Petrie Tucker and Partners Limited

The Anchor Dental Centre

Inspection Report

The Oaktree centre
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Overall summary

We carried out an announced comprehensive inspection on 10 February 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

The Anchor Dental Centre provides primary dental care and treatment to patients whose care is funded through the NHS and to a small number of patients who pay privately. The service is part of Petrie Tucker and Partners Limited, owned by a large provider of dental care, Mydentist. At the time of the inspection, the practice employed two dentists, four dental nurses, two trainee dental nurses (one yet to commence training who also worked as a receptionist), a practice manager and a receptionist. The practice opens 9 am to 5pm Monday to Friday and alternate Saturdays by appointment with a dental hygienist.

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

We received feedback from nine patients either in person or on CQC comments cards from patients who had visited the practice in the two weeks before our inspection. The cards were all positive and commented about the caring

Summary of findings

and helpful attitude of the staff. Patients told us they were happy with the care and treatment they had received. Two patients raised concern about a lack of continuity of their treatment due to staff changes.

Our key findings were:

- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice appeared clean and well maintained.
- Staff received training and development and were appropriately supervised.
- Patients told us they were able to get an appointment when they needed one and the staff were kind and helpful.
- Governance arrangements were in place for the smooth running of the practice. This included the completion of regular audits to help monitor the quality and safety of the service.

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

- Review the practice's policy for the identification of incidents and significant events so that related issues can be reviewed or improved.
- Review the practice's decontamination procedures in relation to manual cleaning of dental instruments and testing of the ultrasonic cleaning bath giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice' on the prevention and control of infections and related guidance.
- Review the relevant guidelines issued by the National Institute for Health and Care Excellence (NICE) and support staff to remain familiar with them. Update to the current Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention.
- Review the records kept of the complaint handling process, the response provided to the patient, the learning identified and actions taken by staff.
- Review the availability of an interpreter service for patients who do not speak English as their first language and the availability of practice information in key alternative languages.
- Review the system used to share audit outcomes with staff

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 appropriate systems in place to manage the service in a safe way. This included investigating and taking action following any accidents and complaints. Incidents had been well managed, however there was no process for identifying these as significant events that caused a risk to the service to ensure that learning was maximised. Staff had received relevant training and were suitably skilled to meet patient's needs. Safeguarding procedures were in place and staff were able to demonstrate knowledge of the training they had received. The practice followed national guidelines for X-rays and the management of radiation equipment. Staff also followed national guidelines for infection control although the practice needed to review some aspects of the decontamination process to ensure that any risks to the spread of infection were always robustly managed. Regular checks and maintenance of equipment ensured that all items were safe and fit for use.

Are services effective?

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

Consultations were carried out in line with best practice guidance from the National Institute for Health and Care Excellence (NICE). Patients received a comprehensive assessment of their dental needs that included an assessment of their medical history. Explanations were given to patients in a way they understood. Risks, benefits, options and costs were explained. The staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

Are services caring?

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

Staff treated patients with dignity and respect and ensured their privacy was maintained. Patient information and data was handled confidentially. We received feedback from nine patients who used the service. They commented on the friendliness and helpfulness of the staff and dentists and said they were good at explaining their treatment and the costs of this.

Are services responsive to people's needs?

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

Appointment times met the needs of patients and waiting times were kept to a minimum. Patients could access treatment and urgent and emergency care when required. We found the practice had a high number of patients who did not speak English as their first language. Many had a limited understanding of the English language but there was no interpreting service available. Information was available to patients although this was not available in the key alternative languages used by the local population. The practice had three ground floor treatment rooms and level access into the building for patients with mobility difficulties and families with prams and pushchairs.

Are services well-led?

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

Summary of findings

The practice manager and other staff had an open approach to their work and shared a commitment to continually improving the service they provided. Governance procedures were in place and policies and procedures were regularly updated. A system of quality monitoring checks was well established and action was taken when improvements were identified. Staff told us that they felt well supported and could raise any concerns with the practice manager. All the staff we met said that the practice was a good place to work.

The Anchor 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.

This inspection took place on 10 February 2016 and was led by a CQC Inspector who was supported by a specialist advisor. Before the inspection, we asked the practice to send us some information that we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, and the details of their staff members including proof of registration with their professional bodies.

