

Mr Anjum Saghir

# Priory Dental Centre

## Inspection Report

4 Priory Terrace  
Leamington Spa  
Warwickshire  
CV31 1BA  
Tel: 01926 312204  
Website: [www.priorydental.co.uk](http://www.priorydental.co.uk)

Date of inspection visit: 15 December 2016  
Date of publication: 01/02/2017

### Overall summary

We carried out an announced comprehensive inspection on 15 December 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**

Priory Dental Centre is a general dental practice which provides care for adults and children. It is situated in the centre of Leamington Spa, Warwickshire. The practice is in a converted townhouse which is grade two listed.

The practice has five dental treatment rooms and provides general dental treatment either funded by the NHS or privately.

The practice has two principal dentists and 4 further dentists one of whom is a foundation dentist. This means that the dentist recently qualified and is undertaking a year of mentored working where they receive support from their in practice trainers as well as attending training days. Both the principal dentists acted as trainers for the foundation dentist.

The practice employed two dental hygienists, three qualified dental nurses and four trainee dental nurses a receptionist and a practice manager.

The practice is open from 8.30 am to 5 pm on Monday, Tuesday and Wednesday. 8.30 am to 7 pm on a Thursday and 8.30 am to 3 pm on a Friday.

One of the principal dentists 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'.

# Summary of findings

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.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience. We received feedback from 41 patients. These provided a positive view of the services the practice provides. Patients commented on the quality of care, the polite and friendly nature of staff and the cleanliness of the practice.

## **Our key findings were:**

- The practice was visibly clean and clutter free.
- Comments from patients indicated that the staff were kind and caring and were skilled at putting nervous patients at ease.
- The practice met the standards set out in national guidance regarding infection control.
- A routine appointment could be secured within a few days and emergency appointments would be arranged on the day they contacted the service.
- The practice had policies in place to assist in the smooth running of the service.
- The practice had medicines and equipment to treat medical emergencies.
- Dentists at the practice used national guidance and standards in the care and treatment of patients.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- Governance arrangements were in place for the smooth running of the service.
- Appropriate pre-employment checks were being carried out; however the practice was not always recording character references or proof of identification.
- Archived dental care records were not stored securely on the premises, although they were stored away from patient areas. Following the inspection they were secured.
- The practice had not adequately assessed the use of 'safer sharps' in line with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

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

- Review the practice's sharps procedures giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Review the storage of dental care records to ensure they are stored securely.
- Review the practice's recruitment policy and procedures to ensure character references for new staff as well as proof of identification are requested and recorded suitably.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

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

The practice had medicines and equipment to manage medical emergencies, although the adult oxygen mask was not covered and was therefore dusty, and there was no child sized oxygen mask. These were purchased following the inspection.

Infection control standards met those outlined in national guidance.

The practice was carrying out appropriate pre-employment checks on staff; however improvements could be made to recording references and proof of identification.

The practice had not switched to using 'safer sharps' on the premises, but started to trial these products across the practice following the inspection.

X-rays taken on the premises were carried out in line with current regulation.

The step leading into the rear of the property presented some safety concerns as it was not secure. This was fixed following the inspection.

Equipment was serviced in line with manufacturers' requirements.

Prescription pads were stored and logged in line with guidance from NHS Protect.

No action



### Are services effective?

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

The dentists used nationally recognised guidance in the care and treatment of patients.

A comprehensive screening of patients was carried out at check-up appointments including assessing risks associated with gum health, cancer and decay.

Staff demonstrated a good understanding of the Mental Capacity Act and Gillick competence and their relevance in establishing consent.

No action



### Are services caring?

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

Comments from patients were overwhelmingly positive about the care and treatment they received.

Patients were involved in the decisions around their treatment and care.

Written treatment plans were given to patients for them to be able to consider their options.

Archived dental care records were kept on the premises away from patient areas, but unsecured. These were secured following the inspection.

