered and there was level access to the waiting area and treatment rooms. Patients were invited to provide feedback via a satisfaction survey and a suggestions box situated in the waiting area.

There was a clear policy in place which was used to handle complaints as they arose. Only two complaints had been received by the practice in the past year. We saw that these had been dealt with promptly and that the complaints handling procedure had been disseminated to staff during a meeting.

Are services well-led?

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

The practice had robust clinical governance and risk management structures in place. These were well maintained and disseminated effectively to all members of staff. A system of audits was used to monitor and improve performance.

Summary of findings

A new provider had taken over the running of the practice in 2014. They had been effectively supported by the previous owner during a transition period to ensure the smooth and safe running of the practice.

Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the principal dentist. They were confident in the abilities of the management team to address any issues as they arose.

Habashi Dental Practice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an announced, comprehensive inspection on 11 June 2015. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a dentist specialist advisor.

We reviewed information received from the provider prior to the inspection. We also informed the NHS England area team and the local Healthwatch that we were inspecting the practice; however we did not receive any information of concern from them.

During our inspection visit, we reviewed policy documents and dental care records. We spoke with seven members of staff, including the management team. 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.

We reviewed 50 Care Quality Commission (CQC) comment cards completed by patients and spoke with two patients in the waiting area. Patients we spoke with and those who completed comment cards were positive about the care they received from the practice. They were complimentary about the 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 an effective system in place for reporting and learning from incidents. There had not been any significant events related to patients in the past year. However, there was a written policy which described what types of events might need to be recorded and investigated. The principal dentist was the lead safety officer responsible for investigating incidents. We discussed the investigation of incidents with the principal dentist who confirmed that if patients were affected by something that went wrong, they were given an apology and informed of any actions taken as a result.

Staff understood the process for accident and incident reporting including the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any such incidents in the past 12 months.

Reliable safety systems and processes (including safeguarding)

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, a risk management process had been undertaken for the safe use of sharps (needles and sharp instruments) to minimise the risk of inoculation injuries to staff. The principal dentist and senior dental nurse described the protocol in place for managing sharps. They explained that the treatment of sharps and sharps waste was in accordance with the current European Union (EU) Directive with respect to safe sharp guidelines. The practice used a system whereby needles were not resheathed using the hands following administration of a local anaesthetic to a patient. A special device was used to resheath the needle following administration. It was also practice policy that the discarding of the used needle was the dentist's responsibility. The senior dental nurse also explained the protocol to follow should a needle stick injury occur. There had been no contaminated sharps injuries since the introduction of the safe sharp system in 2013.

The practice followed national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments in line with guidance from the British Endodontic Society. (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).

The practice had policies and procedures in place for child protection and safeguarding adults. This included contact details for the local authority safeguarding team, social services and other agencies, such as the Care Quality Commission. This information was displayed in the administrative area behind the reception desk so that staff could access the information promptly. These details were also kept with the safeguarding policy. We also observed that staff meeting minutes from June 2015 demonstrated that the safeguarding policy had been discussed.

We discussed safeguarding issues with two of the dentists on duty. They were able to describe in detail the types of behaviour a child would display that would alert them if there were possible signs of abuse or neglect. This showed that the safeguarding policy had been effectively disseminated amongst staff.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. All staff had received training in emergency resuscitation and basic life support. This training was renewed annually. The staff we spoke with were aware of the practice protocols for responding to an emergency.

The practice had suitable emergency equipment in accordance with guidance issued by the Resuscitation Council UK. This included relevant emergency medicines, 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 face masks of different sizes for adults and children. The equipment was regularly tested by staff and a record of the tests was kept.

Staff recruitment

The practice staffing consisted of a principal dentist (who was also the owner), four further dentists, a head nurse, a senior nurse, four other qualified dental nurses, two trainee dental nurses and two receptionists. The majority of staff had worked at the practice for a number of years and we

saw that appropriate checks were carried out when they had started employment at the practice. The practice had carried out checks with the Disclosure and Barring Service (DBS) for all members of staff.

