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Chesterfield Road Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 20 July 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Chesterfield Road Dental Practice is situated in the area of Woodseats in Sheffield, South Yorkshire. It offers mainly NHS treatment to patients of all ages but also offers private dental treatments. The services include preventative advice and treatment, routine restorative dental care and dental implants.

The practice has four surgeries, an X-ray room, two decontamination rooms, two waiting areas and a reception area. The reception area, one waiting area and two surgeries are on the ground floor. The other two surgeries, X-ray room and waiting room are on the first floor. There are toilet facilities on the first floor of the premises. There is a decontamination room on the ground floor and the first floor of the premises.

There are six dentists (one of whom is on maternity leave), two dental hygienists, seven dental nurses (including a trainee), a reception manager and a practice manager.

Summary of findings

The opening hours are Monday to Thursday from 9-00am to 5-15pm and Friday from 9-00am to 5-00pm.

One of the partners 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.

During the inspection we received feedback from 38 patients. The patients were positive about the care and treatment they received at the practice. Comments included that staff were friendly, helpful, respectful and polite. Patients also commented that their treatment was discussed clearly and why it was required.

Our key findings were:

- The practice was visibly clean and uncluttered.
- The practice had systems in place to assess and manage risks to patients and staff including infection prevention, control and health and safety and the management of medical emergencies.
- Staff were qualified and had received training appropriate to their roles.
- Dental care records were detailed and showed that treatment was planned in line with current best practice guidelines.
- Oral health advice and treatment were provided in-line with the 'Delivering Better Oral Health' toolkit (DBOH).
- Patients were involved in making decisions about their treatment and were given clear explanations about their proposed treatment including costs, benefits and risks.
- We observed that patients were treated with kindness and respect by staff.
- Staff ensured there was sufficient time to fully explain the care and treatment they were providing in a way patients understood.
- Patients were able to make routine and emergency appointments when needed.
- There were clearly defined leadership roles within the practice.
- The governance systems were effective.

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

- Review the availability of a policy relating to the use of Closed Circuit Television (CCTV).

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

Staff told us they felt confident about reporting incidents, accidents and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Staff had received training in safeguarding at the appropriate level and knew the signs of abuse and who to report them to.

Staff were suitably qualified for their roles and the practice had undertaken the relevant recruitment checks to ensure patient safety.

Patients' medical histories were obtained before any treatment took place. The dentists were aware of any health or medication issues which could affect the planning of treatment. Staff were trained to deal with medical emergencies. All emergency equipment and medicines were in date and in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines.

The decontamination procedures were effective and the equipment involved in the decontamination process was regularly serviced, validated and checked to ensure it was safe to use.

Are services effective?

No action

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

Patients' dental care records provided comprehensive information about their current dental needs and past treatment. The practice monitored any changes to the patient's oral health and provided treatment when appropriate.

The practice followed best practice guidelines when delivering dental care. These included Faculty of General Dental Practice (FGDP), National Institute for Health and Care Excellence (NICE) and guidance from the British Society of Periodontology (BSP). The practice focused strongly on prevention and the dentists were aware of the 'Delivering Better Oral Health' toolkit (DBOH) with regards to fluoride application and oral hygiene advice.

Staff were encouraged to complete training relevant to their roles. These included fluoride application and radiography. The clinical staff were up to date with their continuing professional development (CPD).

Referrals were made to secondary care services if the treatment required was not provided by the practice.

Are services caring?

No action

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

Summary of findings

During the inspection we received feedback from 38 patients. Patients commented that staff were friendly, helpful, respectful and polite. Patients also commented that their treatment was discussed clearly and why it was required.

We observed the staff to be welcoming and caring towards the patients.

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection.

Staff explained that enough time was allocated in order to ensure that the treatment and care was fully explained to patients in a way which they understood.

The practice provided dental treatment to children visiting Sheffield from Chernobyl. This was part of the Chernobyl Children's Life Line (CCLL) project.

Are services responsive to people's needs?

No action

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

The practice had an efficient appointment system in place to respond to patients' needs. There were vacant appointments slots for urgent or emergency appointments each day.

Patients commented they could access treatment for urgent and emergency care when required. There were clear instructions for patients requiring urgent care when the practice was closed.