We informed NHS England area team that we were inspecting the practice; however, we did not receive any information of concern from them.

During the inspection, we spoke with the practice manager, dentists, the dental nurses, reception staff and reviewed policies, procedures and other documents. We also obtained the views of nine patients either on the day of the inspection or through comment cards that we had provided for patients to complete two weeks before the inspection took place.

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 process in place for reporting and recording any accidents. Staff were able to access and complete accident forms, which were investigated by the practice manager and shared with the management team at head office. The last accident had been reported in 2014 and records demonstrated that appropriate checks were completed and there were no further actions necessary. The practice manager described a good awareness of RIDDOR (The reporting of injuries diseases and dangerous occurrences regulations) and knew when to report any of these injuries.

Other incidents or significant events were reported electronically to the management team at head office. There was no policy to support this or help staff identify when it was appropriate to do so. The manager told us no incidents had occurred to interrupt day to day activity or put the safety of staff, patients or visitors at risk.

The practice received national patient safety alerts such as those issued by the Medicines and Healthcare products Regulatory Authority (MHRA) by email. The practice manager received the alerts, cascaded them to her team and ensured they had been received. Relevant alerts were discussed during staff meetings to facilitate shared learning.

The practice manager understood the principles of the duty of candour and we saw that patients had received an apology when they experienced a poor service. For example when a patient had experienced several cancelled appointments due to the limited availability of dentists.

Reliable safety systems and processes (including safeguarding)

The practice had a clear policy to guide staff in the management of sharp instruments and this was displayed in each treatment room. Staff were able to explain that the treatment of sharps and sharps waste was in accordance with the current EU Directive with respect to safe sharps guidelines, thus helping to protect staff from blood borne diseases. The practice used a system whereby needles were not manually resheathed by hand following administration of a local anaesthetic to a patient. If a needlestick injury were to occur, staff knew the correct action to take. There had been no sharps injuries to staff in the last two years.

We found that staff were knowledgeable about safeguarding issues and knew how to report any concerns they may have in relation to children or vulnerable adults. Staff had completed appropriate training and there was a named lead for safeguarding to advise staff and liaise with outside agencies. Information on the reporting process was visible and accessible to staff. No referrals had been made.

We spoke with a dentist who explained that root canal treatment was carried out using a rubber dam where practically possible. 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. This was also confirmed when we spoke to other staff and supported that they followed appropriate guidance issued by the British Endodontic Society.

Medical emergencies

Staff had access to two emergency medical kits that contained an automated external defibrillator (AED) in line with current guidance. An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. Staff received annual training in managing medical emergencies and completed in-house emergency drills to practice their skills. The practice held emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The expiry dates of medicines and equipment were monitored by the practice using a monthly check sheet, and replaced when items was close to their use by date. The items we checked were all in date. The practice had access to oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines.

Staff recruitment

The practice had a recruitment policy that detailed the checks required to be undertaken before a person started work. For example, proof of identity, a full employment history, evidence of relevant qualifications, adequate medical indemnity cover, immunisation status and

Are services safe?

references. The systems and processes we saw were in line with the information required by Regulation 18, Schedule 3 of Health & Social Care Act 2008 (Regulated Activities) Regulations 2015. We saw three staff recruitment records and found these were all in order with the exception of one member of staff whose file did not contain evidence that their immunity for Hepatitis B had been completed. The practice manager agreed to follow this up. All qualified dentists and dental nurses were registered with the General Dental Council. We saw that all staff had received appropriate checks from the Disclosure and Baring Service (DBS). These are checks to 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.

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies. We found the practice had completed a fire risk assessment in 2015 and most actions had been completed with the exception of the replacement of an extension cable which was planned. Fire marshals had been appointed, staff had received training and fire safety signs were clearly displayed. Records demonstrated that fire safety equipment was regularly serviced and staff were able to describe the action they should take in the event of a fire.

The practice had a health and safety risk management process in place which enabled them to assess, mitigate and monitor risks to patients, staff and visitors to the practice. This included regular systems to check the safety of clinical and electrical equipment and arrangements to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a business continuity plan in place.

Infection control

There were effective systems in place to reduce the risk and spread of infection. An infection control policy was available for staff reference and other infection control manuals were also available to them. The practice manager had completed audits of infection control processes in July 2015 (score of 98%) and February 2016 (score of 91%) to confirm compliance with HTM 01 05 guidelines. We asked why the February 2016 compliance level had a lower score. The practice manager told us they had been inaccurate in her previous judgement. Actions were being taken to address the identified issues.