We reviewed recruitment files for two, newer members of staff and for two longer-standing members of staff. We saw that files contained records of relevant checks to ensure that the person being recruited was suitable and competent for the role. This included the use of an application form, interview notes, review of employment history, evidence of relevant qualifications, the checking of references, a check of registration with the General Dental Council and checks with the DBS.

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety policy in place. The practice had been assessed for risk of fire and there were documents showing that fire equipment were regularly serviced.

There were effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors that were associated with hazardous substances had been identified and actions were described to minimise these risks. We saw that COSHH products were securely stored. Staff training files indicated that staff had received relevant training in managing COSHH products.

The practice responded promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. Copies of MHRA alerts were kept in a file and appropriate actions were taken by the practice following an alert. For example, the practice had responded to the advice on Ebola in August 2014 by displaying information posters in the waiting area and holding discussions with staff about Ebola risk.

There was a business continuity plan with key elements displayed on a noticeboard in an administrative area behind the reception desk. This included information about what to do should any of the key utilities (such as electricity and water supply) were interrupted and contact information for relevant suppliers who could be called to fix any problems.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The provider had delegated the responsibility for infection control procedures to the practice's head dental nurse. We observed the cleaning process and reviewed the practice protocols in relation to infection control. This demonstrated that 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). We observed a recent audit of infection control processes had been carried out by the NHS England Area Infection Control Team which confirmed the practice was compliant with this Memorandum. The practice was also carrying out regular, internal infection control audits on a six-monthly basis.

On the day of our visit the lead nurse for infection control was on leave, however a senior dental nurse described to us the end-to-end process of infection control procedures at the practice. The dental nurse explained the decontamination of the general treatment room environment. She demonstrated to us how the working surfaces, dental unit (including water lines) and dental chair were decontaminated. The drawers in the treatment room were well stocked, clean and well ordered. All of the instruments were pouched and it was obvious which items were single use.

Each treatment room had the appropriate routine personal protective equipment such as aprons, gloves and masks, available for staff and patient use. Dedicated hand washing facilities were available in all rooms with wall mounted dispensers for soap and alcohol rubs.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). The method described was in line with current HTM 01-05 guidelines. A Legionella risk assessment had also been carried out by an appropriate contractor in July 2013. We could see that actions had been implemented following this report, for example, an additional tap had been installed to flush a 'dead leg' pipe. This ensured that risks in relation to Legionella had been minimised.

The practice used a separate decontamination room for instrument processing. This room was well organised, clean, tidy and clutter free. Protocols were displayed on the

wall to remind staff of the processes to be followed at each stage of the decontamination process. Dedicated hand washing facilities were available in this room. The dental nurse demonstrated to us the decontamination 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 machine as part of the initial cleaning process; following inspection, items were placed in an autoclave (a machine used to sterilise instruments). When instruments had been sterilized, they were pouched and stored appropriately until required. All pouches were dated with an expiry date in accordance with current guidelines. The nurse also demonstrated to us that systems were in place to ensure that the washer disinfector and autoclave were working effectively. These included protein residue tests and the automatic control test. We observed the data sheets used to record the essential daily validation checks of the sterilisation cycles; these were always completed.

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

We noted that all the four dental treatment rooms, waiting area, reception and toilets were clean, tidy and clutter free. Hand washing facilities were available including liquid soap and paper towels in each of the treatment rooms and toilets, hand washing protocols were also displayed appropriately in various areas of the practice.

All of the 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. Newer members of staff also had a wider check of their immunisation history including rubella, tetanus, polio and tuberculosis. We discussed the possibility of carrying out these checks for longer-standing members of staff with the principal dentist.

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) was completed in accordance with good practice guidance. PAT is the name of a process during which electrical appliances are routinely checked for safety.

Prescription pads were kept to the minimum necessary for the effective running of the practice. They were individually numbered and stored securely in the administrative office.

