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The Corner Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 17 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

CQC inspected the practice on 3 October 2014 and asked the registered provider to make improvements regarding requirements relating to workers, supporting workers and assessing and monitoring the quality of service provision. We checked these areas as part of this comprehensive inspection and found this had been resolved.

The Corner Dental Practice is situated in Immingham, North East Lincolnshire. It offers mainly NHS treatment to patients of all ages but also offers private dental treatments. The services include preventative advice, treatment and routine restorative dental care.

The practice has two surgeries, a decontamination room, a waiting area and a reception area. Treatment rooms, waiting rooms and an accessible toilet are on the ground and there is step free access to the premises.

There is currently one dentist, a dental hygienist, a qualified dental nurse, four trainee dental nurses and a receptionist.

The opening hours are Monday to Friday 9-00am to 5-30pm.

On the day of inspection 16 patients provided feedback. The patients were positive about the care and treatment they received at the practice. They told us they were treated with dignity and respect in a clean and hygienic environment, informed of treatment options, were able to make appointments in a timely manner and that the staff were helpful and polite.

Summary of findings

Our key findings were:

- The practice had systems in place to assess and manage risks to patients and staff including infection prevention and control, fire and health and safety.
- 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.
- Staff received training appropriate to their roles.
- Patients were treated with care, respect and dignity.
- Patients were able to make appointments in a timely manner at a time which suited them.
- There were clearly defined leadership roles within the practice and staff told us that they felt supported, appreciated and comfortable to raise concerns or make suggestions.

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

- Aim to implement a system for the analysis of accidents.
- Aim to obtain child and adult self-inflating bags for the emergency resuscitation kit.

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.

Staff told us they felt confident about reporting incidents, accidents and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had been two incidents in the last year. However, there had been no significant event analysis for them.

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

The 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 mostly in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines.

Are services effective?

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 made referrals for specialist treatment or investigations where indicated.

The dentist followed best practice guidelines when delivering dental care. These included Faculty of General Dental Practice (FGDP) and National Institute for Health and Care Excellence (NICE). 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.

Consent for treatment was obtained before treatment began. Staff were knowledgeable about the principles of the Mental Capacity Act (MCA) 2005 and its relevance when attempting to obtain consent from patients who may not have capacity to provide consent.

Are services caring?

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

We received feedback from 16 patients. Common themes were that patients felt they were treated with dignity and respect in a safe and clean environment. Patients also commented that they were listened to, involved in treatment options and full explanations of treatment and costs were given.

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.

Are services responsive to people's needs?

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

Summary of findings

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 to enable patients with a disability or limited mobility to access dental treatment.

Are services well-led?

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

There was a management structure in place and all staff felt supported and appreciated in their own particular roles. The practice owner was responsible for the day to day running of the practice and was supported by the receptionist who was currently taking on a more administrative role within the practice.

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

There were arrangements in place to share information with staff by means of monthly practice meetings which were minuted for those staff unable to attend. Staff felt confident to raise any issues at staff meetings and these would be discussed openly in a professional manner.

The Corner 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.

We informed local NHS England area team and Healthwatch North East Lincolnshire that we were inspecting the practice; however we did not receive any information of concern from them.

During the inspection we reviewed feedback from 16 patients, spoke with the dentist, the qualified dental nurse and the 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 guidance for staff about how to report incidents and accidents. We saw evidence of two incidents which had occurred within the last year. This had been documented in the accident book. However, there was no evidence that a more in-depth analysis had taken place for these incidents. This was brought to the attention of the practice owner and we were assured these would be conducted from now on and discussed at the practice meetings in order to disseminate learning.

Staff understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR) and provided guidance to staff within the practice's health and safety policy.

The practice did not have a process to receive alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) that affected the dental profession. However, on the day of inspection we saw that an account was set up in order to receive alerts from the MHRA which would then be shared with staff and discussed at the practice meetings if appropriate.

Reliable safety systems and processes (including safeguarding)

We spoke with the registered provider and the dental nurse on duty about the management of safer sharps. They explained that the treatment of sharps and sharps waste was in accordance with the current EU Directive with respect to safe sharp guidelines. This ensured that staff were protected against blood borne viruses. Sharps bins were wall mounted, correctly labelled and were not overfilled. The practice used a system whereby needles were not re-sheathed using the hands following administration of a local anaesthetic to a patient. The practice used the 'scoop' method for recapping used needles. It was also practice policy that the discarding of the used needle was the dentist's responsibility. The dental nurse we spoke with explained how a needle stick injury would be managed which mirrored the practice protocol that was on display in the practice. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps.

