

Oasis Dental Care (Southern) Limited

Oasis Dental Care Southern - Towcester

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 14 December 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

Background

Oasis Dental Care Southern Towcester is a general dental practice located in the centre of Towcester offering NHS and private dental treatment to adults and children.

The premises consist of a waiting room, treatment room, and decontamination room on the ground floor. There are three further treatment rooms on the first floor, and a staff room and office on the second floor.

The practice is open from Monday to Friday, and Saturday mornings weekly.

The practice manager is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

13 people provided feedback about the service. We looked at comment cards patients had completed prior

Summary of findings

to the inspection and we also spoke with patients on the day of the inspection. Overall patients were positive about their experience and they commented that the staff were always friendly and kind.

Our key findings were:

- There were effective systems in place to reduce the risk and spread of infection. We found the treatment rooms and equipment were visibly clean.
- We observed staff were kind, caring and welcoming which put nervous patients at their ease.
- Robust governance systems were in place to ensure the smooth running of the practice, including tracking of required training for practice staff and regular maintenance of essential equipment.
- The practice regularly undertook clinical audit for the improvement of the service, however these were not always as detailed as they could be.
- Staff were all up to date with the recommended training by the General Dental Council, including cross infection control, radiography, safeguarding vulnerable adults, child protection, medical emergencies and equality and diversity.
- Staff recruitment checks had been carried out in accordance with schedule three of the Health and Social Care Act 2008. Disclosure and barring service checks had been carried out on all staff to ensure the practice employed fit and proper persons.

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

- Review availability of medicines to manage medical emergencies giving due regard to guidelines issued by the British National Formulary (BNF).
- Review audit protocols and consider altering the format in order to achieve the maximum learning opportunities from the audit process.
- Review the legal requirements regarding who can consent on behalf of a minor.
- Review procedures for urgent referral of suspicious oral conditions to hospital.

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 was operating an effective decontamination pathway, with robust checks in place to ensure sterilisation of the instruments.

The practice had robust systems and training in place for the safeguarding of vulnerable adults and children.

The practice demonstrated commitment to 'safer sharps' by employing disposable sharps where possible and using systems that allow for the safe disposal of needles without the need to re-sheath them.

Are services effective?

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

We found the practice was keeping accurate and detailed dental care records, which documented good use of oral screening tools to identify undiagnosed disease.

All clinical staff were registered with the General Dental Council, and were fulfilling the requirements of their professional registration.

Staff we spoke with were confused about who had the legal right to consent for a minor.

Are services caring?

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

Patients told us they had very positive experiences of dental care provided at the practice. Patients felt they were listened to, treated with respect and were involved with the discussion of their treatment options which included risks, benefits and costs. We observed the staff to be caring, friendly and professional.

Are services responsive to people's needs?

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

The practice had systems in place to respond to the individual needs of the patients. Staff were able to contact an interpreter service if needed, and although they were temporarily unable to offer a full service to wheelchair users (due to an X-ray machine being out of order) they had made arrangements for these patients to be treated nearby.

There was a comprehensive out of hours service on offer to NHS patients, but cover for private patients did not extend beyond 9.00 pm.

Are services well-led?

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

The practice had robust systems in place to protect staff, patients and visitors to the practice.

Quality assurance processes were in place at the practice to ensure continuous improvement. Clinical audit was used to identify areas where improvements to practice could be made.

The practice had systems in place to involve, seek and act upon feedback from people using the service.

Oasis Dental Care Southern - Towcester

Detailed findings

Background to this inspection

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

The inspection was carried out on 14 December 2015 by a CQC inspector and a dental specialist advisor.

We informed the NHS England area team and Healthwatch that we were inspecting the practice; however they had no concerns raised within the last year. We also requested details from the provider in advance of the inspection. This included their latest statement of purpose describing their values and objectives and a record of patient complaints received in the last 12 months.

During the inspection we toured the premises, spoke with the practice manager (who was the registered manager), two dentists, two dental nurses and two receptionists. We reviewed a range of practice policies and practice protocols and other records relating to the management of the service.

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

The practice had systems in place to learn from significant incidents. A proforma was available within the significant events file which detailed the incident along with the steps taken to prevent a reoccurrence. Although there was no formal feedback pathway noted; staff informed us that this would be fed back through staff meetings. No significant incidents had been logged in the last year.