Radiography (X-rays)

There was 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. It also held the necessary documentation pertaining to the maintenance of the X-ray equipment. The Local Rules, X-ray set inventory, notification to the Health and Safety Executive, and a series of practice audits in relation to the quality of processed X-ray films were contained in the file.

A separate X-ray equipment file was maintained for the five X-ray sets used in the practice. This file was in good order and complete. Included in the file were the critical examination packs for each X-ray set along with the maintenance logs and a copy of the local rules. The maintenance logs were within the current recommended interval of three years.

The copy of the most recent radiological audit demonstrated that a high percentage of radiographs were of grade one standard. A sample of dental care records where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured every time. These findings showed that practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. The principal dentist and other dentists we spoke to described how they carried out patient assessments using a typical patient journey scenario. The assessment begins with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained in detail.

The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

We reviewed a sample of dental care records. This showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. Details of the treatment were included local anaesthetic details such as the type, site of administration, batch number and expiry date. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth were recorded. (The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums). These were carried out at each dental health assessment and different BPE scores triggered further clinical action.

Health promotion & prevention

The waiting room and reception area at the practice contained literature in leaflet form that explained the services offered at the practice. This included information about effective dental hygiene and how to reduce the risk of poor dental health. The practice had a range of products that patients could purchase that were suitable for both adults and children.

Our discussions with the dentists and nurses, together with our review of the dental care records showed that, where relevant, preventative dental information was given in order to improve the outcome for the patient. This included smoking cessation advice, alcohol consumption guidance and dietary advice. The dentist also carried out a check to look for the signs of oral cancer. Adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. Tooth brushing techniques were explained to them in a way they understood.

Staffing

Staff told us they received appropriate professional development and training. We reviewed staff files and saw that this was the case. The training covered all of the mandatory requirements for registration issued by the GDC. This included responding to emergencies and infection control.

There was an induction programme for new staff to follow to ensure that they understood the protocols and systems in place at the practice. The induction systems were comprehensive and effective. For example, to ensure that new dentists were able to seamlessly integrate into the practice, they were provided with a practice manual. This manual contained 30 sections which covered essential criteria which, when followed, would prevent difficulties from occurring. It included sections on the essential features of the NHS contract that the dentist needed to be aware of, as well as referral criteria for secondary and tertiary care providers.

Staff told us they had been engaged in yearly appraisals which reviewed their performance and identified their training and development needs. We reviewed some of the notes kept from these meetings. We saw examples where the nurses had requested to either learn how to perform particular tasks or take charge of certain procedures. For example, one member of staff had expressed interest in learning how to carry out audits and the notes showed that this had been implemented as the member of staff had started to carry out environmental cleaning audits.

Working with other services

Are services effective?

(for example, treatment is effective)

The principal dentist explained how they worked with other services. Patients who required any specialised treatment were referred to other dental specialists as, necessary. Dentists were able to refer patients to a range of specialists in secondary and tertiary care services if the treatment required was not provided by the practice. When a new dentist started working at the practice they had access to an associates' practice manual. This manual contained a complete list of the secondary and tertiary care providers available locally for referrals. The manual also contained the details of the referral criteria for each provider service.

Referral letters were prepared and sent to the hospital with full details of the dentist's findings. These were stored on the practices' computer dental software system. When the patient had received their treatment they were discharged back to the practice for further follow-up and monitoring. A copy of the referral letter was always available to the patient if they wanted this for their records.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. Staff discussed treatment options, including risks and benefits, as well as costs, with each patient. Notes of these discussions were recorded in the clinical records. Formal written consent was obtained using standard treatment plan forms. Patients were asked to read and sign these before starting a course of treatment.