We asked the dental nurse how the dentist treated the use of instruments that were used during root canal treatment. They explained that these instruments were single patient use only. The nurse also explained that root canal treatment was carried out where practically possible using a rubber dam. We were shown by the dental nurse the rubber dam kit used by the dentist. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). Patients can be assured that the practice followed appropriate guidance by the British Endodontic Society in relation to the use of the rubber dam.

The registered provider acted as the practice lead for child and adult safeguarding. We discussed the different types of abuse that could affect a patient and who to report them to if they came across abuse of a vulnerable child or adult. They were able to describe the types of behaviour a child would display that would alert them if there were possible signs of abuse or neglect. They also had an awareness of the issues around vulnerable elderly patients who present with dementia that require dental care and treatment. We saw that the practice had a policy in place in relation to child and adult safeguarding and evidence that staff had completed recent training in safeguarding. We saw the training records of the staff and found that they had received training appropriate to their clinical role in the practice. We also saw a protocol for escalating child safe guarding issues. This protocol contained the telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. We did find on the day of our inspection that the adult safeguarding contact details were not available, however by the end of the inspection the practice had located the details and amended the local protocol accordingly.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an automated external defibrillator (AED), a portable electronic device that analyses life-threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. The practice had in place the emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. Oxygen

and other related items such as manual breathing aids and portable suction were available. However, we did find that the emergency kit did not contain the adult and child self-inflating bags as specified in the Resuscitation UK guidelines for dealing with common medical emergencies in dental practice. The emergency medicines and oxygen were all in date and stored securely in a central location known to all staff.

The expiry dates of medicines, oxygen and equipment were monitored by staff using a monthly check sheet, this enabled the staff to replace out of date drugs and equipment in a timely manner. We also saw records that showed all staff working at the practice had received training in dealing with common medical emergencies in dental practice during 2015.

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 owner told us the practice 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.

All clinical staff at the practice were 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. An annual health and safety risk assessment was undertaken. 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. Where issues had been identified, remedial action had been taken in a timely manner.

There were policies and procedures in place to manage other risks at the practice. These included infection prevention and control, fire evacuation procedures, use of the autoclave and risks associated with the non-response of staff to the Hepatitis B inoculation.

The practice maintained a file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including substances such as disinfectants, blood and saliva. 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.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The practice utilised a separate decontamination room for the processing of used dental instruments and equipment. We reviewed practice policy and protocols in relation to infection control and found that HTM 01-05 (national guidance for infection prevention control in dental practices) Essential Quality Requirements for infection control were being met. We found the policy was reviewed on a regular basis to take into account changes in national guidelines. It was observed that a current audit of infection control processes confirmed compliance with HTM 01-05 guidelines. We saw that the last audit was carried out in November 2015.

The principal dentist maintained overall responsibility for infection control in the practice and ensured that the nurses followed current national guidelines. The dental nurse on duty described the end-to-end process of infection control procedures at the practice. They explained the decontamination of the treatment room environment following the treatment of a patient. We were shown how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings) they described the method they used which was in line with current HTM 01-05 guidelines. A current Legionella risk assessment had been carried out by an appropriate contractor in 2013. The report contained recommendations that the practice had followed up. The

practice maintained monthly water quality checks including the temperatures of the sentinel water taps. These checks were carried out by an external contractor; we also saw copies of the work sheets confirming this had been carried out. These measures ensured that patients' and staff were protected from the risk of infection due to Legionella.

We noted that the dental treatment rooms, waiting area, reception and toilets were clean and tidy. Clear zoning demarking clean from dirty areas was apparent in the treatment rooms and the decontamination room. Hand washing facilities were available including wall mounted liquid soap, rubs and paper towels in the treatment rooms, decontamination room and toilet. Hand washing protocols were also on display.

We inspected the drawers and cupboards of the treatment rooms and decontamination room. These were well stocked, clean, well ordered and free from clutter. Instruments were pouched and contained an appropriate expiry date in accordance with current guidelines. It was also obvious which items were single use and these items were clearly new. Each treatment room had the appropriate routine personal protective equipment available for staff and patient use.

The dental nurse demonstrated to us the decontamination process from taking the dirty instruments through to clean and ready for use again. The process followed a well-defined system of zoning from dirty through to clean. The practice used a system of manual scrubbing followed by instruments cleaned in an automated washer disinfector as part of the initial cleaning process. Following inspection with an illuminated magnifier, instruments were then placed in an autoclave (a machine used to sterilise instruments). When instruments had been sterilized, they were pouched until required. All pouches were dated with an expiry date in accordance with current guidelines. The nurse also demonstrated that systems were in place to ensure that the autoclaves and automated washer disinfector used in the decontamination process were working effectively. These included the automatic control test for the autoclave, protein test, and soil test for the automated washer disinfector. It was observed that the data sheets used to record the essential daily validation checks of the sterilisation and automated washer disinfector cycles were always complete and up to date.