We saw that the three dental treatment rooms, waiting area, reception and toilets were clean and tidy although some treatment room work surfaces were cluttered which could prevent effective cleaning. Clear zoning of clean and dirty areas was apparent in all treatment rooms and appropriate hand washing facilities were available in each of the treatment rooms. Personal protective equipment was available and routinely used by staff in each treatment room. Staff were clearly aware which dental instruments were single use and which required cleaning and decontamination in between each use.

We examined the facilities for cleaning and decontaminating dental instruments. The practice had a dedicated decontamination room that was set out according to the Department of Health's guidance, Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices. The lead dental nurse showed us how reusable instruments were decontaminated. There were separate zones for clean and dirty instruments to prevent cross contamination of instruments and staff wore appropriate personal protective equipment (including heavy duty gloves and a mask) during the decontamination process.

Dirty instruments were manually scrubbed, inspected, then placed in an ultrasonic bath to complete the cleaning process. We found that staff were not taking the temperature of the water used for manual scrubs although a thermometer was available for this purpose. Following a scrub, instruments were rinsed under running tap water instead of being submerged into clean water. After cleaning, staff placed instruments in an autoclave. This is a device for sterilising dental and medical instruments. Once sterilised, instruments were placed in pouches and dated to indicate when they should be reprocessed if left unused in line with current guidelines.

We found daily, weekly and monthly tests were performed to check that the decontamination equipment was working efficiently and correctly maintained. Records were kept of the results to support this.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria. (Legionella is a

Are services safe?

term for particular bacteria which can contaminate water systems in buildings). Staff described the method they used which was in line with current HTM 01 05 guidelines. We found that dip slide tests were not yet implemented although testing kits had just been purchased to rectify this. The practice had completed their own Legionella risk assessment and also held a copy of the Legionella risk assessment for the building, completed by the landlords. The buildings risk assessment had identified some risks to the main water tank and the practice manager did not know what actions had been taken to follow this up. Action was taken by the practice manager following the inspection to seek further assurance about this from the landlords.

The practice had three autoclaves although one was waiting for repair at the time of the inspection. We were shown the systems in place to ensure that the autoclaves used in the decontamination process were working effectively. It was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were always complete and up to date. However the log book for the ultrasonic cleaning bath showed that regular tests were not being completed to check it was working effectively.

The segregation and storage of clinical 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 stored in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. Waste consignment notices were available for inspection.

General cleaning was completed by a contracted cleaner who was responsible for all of the services within the building through the landlord. Dental nurses were responsible for ensuring that work surfaces, including the dental chairs, were cleaned effectively in between patients.

Equipment and medicines

There were systems in place to check equipment had been serviced regularly and in accordance with the manufacturers instructions. Items included the dental air compressor, autoclaves, fire fighting equipment, oxygen cylinders and the X-ray equipment. We were shown the annual servicing certificates.

An effective system was in place for the prescribing, dispensing, use and stock control of the medicines used in clinical practice such as antibiotics and local anaesthetics. The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored securely for the protection of patients. We found that the practice stored prescription pads securely.

Radiography (X-rays)

The practice had a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for each X-ray set along with the three yearly maintenance logs and a copy of the local rules. The maintenance logs were within the current recommended interval of three years.

We saw that radiographic audits were completed regularly and actions were taken in response to any findings. Dental care records included information when X-rays had been taken, how these were justified, reported on and quality assured. This showed the practice was acting in accordance with national radiological guidelines to protect both patients and staff from unnecessary exposure to radiation. Training records showed all staff where appropriate, had received training for core radiological knowledge under IRMER 2000.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice carried out dental assessments and treatment in line with recognised general professional guidelines. The assessment commenced following the patient completing a questionnaire about their medical history, current health, medication being taken and any allergies. The information was reviewed at appropriate intervals to ensure that any potential health issues were considered as part of their dental assessment and treatment plan. Dentists then completed an assessment that included 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, whether it had changed since the last appointment and any recommended treatments options were discussed.