The practice manager received alerts from Medicines and Healthcare products Regulatory Agency (MHRA) and Central Alerting System (CAS). The practice manager informed us she would confirm the relevance of clinical alerts with the principal dentist, and then the alert was disseminated through the staff by way of an upcoming staff meeting. Alternatively, if the next staff meeting was too far away, a memorandum would be produced for all the staff to read and sign to say that they had read and understood the contents. We saw several examples of this.

Staff were aware of their responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). The practice manager and lead dental nurse informed us of how they would make such a report.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding vulnerable adults. Both these policies were recently reviewed and had been signed by all staff to indicate they had read and understood the contents.

In addition to this, flow charts were displayed in the staff room which detailed useful numbers to contact should they wish to raise a safeguarding concern. These included the local adult care team and the out of hours team.

We discussed safeguarding with members of staff and found there was a robust understanding of the signs of abuse and how to raise a safeguarding concern. We were informed of a situation where a dental nurse had reported a concern to the safeguarding lead in the practice. In this instance the concern was not escalated further, but it demonstrated the understanding of the staff to report concerns.

All members of staff had undertaken safeguarding training for adults and children in the last year.

We discussed the use of rubber dam with dentists and practice staff. A rubber dam is a thin, rectangular sheet, usually of latex rubber. It is used in dentistry to isolate a tooth from the rest of the mouth during root canal treatment; it prevents the patient from inhaling or swallowing debris or small instruments. The British Endodontic Society recommends the use of rubber dam for root canal treatment. We found that a latex-free rubber dam was routinely used for root canal treatments in the practice and we were shown dental care records to illustrate this.

The practice used a system of disposable needles that have a plastic tube that can be drawn up over the needle, and locked into place, to prevent injuries from sharps. This was in accordance with Health and Safety (Sharp Instruments in Healthcare) 2013 guidance. One member of staff requested to maintain the previous syringes that do not have this locking mechanism, and in this case a device was also provided to the member of staff that facilitates safe re-sheathing of the needle. In all cases we were informed that the clinician take sole responsibility of the sharps at the point of use and this mitigates the risk to the dental nurse.

Medical emergencies

The practice carried emergency equipment and medicines to deal with any medical emergencies that may arise. The emergency drugs were checked and found to be present in accordance with the British National Formulary (BNF) guidelines, with the exception of adrenaline.

Adrenaline is kept by dental practices to administer in the event of a serious allergic reaction called anaphylaxis. In this situation a dose of adrenaline may need to be administered to the patient every five minutes to maintain the patients' blood pressure until emergency services arrive. The practice carried a single pre-filled syringe of adrenaline. This was a lower dose than the BNF recommends, and with only one in the practice the practice could not guarantee the patient could be treated until the emergency services arrived. This was brought to the attention of the practice manager and an order placed immediately to rectify the concern.

Are services safe?

Emergency medicines were found to be stored appropriately and temperature sensitive medicines were kept in a designated fridge. The temperature of the fridge was checked daily and logged.

The practice kept emergency equipment as defined by the Resuscitation Council UK guidance, including two automated external defibrillators (portable electronic devices that automatically diagnose life threatening irregularities of the heart and deliver an electrical shock to attempt to restore a normal heart rhythm). Oxygen was also available for use in a medical emergency.

Emergency equipment was checked and logged daily and robust procedures noted to ensure all emergency medicines and equipment was re-ordered before they expired.

All staff underwent annual basic life support training; in addition we saw evidence in the minutes of staff meetings that medical emergencies were discussed.

Staff recruitment

We looked at the personnel files for three staff members to check that the recruitment procedures had been followed. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all staff personnel files. This includes: proof of identity; checking the prospective staff members' skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed). DBS checks identify whether a person had a criminal record or was on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

We found that the recruitment procedures had been followed in accordance with schedule 3 of the Health and Social Care Act. DBS checks had been carried out on all members of staff in accordance with their own recruitment procedure.

An induction process was carried out for every new member of staff; this introduced new members of staff to

the policies and procedures in the practice. It took place over several days, and a checklist was available to ensure that new staff had covered the essential practice information.

Monitoring health & safety and responding to risks

The practice had robust systems in place to monitor and manage risks to patients, staff and visitors to the practice.