No action



# Summary of findings

## Are services responsive to people's needs?

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

The practice made every effort to see emergency patients on the day they contacted the practice.

Evening appointments were available with a dentist on Thursdays ensuring flexibility for patients who may have commitments during normal working hours.

Staff made every effort to assist patients with restricted mobility, including clinicians moving to ground floor treatment room to see patients who could not manage the stairs.

No action



## Are services well-led?

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

The practice had a series of policies to aid in the smooth running of the practice. These were available in hard copy form for staff to access.

Staff felt supported and encouraged to approach the management team with ideas or concerns.

Clinical audit was used as a tool to highlight areas where improvements could be made.

No action



# Priory Dental Centre

## Detailed findings

### Background to this inspection

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

We carried out an announced, comprehensive inspection on 15 December 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Before the inspection we asked the provider for information to be sent this included the complaints the

practice had received in the last 12 months; their latest statement of purpose; the details of the staff members, their qualifications and proof of registration with their professional bodies. We spoke with members of staff and patients during the inspection.

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 a system in place for reporting and learning from untoward incidents, although they had not recorded an incident in the year preceding our visit. A policy was in place which had been reviewed in November 2016 and a template was available to record any incidents.

We discussed the protocol for dealing with incidents with both the principal dentist and practice manager. They described a process by which a thorough investigation would be carried out and fed back to the appropriate people. They also noted that apologies and explanations be issued to any patients involved in an incident.

Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. A clear understanding of this was evident during our discussions with staff.

The practice received communication from the Medicines and Healthcare products Regulatory Agency (MHRA). These were e-mailed to the practice manager and the principal dentists who actioned the alert and disseminated the information to all relevant staff.

The practice were aware of their responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). RIDDOR is managed by the Health and Safety Executive (HSE). The practice had a folder which contained RIDDOR forms and information on how and when to make a report. The practice manager and principal dentist demonstrated clear knowledge and understanding in this area.

### Reliable safety systems and processes (including safeguarding)

The practice had a policy in place regarding safeguarding vulnerable adults and child protection which indicated the signs of abuse to look for and what actions to take if concerned. A flow chart was also available indicating the actions to take and contact numbers were displayed on the wall in the reception area.

All staff had undertaken training in safeguarding and staff we spoke with were able to describe the actions they would take in response to concerns, including how to respond if they felt a vulnerable adult or child were in immediate danger.

The practice had an up to date Employers' liability insurance certificate which was due for renewal in April 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

We discussed the use of rubber dam with the dentist in the practice. 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 and 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 rubber dam was being used routinely by the dentists.

A protocol was in place detailing the actions required in the event of a sharps injury. This directed staff to seek advice from occupational health or accident and emergency in the event of an injury with a contaminated sharp.

The practice were not using 'safer sharps' at the time of the inspection. These are medical sharps that have an in built safety features to reduce the risk of accidental injury. The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 require that practices switch to 'safer sharps' where it is reasonably practicable to do so. Following our inspection the practice started to trial the 'safer sharps' products across the practice.

### Medical emergencies

The dental practice had medicines and equipment in place to manage medical emergencies. These were stored together and all staff we spoke with were aware how to access them. Emergency medicines were in date, stored appropriately, and in line with those recommended by the British National Formulary.

Equipment for use in medical emergency was available in line with the recommendations of the Resuscitation Council UK with the exception of oxygen masks. The adult mask available was uncovered and dusty and the practice did not have a child sized oxygen mask. These were purchased immediately following the inspection.

# Are services safe?

The practice had an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.

Staff had undertaken basic life support training most recently in March 2016 when an external trainer visited the practice. Staff we spoke with were able to describe their actions in the event of a medical emergency and which medicine would be needed for a specific medical emergency. The practice discussed the treatment of different medical emergencies in staff meetings in February and December 2016 and the practice carried out ad hoc scenario training as a revision tool in between the annual training.