There was a procedure in place for responding to patients' complaints. This involved acknowledging, investigating and responding to individual complaints or concerns. Staff were familiar with the complaints procedure.

The practice had made reasonable adjustments for patients with a disability or limited mobility to access dental treatment.

Are services well-led?

No action

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

There was a clearly defined management structure in place and all staff felt supported and appreciated in their own particular roles. The practice manager was responsible for the day to day running of the practice and the registered manager provided was the clinical lead within the practice.

Effective arrangements were in place to share information with staff by means of regular practice meetings which were well minuted for those staff unable to attend.

The practice regularly audited clinical and non-clinical areas as part of a system of continuous improvement and learning.

They conducted patient satisfaction surveys and there was a comments box in the waiting room for patients to make suggestions to the practice.

Chesterfield Road 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.

The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

During the inspection we received feedback from 38 patients. We also spoke with two dentists, one dental hygienist, three dental nurses and a receptionist. To assess the quality of care provided we looked at practice policies and 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 clear guidance for staff about how to report incidents and accidents. We were told that incidents would be reported, documented and plans for prevention would be formulated. Staff were encouraged to suggest solutions to prevent recurrence. Any accidents or incidents would be reported to the practice manager. Incidents would be discussed at staff meetings in order to disseminate learning.

Staff understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR) and there was a folder which contained details of incidents which needed to be reported.

The practice received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) that affected the dental profession. These would then be discussed with staff, actioned if necessary and stored for future reference.

Reliable safety systems and processes (including safeguarding)

The practice had child and vulnerable adult safeguarding policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff. Staff had access to contact details for both child protection and adult safeguarding teams. One of the dentists was the safeguarding lead for the practice and there was a deputy in place if the lead was not available for any reason. All staff had undertaken level two safeguarding training.

The practice had systems in place to help ensure the safety of staff and patients. These included the use of needle re-sheathing devices, a protocol that only the dentists handle sharps and guidelines about responding to a sharps injury (needles and sharp instruments).

Rubber dam was used in root canal treatment 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)

We saw that patients' clinical records were computerised; password protected and securely backed up to secure storage to keep people safe and protect them from abuse.

Medical emergencies

The practice had procedures in place which provided staff with clear guidance about how to deal with medical emergencies. Staff were knowledgeable about what to do in a medical emergency and had completed training in emergency resuscitation and basic life support within the last 12 months.

The practice kept an emergency resuscitation kit, oxygen, emergency medicines and staff knew where the emergency kits were kept. All emergency equipment and medicines were in date and in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines. The practice had a documented risk assessment for the absence of buccal midazolam from the emergency medicine kit and a contingency plan if it were needed.

The practice had an Advisory External Defibrillator (AED) to support staff in a medical emergency. (An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm).

The registered manager had a system in place to ensure all emergency medicines and equipment was checked. These checks ensured that the oxygen cylinder was full, the AED battery was fully charged and the emergency medicines were in date.

Staff recruitment

The practice had a policy and a set of procedures for the safe recruitment of staff which included seeking references, proof of identity, checking relevant qualifications and professional registration. We reviewed a sample of staff files and found the recruitment procedure had been followed. The practice manager told us they carried out Disclosure and Barring Service (DBS) checks for all newly employed staff. These checks 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. We reviewed records of staff recruitment and these showed that all checks were in place.

Are services safe?

Clinical staff at the practice were qualified and registered with the General Dental Council (GDC). There were copies of current registration certificates and personal indemnity insurance (insurance professionals are required to have in place to cover their working practice).

Monitoring health & safety and responding to risks

A health and safety policy and risk assessment was in place at the practice. This identified the risks to patients and staff who attended the practice. The risks had been identified and control measures put in place to reduce them. The practice manager conducted bi-annual health and safety checks on the practice which included whether there was adequate security, the storage of materials, whether there was adequate lighting and the general upkeep of the premises. Staff also conducted weekly walk rounds of the premises to check for any slips, trips or falls.

There were policies and procedures in place to manage risks at the practice. These included a fire risk assessment, trainee dental nurses, lone workers, pregnant workers and risks associated with Hepatitis B.