The dentists followed the guidance from the Faculty of General Dental Practice before taking X-rays to ensure they were required and necessary to help a diagnosis and treatment plan. Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included smoking cessation advice, alcohol consumption guidance and dietary advice and general dental hygiene procedures such as prescribing dental fluoride treatments. The patient notes were updated with the proposed treatment after discussing options with the patient. Patients were monitored through follow-up appointments and these were scheduled in line with National Institute for Health and Care Excellence (NICE) recommendations. However when we spoke with dental staff and asked them about the NICE guidelines for dentistry, they were unable to describe what guidelines they followed without being prompted.

Patients requiring specialised treatment such as conscious sedation were referred to other dental specialists. Their treatment was then monitored after being referred back to the practice once it had taken place to ensure they received a satisfactory outcome and all necessary post procedure care.

Patients spoken with and comments received on CQC comment cards reflected that patients were satisfied with the assessments, information they received and the quality of the dental care they received.

Health promotion & prevention

The practice promoted the maintenance of good oral health as part of their overall philosophy and had considered the Department of Health publication 'Delivering Better Oral Health; a toolkit for prevention' when providing preventive oral health care and advice to patients. However we noted the latest edition of the toolkit was not available. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Adults and children were provided with advice on the steps to take to maintain healthy teeth and correct tooth brushing techniques.Patients could be referred to a dental hygienist although at the time of the inspection, the practice had a waiting list for this. Dental care records we observed demonstrated that dentists had given oral health advice to patients. The waiting room and reception area contained leaflets that explained the services offered at the practice. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area

Staffing

The practice employed two dentists at the time of the inspection and had been carrying a vacancy for a dentist for some time. A new dentist had been appointed and was due to commence employment in a few weeks time. The practice manager also had responsibility for another dental practice and shared her time between the two practices. There were three trained dental nurses, one nurse awaiting her registration with the GDC and two trainee dental nurses who also supported the receptionist. Appointments with a dental hygienist were available for patients on alternate Saturdays.

Planned staff leave could be covered with support from another local practice who shared the same practice manager. If this was not possible agency staff were employed. We saw the practice used a clear induction process for agency staff.

There was a system in place to monitor staff training and we found evidence of this in their staff files. There was a head office based training academy and we saw records that showed staff completed core training through elearning as well as in person. This included areas such as responding to medical emergencies.

There was an appraisal system in place and the staff received six monthly appraisals and a personal

Are services effective?

(for example, treatment is effective)

development plan that identified training and development needs. Staff told us their appraisal was helpful and they felt well supported by the practice manager. A clinical manager for the area completed the dentists' appraisals.

Working with other services

When required, patients were referred to other dental specialists for assessment and treatment. The practice had a system in place for referring and recording patients for dental treatment and specialist procedures such as orthodontics, oral surgery and sedation. This ensured that patients' needs were followed up appropriately after their treatment and dental records were updated.

The dentists we spoke with told us they completed a referral following discussion with the patient so that informed choices could be made where possible. Staff told us the care and treatment required was fully explained to the patient and referrals were completed promptly.

Consent to care and treatment

The practice ensured valid consent from patients was obtained for all care and treatment. Staff confirmed individual treatment options, risks and benefits were discussed with each patient who then received a detailed treatment plan and estimate of costs. Patients were given time to consider and make informed decisions about which option they wanted and this was recorded in their dental care records. They told us that patients with limited English language skills, who were unable to understand details of their dental needs, would not be treated as they would not be able to provide informed consent. In this situation patients were signposted to other local services who could help.

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. The dentists we spoke with demonstrated an understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment. This included assessing a patient's capacity to consent and when making decisions in a patient's best interests. They were also familiar with the Gillick principles to help them judge when children and young people were able to make their own decisions about their treatment. Staff told us that children sometimes interpreted information for their parents or younger siblings who were having treatment because there were no interpreting services available.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The practice took care to maintain patients personal information. Treatment rooms were situated away from the main waiting areas and we saw that doors were closed at all times when patients were with the dentists. Patients' clinical records were stored electronically and in paper form. Computers were password protected and regularly backed up to secure storage with paper records stored in lockable records storage cabinet. Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception.Staff explained how they ensured information about patients using the service was kept confidential particularly at the reception desk. When a patient required a confidential discussion about their care or treatment staff ensured these took place in a treatment room or office where information could not be overheard. On the day of our inspection, we observed staff being polite, friendly and welcoming to patients.