A health and safety policy was in place at the practice, this was dated May 2015, and all staff had signed the policy to confirm they had read and understood the contents. The topics covered by the policy included manual handling, waste management, mercury spillage and a fire policy.

An external fire risk assessment had been carried out in December 2014. Fire alarms were tested weekly, and fire drills carried out every six months. Fire extinguishers had been regularly serviced, as had the emergency lighting.

Staff we spoke with all had a clear understanding of their role in the event of a fire, and could describe the evacuation procedure and muster point for the building. All employed staff had undertaken fire awareness training within the last year.

A generic risk assessment had been carried out by the practice in March of this year. This highlighted areas of risk including slips and trips, manual handling, latex allergy and storage heaters. Specific risk assessments had been put in place for new or expectant mothers visiting the practice and work experience students.

There were adequate arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a file of information pertaining to the hazardous substances used in the practice and actions described to minimise their risk to patients, staff and visitors.

Infection control

The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' Published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for cleaning, sterilising and storing dental instruments and reviewed their policies and procedures.

The practice had an infection control policy. This documented procedures in place pertaining to

Are services safe?

decontamination (decontamination is the process by which contaminated re-usable instruments are washed, rinsed, inspected, sterilised and packaged ready for use again), hand hygiene, personal protective equipment (PPE), single use items, inoculation injuries, dental unit water lines and manual cleaning of dental instruments.

Infection control audits had been carried out at the practice every six months, and an action plan drawn up to indicate where improvements could be made. A time limit was placed on these actions by which time the improvement should be implemented.

We observed the staff undertaking the decontamination process in their designated decontamination room. Instruments were cleaned manually, rinsed and inspected for debris or defects under an illuminated magnifier. This was in accordance with the practice policy and in line with HTM 01-05.

The instruments were sterilised in an autoclave before being placed in pouches and dated a year from decontamination, after which the sterilisation would become ineffective.

Staff showed us the checks that were in place to ensure the process was effective. This included a test strip being placed in the autoclave with every new load to pass through. This changes colour when the appropriate temperature and pressure is reached, and so effective sterilisation could be assured over time.

Where possible the practice utilised single use items of equipment. This included dental syringes, burs for the drills, files for root canal treatment and matrix band systems (a strip of metal that is positioned around a tooth during placement of a restoration if the defect for filling extends down the side of the tooth). This negates any risk of re-use, as well as reducing the risk of inoculation (sharps) injuries to staff from handling the equipment.

The practice demonstrated appropriate storage and disposal of clinical waste. Waste consignment notices were seen for clinical waste, amalgam, sharps, teeth and gypsum. This was underpinned by policies on waste management and healthcare waste.

All clinical staff had documented immunity against Hepatitis B. Staff 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 the risk of contracting blood borne infections.

There were systems in place to protect staff, patients and visitors from the risk of water lines becoming contaminated with Legionella bacteria. An external assessment was carried out in November 2011, from which an action plan was drawn up. We saw evidence that water temperatures were being checked monthly in 12 sites around the building. Staff told us that dental water lines were flushed at the start and end of the day, as well as in between patients, and water lines were disinfected regularly.

In addition the practice carried out regular water checking which were sent off for analysis, in response to this they had received a certificate that indicated the quality of the water was maintained.

Equipment and medicines

We saw that the practice had equipment to enable them to carry out a range of dental procedures.

We saw that regular servicing and testing had been carried out on the autoclave and compressor, in line with the manufacturer's instructions.

Prescription pads were kept locked away from patient facing areas and issued to dentists as and when required. A record of the prescription number was logged in the patient dental care record, so that specific prescriptions could be traced back to their recipients.

Evidence was seen in the dental care records that expiry dates and batch numbers of local anaesthetic were checked at the chairside, and logged.

Glucagon is an emergency drug that is used to treat diabetics with low blood sugar. It needs to be stored between two and eight degrees Celsius in order to be effective until the expiry date. We found that although this medication was being stored in a medicines fridge, and the temperature of the fridge was being checked regularly, the minimum and maximum range of the fridge temperature could not be confirmed. Therefore the practice could not be sure that this medicine would be effective in the case of a medical emergency. We raised the concern with the

Are services safe?

practice manager, who took immediate steps to ensure it was stored appropriately, and modified the expiry date to account for the fact that the temperature of cold storage could not be assured.