The practice maintained a file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including substances such as disinfectants, and dental materials in use in the practice. The practice identified how they managed hazardous substances in its health and safety and infection control policies and in specific guidelines for staff, for example in its blood spillage and waste disposal procedures. One of the dental nurses was responsible for the COSHH folder and we saw it was regularly checked and updated as necessary.

Infection control

There was an infection control policy and procedures to keep patients safe. These included hand hygiene, managing waste products and decontamination guidance. The practice followed the guidance about 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)'. One of the dental nurses was the infection control lead for the practice who was responsible for overseeing that decontamination was carried out safely and effectively.

Staff had received in-house training in infection prevention and control. We saw evidence that staff were immunised against blood borne viruses (Hepatitis B) to ensure the safety of patients and staff.

We observed the treatment rooms and the decontamination rooms to be clean and hygienic. Work surfaces were free from clutter. Staff told us they cleaned the treatment areas and surfaces between each patient and at the end of the morning and afternoon sessions to help maintain infection control standards. There was a cleaning schedule which identified and monitored areas to be cleaned. There were hand washing facilities in the treatment rooms and staff had access to supplies of personal protective equipment (PPE) for patients and staff members. Posters promoting good hand hygiene and the decontamination procedures were clearly displayed to support staff in following practice procedures. Sharps bins were appropriately located, signed and dated and not overfilled. We observed waste was separated into safe containers for disposal by a registered waste carrier and appropriate documentation retained.

Decontamination procedures were carried out in dedicated rooms. This had been implemented to prevent instruments having to be transported up or down stairs. An instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination rooms which minimised the risk of the spread of infection.

We were shown the procedures involved in disinfecting, inspecting and sterilising dirty instruments; packaging and storing clean instruments. The practice routinely used an ultrasonic bath or a washer disinfector to clean the used instruments, examined them visually with an illuminated magnifying glass, and then sterilised them in a validated autoclave (a device for sterilising dental and medical instruments). The ground floor decontamination room had clearly defined dirty and clean zones in operation to reduce the risk of cross contamination. The arrangement for decontamination on the first floor involved a room for decontamination and a separate room for sterilisation. Instruments were passed from the decontamination room to the sterilisation room through a hatch. This arrangement greatly reduces the risk of cross contamination. Staff wore appropriate PPE during the process and these included disposable gloves, aprons and protective eye wear.

Are services safe?

The practice had systems in place for daily and weekly quality testing the decontamination and sterilisation equipment and we saw records which confirmed these had taken place. There were sufficient instruments available to ensure the services provided to patients were uninterrupted.

The practice had carried out an Infection Prevention Society (IPS) self- assessment audit in April 2016 relating to the Department of Health's guidance on decontamination in dental services (HTM01-05).This is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. The audit showed the practice was meeting the required standards.

Records showed a risk assessment process for Legionella had been carried out in October 2015 (Legionella is a term for particular bacteria which can contaminate water systems in buildings). The practice undertook processes to reduce the likelihood of legionella developing which included running the water lines in the treatment rooms at the beginning and end of each session and between patients, monitoring cold and hot water temperatures each month, the use of a water conditioning agent and regular tests on the on the water quality to ensure that Legionella was not developing.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as X-ray machines, the autoclaves and the compressor. We saw evidence of validation of the autoclaves, ultrasonic baths and the compressor. The practice manager kept a log of when equipment needed to be serviced to ensure it was done in a timely manner.

Portable appliance testing (PAT) had been completed in May 2016 (PAT confirms that portable electrical appliances are routinely checked for safety).

NHS prescription pads were kept locked away at night to ensure their safe use.

Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. Records we viewed demonstrated that the X-ray equipment was regularly tested and serviced. A Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure that the equipment was operated safely and by qualified staff only. We found there were suitable arrangements in place to ensure the safety of the equipment. Local rules for all machines were available within the radiation protection folder for staff to reference if needed. We saw that a justification, grade and a report was documented in the dental care records for all X-rays which had been taken.

The practice used an automated X-ray developing machine for developing OPTs. We saw evidence that regular checks were undertaken on the machine to ensure the quality of processing was satisfactory. We saw that used X-ray developing chemicals were stored safely in containers for disposal by a registered waste carrier and appropriate documentation retained.