## Staff recruitment

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all recruitment 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 reviewed the staff recruitment files for six members of staff. DBS checks had been sought for all staff although at the time of the inspection four were outstanding, the practice did not have a risk assessment or protocol in place for new staff working prior to their DBS certification coming through. The practice implemented a risk assessment following the inspection.

References and identification documents were not always present in the recruitment files we were shown, however they were provided following the inspection.

## Monitoring health & safety and responding to risks

The practice had systems in place to monitor and manage risks to patients, staff and visitors to the practice. A health and safety policy was updated in November 2016 and was

available for all staff to reference. This included topics such as accidents, personal protective equipment, electrical safety and autoclaves. In addition to this a health and safety checklist was completed in September 2016.

A full practice risk assessment was completed in September 2016 and assessed risks arising from autoclaves, manual handling, slip, trips and falls as well as the use of medical sharps on the premises.

An internal fire risk assessment had been completed most recently in September 2016; in addition to this the practice undertook weekly fire alarm tests, quarterly fire drills and emergency lighting checks. Staff we spoke with were able to describe the actions they would take in the event of a fire and identify the external muster point. Information for patients was displayed in the waiting area.

Separate risk assessment had also been completed pertaining to trainee dental nurses, staff who had not responded to a course of Hepatitis B vaccinations and pregnant and nursing mothers.

There were 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. This had been reviewed and updated in January 2016.

The practice had a business continuity plan in place which detailed the actions to take should the premises be unusable due to unforeseen circumstances. This include an arrangement for emergency patients to be seen at a neighbouring practice. The practice reciprocated this offer with other local dental practices.

## 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 in place, this was available as part of the policy folder which had been reviewed and updated in November 2016. This included



# Are services safe?

topics such as hand hygiene, blood borne viruses, clinical waste and personal protective equipment. In addition an annual statement in infection control had been completed in November 2016.

The practice was visibly clean and clutter free.

The practice had a dedicated decontamination facility; this had an unusual layout where staff were required to walk past the 'clean' area in order to access the 'dirty' area. This created a risk that staff place dirty instruments in the 'clean' area as it was directly in front of them as they entered the room. The practice had attempted to ensure the zoning of the 'clean and 'dirty' areas by markings on the floor as well as signage above the work tops. Although the layout was not ideal we witnessed staff using the area appropriately.

The decontamination room had two sinks for manually cleaning and then rinsing dental instruments. There was not a hand wash sink available in the decontamination room and no nearby facility for this. We raised this with the principal dentists and practice manager who took immediate steps to rectify the situation by designating one of the sinks in the decontamination room a hand wash sink, and purchasing a removable bowl for the second sink which could therefore be used for the manual cleaning and rinsing of dental instruments.

The practice also had an ultrasonic cleaner which is a piece of equipment designed to clean dental instruments by passing ultrasonic waves through a liquid.

Instruments were inspected under an illuminated magnifier prior to sterilisation in one of two autoclaves and then pouched and stamped with the date they were sterilised.

Appropriate testing of the ultrasonic cleaner and autoclaves took place, in line with the recommendations of HTM 01-05.

We noted some dental forceps which were stored in the decontamination room were not dated and so it could not be assured that were sterilised within the previous year. We raised this with the practice manager who recognised that this should not be the case but the risk was mitigated by the fact that the practice re-processed all their instruments once a year.

The practice had contracts in place for the disposal of contaminated waste and waste consignment notes were seen to confirm this. Clinical waste was stored in a locked

bin prior to its removal; however the clinical bin was not secured to prevent it been wheeled away. Following the inspection we were sent photographic evidence that this was now secured.

The practice had a cleaning company who undertook the environmental cleaning of the practice daily. We saw schedules of the cleaning to be carried out and saw that equipment for cleaning conformed to the national standard for colour coding cleaning equipment in a healthcare setting.