Radiography (X-rays)

The practice demonstrated compliance with the Ionising Radiation Regulations (IRR) 1999, and the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.

All treatment rooms displayed the 'local rules' of the X-ray machine on the wall. These are specific documents to each set detailing (amongst other things) the designated Radiation Protection Advisor, and Radiation Protection Supervisor. The location of the cut-off switch for the unit, and a schematic diagram of the surgery pertaining to possible X-ray scatter, this is the tiny amount of radiation that can spread beyond the beam area.

The practice used exclusively digital X-rays, which are available to be viewed almost instantaneously, as well as delivering a lower effective dose of radiation to the patient.

Daily routine maintenance checks were carried out for each X-ray set, and critical examination and acceptance tests had been carried out for all machines within the last two years.

All X-rays taken were graded and audited in accordance with IR(ME)R 2000, and justification for the X-ray was illustrated in the dental care records shown to us. As was a report on the findings of the radiographs.

In this way the effective dose of radiation to the patient was kept as low as reasonably possible.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

During the course of our inspection patient care was discussed with the dentists and we saw patient care records to illustrate our discussions.

A comprehensive medical history form was completed for every new patient at the practice, this included questions regarding social use of alcohol and nicotine or nicotine containing products, which may affect oral health and specific questions regarding medication that may affect bone healing following a tooth extraction. The form was updated and signed by the patient every new course of treatment.

Records showed assessment of the periodontal tissues (the gums and soft tissues of the mouth) had been undertaken. These had been recorded using the basic periodontal examination (BPE) screening tool. BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to patients' gums.

The dentists used current National Institute for Health and Care Excellence (NICE) guidelines to assess each patient's risks and needs and to determine how frequently to recall them. They also used NICE guidance to aid their practice regarding antibiotic prophylaxis for patients at risk of infective endocarditis (a serious complication that may arise after invasive dental treatments in patients who are susceptible to it), and removal of lower third molar (wisdom) teeth.

The decision to take X-rays was guided by clinical need, and in line with the Faculty of General Dental Practitioners directive.

It was demonstrated through the dental care records that we were shown that the dentists were keeping accurate and comprehensive records of the patients' oral health, as well as discussions that had taken place regarding their treatment, the reasons for taking X-rays and the findings of the X-rays.

Health promotion & prevention

The practice promoted the maintenance of good oral health as part of their overall philosophy.

Medical history forms requested information regarding smoking habits, and discussions with the dentists were documented in the patient care records regarding smoking cessation and alcohol intake. Information leaflets were available for the dentists to provide to the patients.

We found a comprehensive application of guidance issued in the DH publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Free samples of toothpaste were available in reception, as well as a range of oral hygiene products to purchase, although a patient commented that there used to be more choice in these products and her children missed coming in to pick their new toothbrushes.

Staffing

The practice had four dentists, two hygienists, three dental nurses, two practice co-ordinators (one on maternity leave) two receptionists, and a practice manager. Prior to the inspection we checked the registrations of all dental care professionals with the General Dental Council (GDC) register. We found all staff were up to date with their professional registration with the GDC.

The practice utilised dental nurses with extended competencies, namely in radiography where two dental nurses were qualified to take X-rays. We found that these and all other clinical staff were up to date with the Ionising Radiation (Medical Exposure) Regulations to undertake at least five hours of specific training regarding X-rays every five years.

Staff told us they had good access to ongoing training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians and dental technicians.

Clinical staff were up to date with their recommended CPD as detailed by the GDC including medical emergencies, infection control, safeguarding and fire awareness training.

Working with other services

Are services effective?

(for example, treatment is effective)

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment. As the practice was part of a group they were in a position to utilise the skills available at other local Oasis practices. This meant that patients could be referred within the group for dental implants or routine oral surgery.

We asked the practice how they ensured the timeliness of a referral where a serious condition was suspected. There seemed to be some confusion in this area, and there was not a specific policy in place to guide staff in this regard. Upon discussion with the practice manager it transpired that the local hospital had recently changed the way in which they receive referrals, and this could have led to the confusion. We were given assurances the new system of referrals would be circulated to all staff to clarify the matter.