X-ray audits were carried out every six months. This included assessing the quality of the X-rays which had been taken. The results of the most recent audit undertaken confirmed they were compliant with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept up to date detailed electronic dental care records. They contained information about the patient's current dental needs and past treatment. The dentists carried out an assessment in line with recognised guidance from the Faculty of General Dental Practice (FGDP). This was repeated at each examination in order to monitor any changes in the patient's oral health. The dentists used NICE guidance to determine a suitable recall interval for the patients. This takes into account the likelihood of the patient experiencing dental disease such as decay, gum disease or cancer. We saw evidence in dental care records of different recall intervals for patients in line with NICE guidance.

During the course of our inspection we discussed patient care with the dentists and checked dental care records to confirm the findings. Clinical records were comprehensive and included details of the condition of the teeth, soft tissue lining the mouth, gums and any signs of mouth cancer. If the patient had more advanced gum disease then a more detailed inspection of the gums was undertaken. Patients with more advanced gum disease were also referred to the dental hygienist for further treatment.

During the inspection we noted that a dental microscope was used by the registered provider when providing endodontic treatment. Dental microscopes provide the dentist with a degree magnification which improves visual acuity which helps improve the outcome of endodontic treatment for patients.

Records showed patients were made aware of the condition of their oral health and whether it had changed since the last appointment. Medical history checks were updated by each patient every time they attended for treatment and entered in to their electronic dental care record. This included an update on their health conditions, current medicines being taken and whether they had any allergies.

The practice used current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, following clinical assessment, the dentists followed the guidance from the FGDP before taking X-rays to ensure they were required and necessary. Justification for the taking of an X-ray, quality assurance of each x-ray and a detailed report was recorded in the patient's care record.

Health promotion & prevention

The practice had a strong focus on preventative care and supporting patients to ensure better oral health in line with the 'Delivering Better Oral Health' toolkit (DBOH). DBOH is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. For example, the dentists applied fluoride varnish to children who attended for an examination. Fissure sealants were also applied to children at high risk of dental decay. High fluoride toothpastes were prescribed for patients at high risk of dental decay.

The practice had a selection of dental products on sale in the reception area to assist patients with their oral health.

The medical history form patients completed included questions about smoking and alcohol consumption. We were told by the dentists and saw in dental care records that smoking cessation advice was given to patients where appropriate. Patients would be made aware of the link between smoking and gum health and oral cancer. There were health promotion leaflets available in the waiting room to support patients.

The practice was involved in the pilot rehearsal trial of the "Filling Children's Teeth: Indicated Or Not?" (FiCTION) trial. The FiCTION trial compares alternative methods of managing dental decay in the primary dentition. These methods included purely preventative care, preventative care plus biological intervention (partial decay removal) and preventative care plus surgical intervention (full decay removal). This research could have a major impact on the way dentists treat dental decay in children. We think this is notable practice because it demonstrates a commitment to improving the quality of treatment provided to children by involving themselves in current research.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. The induction process included getting the new member of staff aware of the location of emergency medicines,

Are services effective?

(for example, treatment is effective)

arrangements for fire evacuation procedures, infection control procedures and how to use the computer system. We saw evidence of completed induction checklists in the recruitment files.

Staff told us they had good access to on-going 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 practice organised in house training for medical emergencies and infection control. The registered provider also arranged for all staff to attend postgraduate deanery events in the evening. Records showed professional registration with the GDC was up to date for all staff and we saw evidence of on-going CPD.

Staff had annual appraisals and training requirements were discussed at these. We saw evidence of completed appraisal documents. Staff also had up to date personal development plans. We saw evidence that dental nurses were encouraged to pursue further training and several nurses were qualified to carry out extended duties including radiography.

Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. For example, referrals were made to hospitals and specialist dental services for further investigations or specialist treatment including orthodontics, oral surgery and sedation. The practice had a procedure for the referral of a suspected malignancy. The registered manager had good links to the local dental hospital.

The dentists completed detailed proformas or referral letters to ensure the specialist service had all the relevant information required. A copy of the referral letter was kept in the patient's dental care records. Letters received back relating to the referral were first seen by the referring dentist to see if any action was required and then stored in the patient's dental care records.

Referral logs were maintained in the surgeries. These were monitored by the dentists to ensure referrals were sent in a timely fashion.