We noted some areas that were difficult to clean due to damage; the veneer was chipped on the work surface in the decontamination room exposing the wood, and in small areas the flooring seal had come away. These were addressed following the inspection and the work surface in the decontamination room was replaced.

The practice had a risk assessment regarding Legionella. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The assessment had been carried out by an external company in August 2016. This highlighted the need for some staff to undertake training in Legionella, which four staff members had completed.

Monthly water temperatures were checked for two points in every treatment room and other sites around the building. We examined the logs of these going back several years, during this time there were some results which did not meet the minimum temperature requirement, but it was not clear if any action was taken regarding this. Following the inspection the practice implemented a detailed protocol for the monthly water checks including a clear escalation pathway if the temperature was out of range.

The practice also completed dip slides which measure the amount of bacteria in the water. These were completed in October 2016 all treatment rooms passed this test at that time.

The dental unit waterlines were appropriately managed by staff and management of the waterlines was discussed at the practice staff meeting on 11 April 2016.

## Equipment and medicines

The practice had a full range of equipment to carry out the services they offered and in adequate number to meet the needs of the practice.



# Are services safe?

Portable appliance testing had been carried out in September 2016 and the fire extinguishers had been serviced in September 2016.

The compressors and autoclaves had all been serviced and tested in the year before the inspection and in line with manufacturers' instructions.

We noted that the two steps leading up to the rear entrance of the building were loose. This entrance was used by staff and a temporary ramp was positioned on these steps to allow wheelchair access for patients. This would be potentially dangerous given that the steps were themselves not secure. Immediately following the inspection we received photographic evidence that the steps had been fixed, and the practice put into place a plan to replace these steps with a permanent ramp in the future.

Prescription pads were secured and logged in line with the guidance from NHS Protect.

## **Radiography (X-rays)**

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

The practice had five intra-oral X-ray machines that were able to take an X-ray of one or a few teeth at time and one panoramic machine that takes an X-ray of the whole jaws.

Rectangular collimation on intra-oral X-ray machines limits the beam size to that of the size of the X-ray film. In doing so it reduces the actual and effective dose of radiation to patients. We saw that rectangular collimators were in use by clinicians.

The required three yearly testing of the equipment was carried out in October 2016 and this included the annual service.

We saw from the dental care plans we were shown that clinicians were routinely noting the justification for taking an X-ray as well as the quality grade and report of the findings.

# 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 by patients at every examination appointment, and updated verbally at each attendance. This ensured that the dentist was kept informed of any changes to the patient's general health which may have impacted on treatment.

Dental care records showed that the dentists regularly checked gum health by use of the basic periodontal examination (BPE). This is a simple screening tool that indicates the level of treatment need in regard to gum health. Scores over a certain amount would trigger further, more detailed testing and treatment.

Screening of the soft tissues inside the mouth, as well as the lips, face and neck was carried out to look for any signs that could indicate serious pathology.

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.

### Health promotion & prevention

Dental care records we saw indicated that an assessment was made of patient's oral health and risk factors. Medical history forms that patients were asked to fill in included information on nicotine use; this was used by dentists to introduce a discussion on oral health and prevention of disease.

We found a good 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 a

toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. The practice used diet analysis sheets for children to highlight where hidden sugars or other issues which may affect oral health.

Patients had access to the details of the local stop smoking service from cards available in the waiting room.

### Staffing

The practice was staffed by six dentists, two dental hygienists, three qualified dental nurses, and four trainee dental nurses, supported by a practice manager and a receptionist.

Prior to our inspection we checked that all appropriate clinical staff were registered with the General Dental Council and did not have any conditions on their registration.

We spoke with the foundation dentist and principal dentists regarding their role as trainers. They provided weekly tutorials for the foundation dentist, who felt well supported by the principals and the practice as a whole.

The dental hygienists were directly supported by dental nurses in line with the General Dental Council standards.

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 GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians, dental technicians, and orthodontic therapists.