Consent to care and treatment

The practice demonstrated a thorough understanding of the processes involved in obtaining full, valid consent for treating adults. Staff informed us that patients were always involved in discussions about their care, and the options, risks and costs of treatment always explained fully. This was evidenced through dental care records that were shown to us, and also from the feedback that we received from patients.

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. Staff demonstrated an understanding of the MCA and how this

applied in considering whether or not patients had the capacity to consent to dental treatment. This included assessing a patient's capacity to consent, understanding that capacity should be assumed even if the patient has a condition which may affect their mental capacity, and when it may be necessary to make decisions in a patient's best interests.

We discussed with staff how consent is obtained for children under the age of 16. There was some confusion about who can consent on behalf of a child, particularly whether grandparents or adult siblings could agree to treatment. Some staff felt that any adult family member who attends with the minor could consent on their behalf.

In routine circumstances only those with parental responsibility for a child can consent on behalf of the child (the concept of parental responsibility was introduced by the Children Act 1989). Mothers always have parental responsibility. Fathers have automatic parental responsibility if they were married to the mother at the time of the child's birth, but not necessarily otherwise. We discussed this with the practice manager who agreed that they would review their policies in this regard.

Another legal precedent involving consent for minors is that of Gillick competence. This is where a child under the age of 16 is deemed to have adequate understanding of the treatment, risks and benefits that they are able to consent for themselves. The practice demonstrated good understanding of this concept.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Staff we spoke with explained how they ensured information about people using the service was kept confidential. Dental care records were held electronically and password protected, any paper records were stored in locked cabinets behind reception desk. Staff at reception demonstrated that their monitors were positioned in such a way that they could not be viewed by patients standing at the desk.

They also explained how any patient wishing to have a confidential discussion could be taken aside to an unused treatment room so that the discussion was not overheard.

The practice had a clinical records, patient privacy and confidentiality policy which was available in hard copy form for staff to refer to. The patients could access a leaflet entitled 'How we deal with your personal information' which was available in the waiting area.

We observed staff at reception welcoming patients, and speaking with them in a polite, friendly and discreet manner.

Feedback we received from patients commented on how friendly the team were, and nervous patients were put at ease.

Involvement in decisions about care and treatment

The practice had a patient communication policy, which had been read and signed by all staff this year. It detailed ways in which patients should be informed about their treatment, including the use of written treatment plans and involvement of interpreters if necessary.

Patients we spoke with were happy that they were always involved in decisions about their care, and this was evidenced in the dental care records which documented the details of these discussions.

Price lists for both NHS and private treatment were clearly displayed in the waiting room.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We examined appointments scheduling, and found that adequate time was given for each appointment to allow for assessment and discussion of patients' needs.

Several patients told us the practice had been very caring and reassuring when dealing with their anxiety relating to the anticipation of dental treatment. A patient we spoke with on the day of our visit also told us the practice had been especially supportive and responsive when providing care and support to their children.

The practice detailed arrangements for out of hours cover on the answerphone. For NHS patients this included a service for direct access until 8.00 pm, after which the NHS 111 service could be utilised. For private patients to the practice there was a rota arranged providing cover until 9.00pm but no specific instructions for patients to follow after that time.

Tackling inequity and promoting equality

Staff told us they welcomed patients from diverse backgrounds and cultures, and they were all treated according to their needs. This was underpinned by the practice's fair and accessible care policy, which was available to staff in hard copy form.

At the time of the inspection the practice did not have any patients that required a translator, but the practice was registered with a translation service. An interpreter could be arranged to attend the practice, or speak on the phone should the need arise.

The practice had carried out a disability discrimination audit in September 2015. This had highlighted that although there was a ground floor surgery that could be accessed by wheelchair users, this surgery had a faulty X-ray machine that had been condemned and was awaiting replacement.

In response to this the practice had put into place an arrangement with a nearby sister practice whereby patients who required this service could be seen at this practice until the situation was resolved.

The practice had in place a whistleblowing policy that directed staff on how to take action against a co-worker whose actions or behaviours were of concern. This policy was reviewed in May 2015, and had been signed by all staff to indicate that they understood the contents.

Access to the service

The practice is open from 8.30am to 6pm Monday to Thursday, 8.30am to 5pm on Friday and 8.30am to 12pm on a Saturday. In this way access to the service is ensured for the working population who are able to access evening or weekend appointments.

Emergency appointments were set aside daily, and we witnessed patients in pain being seen on the day they called.