Consent to care and treatment

Patients were given appropriate information to support them to make decisions about the treatment they received. Staff were knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent. Staff described to us how valid consent was obtained for all care and treatment and the role family members and carers might have in supporting the patient to understand and make decisions. Staff were clear about involving children in decision making and ensuring their wishes were respected regarding treatment.

Staff had received training and had a good understanding of the principles of the Mental Capacity Act (MCA) 2005 and how it was relevant to ensuring patients had the capacity to consent to their dental treatment. The registered manager described to us of an occasion where they had a best interest meeting with a local GP about a patient who had Alzheimer's disease.

Staff ensured patients gave their consent before treatment began and a form was signed by the patient. We were told and saw evidence that individual treatment options, risks, benefits and costs were discussed with each patient. Patients would be given time to consider their options for more complicated procedures.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Feedback from patients was positive and they commented that they were treated with care, respect and dignity. Staff told us that they always interacted with patients in a respectful, appropriate and kind manner. We observed staff to be friendly and respectful towards patients during interactions at the reception desk and over the telephone.

We observed privacy and confidentiality were maintained for patients who used the service on the day of inspection. Dental care records were not visible to the public on the reception desk. We observed staff were helpful, discreet and respectful to patients. Staff said that if a patient wished to speak in private, an empty room would be found to speak with them. The waiting rooms were separate to the reception area which reduced the chance of any patients overhearing an inadvertent breach of confidentiality.

Patients' electronic care records were password protected and regularly backed up to secure storage.

The practice provided dental treatment to children from Chernobyl. This was part of the Chernobyl Children's Life Line (CCLL) project. The CCLL is a nationwide project which brings 3000 children to the UK each year for four weeks. The children stay with local families and the project organises activities for the children to participate in. It is thought that by spending four weeks a year in the UK that the immune system has time to improve away from the chronically contaminated area in Chernobyl. The dental practice provided dental care to these children who were staying in Sheffield during their stay. This included routine dental treatment and any emergency treatment which may be required. Historically the practice owners also provided dental care to children in rural Romania for two weeks.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients commented that their treatment was discussed clearly and why it was required. Staff described to us how they involved patients' relatives or carers when required and ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood.

When treating children the dentists told us that he would use the "tell-show-do" technique in order to help children overcome any anxieties. They would also use models to help involve children with their treatment. The dentists understood the concept of Gillick competency with regards to obtaining consent from children under the age of 16.

Patients were also informed of the range of treatments available on notices and leaflets in the waiting area and on the practice website.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We found the practice had an efficient appointment system in place to respond to patients' needs. Staff told us that patients who requested an urgent appointment would be seen the same day. We saw evidence in the appointment book that there were dedicated emergency slots available each day for each dentist. If the emergency slots had already been taken for the day then the patient was offered to sit and wait for an appointment if they wished.

Patients commented they had sufficient time during their appointment and they were not rushed. We observed the clinics ran smoothly on the day of the inspection and patients were not kept waiting.

Tackling inequity and promoting equality

The practice had equality and diversity, and disability policies to support staff in understanding and meeting the needs of patients. Reasonable adjustments had been made to the premises to accommodate patients with mobility difficulties. These included wheelchair access through the rear of the premises and a hearing loop. The ground floor surgeries were large enough to accommodate a wheelchair or a pram. We were told that the ground floor surgeries would be used for those patients who could not manage the stairs. As there was no ground floor toilet facilities we were told that any patients who could not climb the stairs would be made aware of this prior to booking an appointment. The practice manager told us that they could use fax to communicate with persons who had any hearing impairment.

Access to the service

The practice displayed its opening hours in the premises and on the practice website. The opening hours are Monday to Thursday from 9-00am to 5-15pm and Friday from 9-00am to 5-00pm.

Patients told us that they were rarely kept waiting for their appointment. Patients could access care and treatment in a timely way and the appointment system met their needs. Where treatment was urgent patients would be seen the same day. The practice had a system in place for patients requiring urgent dental care when the practice was closed. Patients were signposted to the 111 service on the telephone answering machine. The practice were also involved in a local rota which offered emergency dental treatment when the practice was closed. Information about the out of hours emergency dental services was also displayed in the waiting area and in the practice information leaflet.