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

### Working with other services

The practice made referrals to other dental professionals when it was unable to provide the treatment themselves.

A referrals folder not only provided the details for services to refer to in all specialities, but also provided templates for those referrals to be made.

Referrals for suspicious lesions were made by fast track email to the hospital which was then followed up by a phone call from the practice to ensure it had been received.

# Are services effective?

(for example, treatment is effective)

Each individual treatment room kept track of the referrals made. This log was checked weekly to ensure that patients were seen in a timely manner.

## **Consent to care and treatment**

We spoke to clinicians about how they obtained full, educated and valid consent to treatment. Comprehensive discussions took place between clinicians and patients where the options for treatment were detailed. Visual aids such as models and diagrams were used to demonstrate clearly to the patients and an intra-oral camera was available to show patients the area being discussed within their mouth.

Dentists we spoke with indicated that time was given for patients to consider their options before starting treatment.

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 a good understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment. This was underpinned by a policy dated 7 January 2016 which was available to staff to reference in the policy folder.

Similarly staff had a good understanding of the situations where a child under the age of 16 would be able to consent for themselves. This is termed Gillick competence and relies on an assessment of the competency of the child to understand the treatment options.

# Are services caring?

## Our findings

### **Respect, dignity, compassion & empathy**

Comments that we received from patients indicated consistently that the care and treatment they received was of a high standard. Staff were described as helpful, friendly and professional, and comments indicated that the dentists took the time to explain fully to the patients their options and treatment.

We witnessed patients being spoken to in a polite and courteous manner, and patients indicated that staff were skilled at putting nervous patients and children at ease.

Patients that had undergone complex treatment or extractions were contacted by the practice the following day to ensure that they were well.

We discussed and witnessed how patients' information was kept private. The computer at the reception desk was angled away so that it could not be overlooked by patients stood at the desk.

Reception staff explained how they took care when speaking to patients on the telephone as a potential situation where care had to be taken not to divulge private

information. In addition sensitive discussions with patients in the practice were taken away from the reception desk where they could be overheard by other patients in the waiting room, and would take place in private.

These measures were underpinned by practice policies on confidentiality and data protection.

During the inspection we noted that some archived paper dental care records, which were stored away from patient areas, were not secured, and as such could be accessed by external contractors when on the premises. We raised this with the principal dentists and received evidence immediately following the inspection that these records had been secured.

### **Involvement in decisions about care and treatment**

Following examination and discussion with the clinician patients were all given a copy of a treatment plan to consider.

Comments received from patients indicated that they felt listened to and dentist took the time to respond to their concerns. Options were explained to patients and advice given.

The NHS and private price lists were displayed in the waiting area.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting patients' needs

As part of our inspection we conducted a tour of the practice and found the premises and facilities were appropriate for the services delivered.

At the time of our inspection the practice was accepting new NHS and private patients and a new patient could expect to receive an appointment within a week. We examined appointments scheduling and found that there was enough time allocated for assessment and discussion of the patients' needs.

Reminders of appointments were sent to patients by email, text message or letter depending on the preference of the patient. In addition queries could be sent to the practice via the practice website; these queries were checked daily and answered by a dental nurse.

For the comfort of patients there was a television in the waiting room.

### Tackling inequity and promoting equality

The practice had an equality and diversity policy which indicated the practice's intention to welcome patients of all cultures and backgrounds. This was corroborated by staff we spoke to during the inspection who expressed that they welcomed patients from all backgrounds and cultures, and all patients were treated according to their individual needs.

We spoke to staff about ways in which they assisted those with individual needs attending the practice.

The practice had staff that spoke a variety of languages and in addition to this interpreters could be arranged for individual patients who did not speak English as a first language.

The practice could provide wheelchair access through the rear of the premises by use of a temporary ramp, but had plans in place to construct a permanent ramp to improve access.

Staff assisted patients with restricted mobility and clinicians would change rooms in order to accommodate patients in ground floor treatment rooms that were unable to manage the stairs with ease.