Patient feedback was generally positive in this regard, with comments regarding how accommodating staff were with arranging appointments, however we did receive feedback from one patient regarding how often appointments were changed by the practice.

Concerns & complaints

The practice had a policy guiding staff on effective complaints handling, this was reviewed in May 2015. Information on how a patient could raise a complaint was evidenced on a poster in the waiting room, and in the patient information file available at reception. We spoke to the practice manager about making these clearer, as they were entitled 'Code of Conduct', rather than 'Complaints', and were easy to overlook. The practice manager agreed, and assured us that this would be made more prominent.

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. The practice team viewed complaints as a learning opportunity and we saw evidence that complaints were a fixed part of the agenda for the monthly staff meetings. Staff we spoke with confirmed that all complaints were discussed with a view to improving the service going forward.

We were shown an example where a patient complaint had led to a change in practice. Confusion had arisen around hygiene appointments, which a change on the computer system clarified. Letters were exchanged with the

Are services responsive to people's needs?

(for example, to feedback?)

complainant, apologies issued, and the complainant had replied to thank them for addressing his complaint so thoroughly and explaining what had been changed in response to his complaint.

Are services well-led?

Our findings

Governance arrangements

The practice manager (as the registered manager) was responsible for the day to day running of the practice. They were supported by the practice co-ordinators. The principal dentist took the clinical lead, supported by the other dentists and clinical staff. There were clear lines of responsibility and accountability; staff knew who to report to if they had any issues or concerns.

Certain staff had lead positions, such as safeguarding lead, and infection control lead, and all the staff we spoke with were able to identify these individuals.

The practice had policies and procedures in place to support the management of the service, and these were readily available in hard copy form for the staff to reference. These included a complaints policy, safeguarding, and infection control policies, as well a robust health and safety policy, and business continuity plan to allow the continuation of the service in adverse circumstances.

Risk assessments were in place to minimise risks to staff, patients and visitors to the practice, these included fire safety, manual handling and Control of Substances Hazardous to Health.

The practice manager had access to an audit tool which highlighted when areas of practice were due for renewal / service, and also tracked the training undertaken by the staff.

In this way the practice manager was able to keep up to date with all the governance arrangements required to safely run a dental practice.

Leadership, openness and transparency

Staff reported a culture of honesty throughout the practice, where staff were encouraged to raise concerns and comments about the service.

We saw evidence that a recent memorandum had been sent regarding professional duty of candour (staff responsibility to raise concerns) all staff had signed the document to indicate they had read and understood it.

Learning and improvement

The practice sought to continuously improve standards by use of quality assurance tools, and continual staff training.

Clinical audit was used to identify areas where improvements to practice could be made. We saw that infection control audits had been carried out six monthly, and action plans drawn up highlighting ways in which improvements could be made. These actions were given time limits for implementation. Record keeping audits were regularly carried out to ensure appropriate notes were being kept.

All X-rays were graded for quality, and periodically audited. However the full learning opportunity was not being explored in this audit, and although the results of the audit were satisfactory, auditing in greater detail would perhaps have given a clearer outcome for learning; for example auditing X-rays for individual clinicians, rather than all together would highlight any concerns with the individual.

Staff were supported in achieving the General Dental Council's requirements in continuing professional development (CPD) underpinned by the practice's training and development policy. We saw evidence that all clinical staff were up to date with the recommended CPD requirements of the GDC.

Staff received annual appraisals, and personal development plans were drawn up to aid their career progression.

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

The practice had systems in place to involve, seek and act upon feedback from people using the service. There was a comments box, and comments form for patients to complete. A patient satisfaction survey was undertaken within the last year, and the results were displayed in the waiting room.

The practice held monthly staff meetings, and the agendas and minutes for the meetings were available for staff to view, in addition, the most recent minutes were placed on the noticeboard, where those staff that were unable to attend could read and sign the minutes. The minutes indicated that staff took the opportunity during these meetings to bring up any suggestions, and recently a change had been made to the way dirty and clean areas of the surgery are segregated, in response to a suggestion from a member of staff.

Staff gave an example of patient feedback that has effected a change in regard to the scheduling of hygiene

Are services well-led?

appointments. There has now been a separate option placed on the computer system to avoid the confusion between two sessions in one appointment, or two appointments of one session.