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 this was in accordance with current guidelines. The practice used an appropriate contractor to remove dental waste from the practice and 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. Patients' could be assured that they were protected from the risk of infection from contaminated dental waste.

Clinical staff working at the practice had all received update training in infection control during 2015 and records showed that they were also immunised against common blood borne viruses such as Hepatitis B.

Equipment and medicines

Records we viewed reflected that equipment in use at the practice was regularly maintained and serviced in line with manufacturers guidelines. We observed the maintenance schedules ensuring that the autoclaves were maintained to the standards set out in the Pressure Systems Safety Regulations 2000, the most recent service being carried out in September and December 2015. The practice compressor had been serviced in January 2015. The automated washer disinfector was serviced in November 2015. A specialist company attended at regular intervals to calibrate and the X-ray sets to ensure they were operating safely. The most recent reports were dated 1st December 2015 that was in accordance with inspection interval of three years as recommended under the Ionising Radiation Regulations 1999. We also observed that a portable appliance test (PAT) had been carried out in accordance with current guidelines. PAT is the name of a process during which electrical appliances are routinely checked for safety. We saw that medicines such as local anaesthetics were stored safely and NHS prescription pads were securely stored to prevent loss of prescriptions due to theft.

Radiography (X-rays)

The practice maintained a radiation protection file in accordance with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). This file contained the names of the Radiation Protection Adviser and a Radiation Protection Supervisor. Included in the file were the local rules, radiological risk

Are services safe?

assessment, details of the IRMER training received by the Radiation Protection Supervisor and the quality assurance process. The Radiation Protection Adviser had carried out the routine maintenance of the two X-ray sets in December 2015.

A copy of the most recent radiological audit was available for inspection. The audit contained a detailed analysis of the quality of the X-rays and the series of audits demonstrated that a high percentage of radiographs were of grade one standard. We saw dental care records that showed where the dentist, the dental X-rays, had taken X-rays were justified, reported on and quality assured every time. These findings demonstrated 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 dentist carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. They described how they carried out patient assessments using a typical patient journey scenario. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. 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 to the patient.

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 general dental hygiene procedures such as brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A written 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 saw dental care records that showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. The clinical records observed were structured and contained sufficient detail about each patient's dental treatment. We saw that 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 that is used to indicate the level of examination needed and to provide basic guidance on treatment need). The records we saw also showed that dental X-rays were justified, reported on and quality assured every time.

Health promotion & prevention

The practice engaged the services of a dental hygienist on a part-time basis who provided a range of treatment and advice for patients with gum problems. We saw dental care records, which showed that both the dentist and the dental hygienist provided advice on how to maintain healthy teeth. Tooth brushing techniques were explained to them in a way they understood and dietary, smoking and alcohol advice was also given to them.

The waiting room and treatment rooms 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.

Staffing

New staff to the practice had a period of induction specific to their role in order to familiarise themselves with the way the practice ran. The induction process included making the new member of staff aware of the infection control procedures, showing the new staff member the location of emergency medicines and arrangements for fire evacuation procedures. We saw evidence of completed induction checklists.

Staff told us they were encouraged to complete training to support their skill level and to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC).

Records showed professional registration with the GDC was up to date for all clinical staff and we saw evidence of on-going CPD. Mandatory training included basic life support and infection control.

Dental nurses were supervised by the dentist. Staff told us the dentist was readily available to speak to at all times for support and advice. Staff told us that there was a nice supportive environment at the practice and they felt comfortable when asking for help if needed.

Working with other services

The practice had a system in place showing how they worked with other services. The dentist was 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. The practice had a file containing a list of the secondary care providers that a dentist can refer patients

Are services effective?

(for example, treatment is effective)

to where appropriate. This file contains the details of the referral criteria for each provider service where appropriate and included services such as orthodontics, conscious sedation and oral surgery.

Consent to care and treatment

The dentist had a clear understanding of consent issues. They stressed the importance of communication skills when explaining care and treatment to patients. The dentist felt that patients should be given time to think about the treatment options presented to them. This made it clear that a patient could withdraw consent at any time and that they had received a detailed explanation of the type of treatment required, including the risks, benefits and options. Costs were made clear in the treatment plan. The dental care records we saw confirmed this approach had taken place.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patients were positive about the care they received from the practice. They commented they were treated with respect and dignity. They said staff supported them and were quick to respond to any distress or discomfort during treatment. We noted that most of the patients had been attending the practice for several years and staff had built up good relations with them. We witnessed interactions between staff and patients to be friendly, helpful and compassionate.