Concerns & complaints

The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. There were details of how patients could make a complaint displayed in the waiting room. The practice manager was responsible for dealing with complaints when they arose. Staff told us they raised any formal or informal comments or concerns with the practice manager to ensure responses were made in a timely manner. Staff told us that they aimed to resolve complaints in-house initially. The practice had received one complaint received in the past 12 months. We reviewed this complaint and found that it had been dealt with in line with the practices policy and to the patient's satisfaction.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients. We found there was an effective system in place which helped ensure a timely response. This included acknowledging the complaint within three working days and providing a formal response within six months. If the practice was unable to provide a response within six months then the patient would be made aware of this.

Are services well-led?

Our findings

Governance arrangements

The practice was a member of the British Dental Association 'Good Practice' accreditation scheme. This is a quality assurance scheme that demonstrates a visible commitment to providing quality dental care to nationally recognised standards.

The practice manager was responsible for the day to day running of the service. The registered manager was the clinical lead within the practice and offered support and advice to other dentists. These positions were conducive to an effective management structure. Staff told us that they felt supported and were clear about their roles and responsibilities.

There was a range of policies and procedures in use at the practice. These included infection control, safeguarding and health and safety. We noted that the practice used CCTV in the practice. There were signs to inform patients of the use of CCTV. There was no policy in relation to the use of CCTV. This policy should outline the reasons for needing CCTV, the time they are stored for and how the images are stored. We spoke to the practice manager about this who told us they would ensure a policy governing the use of CCTV was put in place at the practice.

We saw they had systems in place to monitor the quality of the service and to make improvements. The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately.

The practice had an effective approach for identifying where quality or safety was being affected and addressing any issues**.** Health and safety and risk management policies were in place and we saw a risk management process to ensure the safety of patients and staff members. For example, we saw risk assessments relating to fire safety, trainee dental nurses, lone workers, pregnant workers and risks associated with Hepatitis B.

Leadership, openness and transparency

The culture of the practice encouraged candour, openness and honesty to promote the delivery of high quality care and to challenge poor practice. Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. These would be discussed openly at staff meetings where relevant and it was evident that the practice worked as a team and dealt with any issue in a professional manner.

The practice held regular staff meetings. The days of staff meetings were changed to ensure that all staff members had the opportunity to be present. These meetings were minuted for those who were unable to attend. The practice manager would also speak to any members of staff about topics which were discussed at the staff meeting. During these staff meetings topics such as decontamination, referral protocols and audit results.

All staff were aware of with whom to raise any issue and told us that the principal dentist was approachable, would listen to their concerns and act appropriately. We were told that there was a no blame culture at the practice and that the delivery of high quality care was part of the practice's ethos.

Learning and improvement

Quality assurance processes were used at the practice to encourage continuous improvement. The practice audited areas of their practice as part of a system of continuous improvement and learning. This included clinical audits such as dental care records, X-rays and infection control. We looked at the audits and saw that the practice was performing well. However, where improvements could be made these were identified and followed up by a repeat audit. Results of audits were regularly discussed at staff meetings in order to disseminate learning to all staff.

Staff told us they had access to training and this was monitored to ensure essential training was completed each year. The practice organised in house training for medical emergencies, basic life support and infection control. Staff were also encouraged to complete on-line training. Staff working at the practice were supported to maintain their continuous professional development as required by the General Dental Council.

All staff had annual appraisals at which learning needs, general wellbeing and aspirations were discussed. We saw evidence of completed appraisal forms in the staff folders. It was evident that the appraisal process was seen as a positive experience and we saw that from appraisals that dental nurses were enrolled on courses which enabled them to undertake extended duties.

Are services well-led?

We were told that the practice offered mentoring to a struggling dental student in order to help them through their exams. They have also offered work experience to school children who are interested in pursuing a career in dentistry.

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 including carrying out a rolling patient satisfaction survey. The satisfaction survey included questions about what the practice did well and what they did not do so well. They were about to incorporate a question about whether any member of staff excelled within the practice. The most recent patient survey showed a high level of satisfaction with the quality of the service provided.

The practice also undertook the NHS Friends and Family Test (FFT). The FFT is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. The latest results showed that 100% of patients asked said that they would recommend the practice to friends and family.