We saw evidence that the requirements of the Mental Capacity Act 2005 (MCA) had been discussed at staff meetings. Staff training files showed that some staff had completed training courses in this topic. The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

All the dentists we spoke with explained how they would take consent from a patient who was affected by any impairment which might mean that they might were unable to fully understand the implications of their treatment. The dentists explained that if there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed. They explained that they would involve relatives and carers in the decision-making process, and determine what was in the patient's best interests in relation to their dental care. This followed the guidelines of the Mental Capacity Act 2005.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The comments cards we received and the patients we spoke with all commented positively on staff's caring and helpful attitude. Patients indicated that they felt comfortable and relaxed with their dentists and that they were made to feel at ease during consultations and treatments. We observed staff were welcoming and helpful when patients arrived for their appointment.

The practice obtained regular feedback from patients via a satisfaction survey. This was carried out at ad hoc intervals with the last three having been done in April 2015, May 2015 and October 2014. We noted that the overwhelming majority of feedback about staff was positive and corroborated our own findings regarding staff's caring attitude.

Doors were always closed when patients were in the treatment rooms. Patients indicated they were treated with dignity and respect at all times.

There were systems in place to ensure that patient's confidential information was protected. Patient records were stored electronically and in a paper format. Electronic records were password protected and regularly backed up. Paper records were stored securely behind the reception desk and could only be accessed via a key-coded door. Staff understood the importance of data protection and confidentiality and had received training in information governance. Reception staff told us that people could request to have confidential discussions in an empty treatment room, if necessary.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area which gave details of NHS and private dental charges or fees. There was a range of information leaflets in the waiting area which described the different types of dental treatments available. Patients were routinely given copies of their treatment plans which included useful information about the proposed treatments and associated costs. We reviewed dental care records and saw examples where notes had been kept of discussions with patients around treatment options, as well as the risks and benefits of the proposed treatments.

We spoke with two dentists and two nurses who were on duty on the day of our visit. They stressed the importance of communication skills when explaining care and treatment to patients. They indicated that patients were given time to think about the treatment options presented to them. The dental staff were clear that a patient could withdraw consent at any time and that they all patients received a detailed explanation of the type of treatment required, including the risks, benefits and options.

The patient feedback we received via discussions and comments cards, together with the data gathered by the practice's own survey, confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. Each dentist could decide on the length of time needed for their patient's consultation and treatment. They could schedule additional time for patients depending on physical need as well as based on psychological need. For example, dentists knew which patients might be nervous or anxious and would need some additional care.

Staff told us they had enough time to treat patients and that patients could generally book an appointment in good time to see the dentist of their choice. The feedback we received from patients confirmed that they could get an appointment within a reasonable time frame and that they had adequate time scheduled with the dentist to assess their needs and receive treatment. Patients noted that they could see the dentist they preferred, but could also move between dentists if they asked to do so.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. Reception staff showed us they had access to a translation service and had printed information about the practice in a range of languages. The principal dentist told us they provided written information for people who were hard of hearing and used large print documents for patients with some visual impairment.

The practice had been purpose built and therefore had adequate wheelchair access. There was a wheelchair ramp at the front of the building and a disabled toilet. All of the treatment rooms were on the ground floor and were accessible via wheelchair. The corridors were wide enough to allow for easy wheelchair access.

Access to the service

The practice was open from Monday to Friday from 9.00am to 1.00pm and from 2.00pm to 5.00pm. The practice displayed its opening hours on their premises and on the practice website. New patients were also given a practice information sheet which included the practice contact details and opening hours.

We asked the principal dentist about access to the service in an emergency or outside of normal opening hours. They told us the answer phone message gave details on how to access out of hours emergency treatment.

The principal dentist told us that all of the dentists had some gaps in their schedule on any given day which meant that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, could be accommodated. We reviewed the electronic appointments system and saw that this was the case.

Concerns & complaints

There was a complaints policy describing how the practice handled formal and informal complaints from patients. There had been two complaints recorded in the past year. These complaints had been responded to in line with the practice policy. The principal dentist had carried out investigations and discussed learning points with relevant members of staff. Patients had received a written response, including an apology, when anything had not been managed appropriately. We noted that complaints handling had also been discussed at a staff meeting in September 2014 so that staff could share information or learning points.