We observed privacy and confidentiality was generally maintained for patients who used the service on the day of inspection. We observed staff were 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.

Patients' electronic care records were password protected and regularly backed up to secure storage. If computers were ever left unattended then they would be locked to ensure confidential details remained secure. Any paper documentation which had patients' details on were locked in cabinets when the practice was closed.

Involvement in decisions about care and treatment

The Mental Capacity Act 2005 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. The dentist we spoke with gave a specific example of how they had taken mental capacity issues into account when providing dental treatment. They were aware of the Mental Capacity Act and explained how they would manage a patient who lacked the capacity to consent to dental treatment. They explained how they would involve the patient's family along with social workers and other professionals involved in the care of the patient to ensure that the best interests of the patient were met. They were therefore able to demonstrate a clear understanding of requirements of the Act.

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. The receptionist told us that patients who requested an urgent appointment would be seen within 24 hours if not 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 receptionist would speak with the dentist to find a suitable time for the patient to be seen that day.

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 an equality and diversity policy to support staff in understanding and meeting the needs of patients. Reasonable adjustments had been made to the premises to accommodate disabled patients. These included a small removable ramp to get over the bottom of the door frame and a hearing loop. The receptionist told us that they would speak slowly and maintain eye contact if a patient was lip reading. The practice also had access to telephone translation services for those whose first language was not English. Staff also had access to a magnifying sheet for partially sighted patients. There were accessible toilet facilities on the ground floor of the premises. Two of the surgeries were located on the ground floor and were large enough to accommodate a wheelchair.

Access to the service

The practice displayed its opening hours in the premises, on the practice website and in the practice leaflet. The opening hours are Monday to Friday 9-00am to 5-30pm. 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 within 24 hours or sooner if possible.

When the practice was closed patients who required emergency dental care were signposted to the local emergency dental service on the telephone answering machine. Details for patients of what to do if they have a dental emergency outside of the practice opening hours were also displayed in the waiting area and in the practice leaflet.

Concerns & complaints

The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. Staff told us they raised any formal or informal comments or concerns with the practice owner to ensure responses were made in a timely manner.

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 10 working days. If the practice was unable to provide a response within 10 working days then the patient would be made aware of this.

Information for patients about how to raise a concern or offer suggestions was available in the waiting room and in dedicated comments and complaints leaflet. We reviewed records of complaints which had been received in the past 12 months and it had been dealt with in a timely manner. It was evident from these records that the practice had been open and transparent with the patient and an apology had been given. We also saw that as a result of a complaint regarding the temperature of the waiting room, a water cooler had been installed in the waiting room.

Are services well-led?

Our findings

Governance arrangements

The practice owner was in charge of the day to day running of the service and was supported by the receptionist who was currently taking on a more administrative role. 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 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, the use of equipment, sharps and infection control.

There were a range of policies and procedures in use at the practice. The practice held staff meetings every month where governance was discussed. Staff meetings were minuted to ensure that any staff not present could be made aware of topics which had been discussed.

There was a management structure in place to ensure that responsibilities of staff were clear. Staff told us that they felt supported and were clear about their roles and responsibilities.

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 at staff meetings where relevant. It was evident that the practice worked as a team and dealt with any issue in a professional manner. Staff were aware of whom to raise any issue with and told us that the practice owner was approachable, would listen to their concerns and act appropriately. If the practice owner was not available or the issue related to the practice owner, staff were familiar with external contacts to seek advice.

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 clinical records, X-rays and infection control. The most recent clinical record audit cycle was completed in September 2015 and showed that the dentist was performing well. The clinical record audit covered areas such as whether patients' medical histories were updated, risk factors documented, signed consent obtained and whether treatment options had been discussed with the patient.

Staff told us they we encouraged to complete training relevant to their roles to ensure essential training was completed; this included medical emergencies and basic life support. Staff working at the practice were supported to maintain their continuous professional development as required by the General Dental Council.

The practice held staff meetings every month at which ways to make the practice more effective were discussed and learning was disseminated.

Staff received annual appraisals at which performance, learning needs, general wellbeing and aspirations were discussed. We saw evidence of completed appraisal forms in the staff folders.

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

The practice had systems in place to seek and act upon feedback from patients using the service. These included carrying a monthly patient survey which included questions about the general appearance of the practice, the ability to book emergency appointments, being kept informed if the dentist is running late, whether the dentist is friendly and caring and whether treatment options had been discussed. The most recent results of the patient surveys indicated a high patient satisfaction. We saw evidence that as a result of comments about the general décor of the practice that some maintenance work had been undertaken.

Are services well-led?

The practice also conducted the NHS Friends and Family Test. The most recent test results showed that 100% of patients would recommend the practice to friends or family.