The practice had a lowered reception desk to assist patients using wheelchairs.

### Access to the service

The practice was open from 8.30 am to 5 pm on Monday, Tuesday and Wednesday. 8.30 am to 7 pm on a Thursday and 8.30 am to 3 pm on a Friday. The availability of evening appointments on a Thursday meant that patients would have other commitments during normal working hours could be accommodated.

Emergency slots were set aside daily and the practice endeavoured to offer an appointment to any emergency patient on the day they contacted.

Out of hours arrangements were available for patients to hear on the answerphone. The arrangements in place were to contact the NHS 111 out of hour's service.

### Concerns & complaints

The practice had a complaints handling policy dated January 2016. Details that were displayed for patients adjacent to the reception desk detailed how a patient could raise a complaint with the practice, and the timeframe in which they could expect to have received a response.

This poster did not give the contact details for agencies to whom a patient could raise a complaint external to the practice, or to escalate a complaint should they remain dissatisfied following a response from the practice. This information was added to the poster during the inspection.

We were shown examples of complaints made to the practice and saw that they were dealt with in a timely manner and appropriately. The outcomes of complaints were fed back to staff to reduce the chance of reoccurrence.

# Are services well-led?

## Our findings

### Governance arrangements

The principal dentists (one of whom was the registered manager) took responsibility for the day to day running of the practice, supported by the practice manager. We noted clear lines of responsibility and accountability across the practice team.

Monthly staff meetings were used to discuss the running of the practice as well as revision opportunities for topics such as medical emergencies and infection control. Any information that needed to be disseminated to staff in between meetings was done so in one of two ways. Urgent information would be sent round in a memorandum to ensure that everyone was aware, non-urgent information was placed in a folder for staff to read. Dentists and dental nurses had separate folders so that it remained relevant to them.

The practice had policies and procedures in place to support the management of the service, and these were readily available in hard copy form. Policies were noted in infection control, health and safety, complaints handling, safeguarding and whistleblowing. The policy folder had a useful index sheet in the front for ease of use.

### Leadership, openness and transparency

Staff we spoke with reported an open and honest culture across the practice and they felt fully supported to raise concerns with the principal dentists or practice manager. Staff commented that they felt appreciated by the management team and appreciated the responsibilities given to them within their roles.

The principal dentists described an open door policy in place in the practice which meant that all staff were able to approach them with clinical or non-clinical matters.

The practice had a duty of candour statement which was displayed in the waiting room. This indicated the practice's expectations of staff to be open and honest.

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, including the

contact details of outside agencies where a staff member could obtain independent advice. The policy was dated January 2016 and was available for staff to reference in the policy folder.

### Learning and improvement

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

Clinical audits were used to identify areas of practice which could be improved. Infection control audits had been carried out at six monthly intervals in line with the recommendations of The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' published by the Department of Health. They had generated action plans for improvement.

Clinical audit on the quality of X-rays taken had been completed most recently in December 2016. This indicated some results which were out of range from the National Radiological Protection Board's Guidance Notes for Dental Practitioner's expected results. We discussed this with the principal dentists who were aware of the results and the fact that they were not in keeping with results from previous audit. They planned to address this by immediately re-auditing to confirm the accuracy of the results and identifying any reasons for the results.

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

The practice had made an online training facility available to all staff to assist with training. This training could be delivered individually or in groups.

The practice had plans in place to implement appraisals from January 2017, as part of this annual process CPD would be checked so that the management team kept oversight of any training needs of staff.

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

The practice sought feedback for patients and staff through various sources. They invited comment through the NHS friends and family test and the results of this was reviewed by the principal dentists and fed back to staff through the staff meetings.

## Are services well-led?

Staff indicated several examples of where suggestions and feedback had been taken on board by the management team including staggering the lunch times so that patients were always able to speak to someone and introducing a new clinical system for completing root canal treatment.