Information about how to make a complaint was displayed in the reception area and on the practice website. The practice also had a suggestions box displayed in the waiting area. We reviewed some of the suggestions made by patients and could see that changes have been implemented. For example, some suggestions related to the quality of the waiting area environment. We could see that the suggested changes had been made.

Are services well-led?

Our findings

Governance arrangements

The governance arrangements for this location were robust. There was a comprehensive system of policies, protocols and procedures in place covering all of the clinical governance criteria expected in a dental practice. The systems and processes were maintained in an orderly fashion with files that were regularly reviewed and completed. Records, including those related to patient care and treatments, as well as staff employment, were kept accurately.

The staff fully understood all of the governance systems because there was a clear line of communication running through the practice. This was evidenced through the effective use of staff meetings, where relevant information was shared and recorded in meeting minutes, and through the high level of knowledge about systems and processes which staff were able to demonstrate to us via our discussions on the day of the inspection.

There was a clear management structure in place. A new provider had taken over the running of the practice in November 2014. The previous provider was still available one day per week during the transition period to provide clinical and managerial support to the new provider. The head dental nurse also provided clinical and managerial support, with a specific focus on managing the nursing and reception staff. It was evident that the new provider was adopting the same approach to the management systems to ensure continuity of the service.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said that they felt comfortable about raising concerns with the principal dentist, head nurse or senior nurse. They felt they were listened to and responded to when they did so.

We spoke with the principal dentist who outlined the practice's ethos for providing good care for patients. It was apparent through our discussions with the dentists and nurses that they shared the principal dentist's philosophy about putting patients at the heart of the practice. The dentists described a holistic approach to care where patient's physical and psychological health was considered.

We found staff to be hard working, caring and committed to their work and overall there was a strong sense that staff worked together as a team. There was a system of yearly staff appraisals to support staff in carrying out their roles to a high standard. Notes from these appraisals also demonstrated that they successfully identified staff's training and career goals.

Management lead through learning and improvement

The practice had a rolling programme of clinical audit in place. These included audits for infection control, clinical record keeping, X-ray quality, and antibiotic prescribing. Audits were repeated at appropriate intervals to evaluate whether or not quality had been maintained or if improvements had been made. We looked at a sample of audits for the first quarter of 2015. All audits revealed a high level of compliance against agreed standards. For example, the clinical record keeping audit ensured that dentists were recording essential clinical data such as medical history taking, condition of the gums and soft tissues of the mouth, and the dental recall interval. The antibiotic prescribing audit demonstrated that, when medicines were prescribed, the clinical justification, type of antibiotic, dose and frequency was always recorded by the dentists. This evidence demonstrated that the practice was committed to maintaining good standards in clinical care. We saw notes from meetings which showed that results of audits were discussed in order to share achievements or action plans for improving performance.

As part of the culture of openness and transparency, the practice had adopted a system of 360 degree peer appraisal. The nurses rotated their working so that they worked with each dentist in the practice. The practice had four dentists at present. The nurses provided feedback on each dentist's approach to patient care. Any concerns were then fed back to dentists via the principal dentist as part of the culture of driving improvements in care.

Staff were also being supported to meet their professional standards and complete continuing professional development (CPD) standards set by the General Dental Council (GDC). We saw evidence that staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the GDC.

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

Are services well-led?

The practice gathered feedback from patients through the use of a patient satisfaction survey and a suggestions box. They had also collected information through the 'Friends and Family Test', with twenty responses received so far since April 2015. The overwhelming majority of feedback had been positive. For example, all of the people responding the 'Friends and Family Test' said that they would be 'extremely likely' to recommend this practice to someone else.

We noted that the practice acted on feedback from patients where they could. For example, some people had made a suggestion regarding the provision of toys for children in the waiting area. We could see that there was a clearly designated area for children to play in the waiting area with a supply of toys. This showed that the feedback had been used to improve patient's experiences of coming to the practice.