We received five CQC comments cards completed by patients during two weeks leading up to the inspection. The cards gave positive comments about the caring and helpful attitude of the staff and patients told us they were happy with the care and treatment they had received. We spoke with four patients in the waiting area who supported these views.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. Patients we spoke with confirmed they received a good level of information about their care and treatment. We also saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them.

A poster detailing NHS and private treatment costs was displayed in the waiting area. The practice website also gave details of the cost of treatment and entitlements under NHS regulations.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice waiting area displayed information including how to book online appointments, access a dentist outside of normal working hours and information about cosmetic treatments that were also available.There were details about the complaints process, the cancellation policy and reference to information about oral healthcare for children. We noted there were no health promotion information leaflets in the waiting room that related to adult dental care.

We observed that the appointment diaries were not overbooked and that this provided capacity each day for patients with dental pain who required urgent appointments. The practice had been operating with two, instead of three dentists since February 2015. They had used some locum cover but this was not ideal for patients and had caused a lack of continuity. Two patients raised concern about a lack of continuity of their treatment due to staff changes. A new dentist had been recruited and was due to commence employment in the near future. This meant the practice could provide a more responsive service to their patients. In the meantime, when the practice did not have further capacity to meet the demand for urgent appointments, patients were advised to attend the local dental access service or they were offered a next day appointment if this was available.

The dentists decided how long a patient's appointments needed to be and took into account any special circumstances such as whether a patient was very nervous, had a disability and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice was situated within a purpose built NHS community health building that was very accessible to patients with disabilities. There were accessible toilets and baby change facilities. A high proportion of patients spoke limited English and staff told us this caused some difficulty with communication as they did not have access to a translation service. There was no general information about the practice available in alternative languages.

The staff explained they would also help patients to complete NHS and other forms if they were partially sighted or hard of hearing.

Access to the service

The practice was open 9am – 5pm Monday to Friday and on alternate Saturday mornings (for the dental hygienist only)**.** The practice used the NHS 111 service to give advice in case of a dental emergency when the practice was closed. This information was publicised in the practice information leaflet, practice website and on the telephone answering machine when the practice was closed.

Concerns & complaints

The practice had a complaints policy and a procedure that set out how complaints would be addressed and the timeframes for responding. Information for patients about how to make a complaint was seen in the patient leaflet, a poster in the waiting area and information on the patient website. Staff told us they adopted a proactive response to any patient concern or complaint to seek a resolution as soon as practically possible. Some complaints were received and dealt with by the patient support team at head office. All complaints were shared with the practice manager who invesitgated issues when it was relevant to do so and communicated the outcome to the patient support team.

The practice had received eight complaints in the last year and we reviewed the records of these. We found the complaints were summarised and action had been taken appropriately. However, it was not clear from the records kept whether the complaints policy had been followed in terms of timeliness. It was not always clear what corresondence or information had been provided to the patient or when learning or improvements had taken place as a result of the complaint.

Are services well-led?

Our findings

Governance arrangements

It was the responsibility of the practice manager to lead on governance and quality monitoring issues. The practice shared business support services and policies issued by the provider which aimed to support a common approach. A range of policies and procedures were in use at the practice. These included health and safety, infection prevention and control, patient confidentiality and recruitment. Staff we spoke with were aware of the policies, had easy access to them and could demonstrate knowledge of the policies used to support their practice. A staff bulletin was published weekly by the provider and this included clinical and administrative updates for staff. Monthly practice meetings had been established and these followed a meetings template to include issues such as patient feedback, health and safety and complaints. The practice manager told us she planned to introduce infection control meetings for the dental nurses to enable a clear focus on updating practice and improving quality.

Systems were in place to ensure the safety of the environment and of equipment such as machinery used in the decontamination process and fire safety equipment. Risk assessments were in place although some centrally held risk assessments had not been updated. Records we reviewed demonstrated that regular audits took place for infection control, radiography and dental care records. The practice manager gave feedback to individual staff in relation to performance and although we did not see evidence that the general findings were shared at team meetings.

Leadership, openness and transparency

There was a clear leadership structure in place and staff understood their roles and responsibilities within the practice. For example there was a lead dental nurse who had overall responsibility for the practice when the manager was not on site, fire marshals, first aiders and a safeguarding lead. The practice manager set standards and ensured they were maintained.

Staff we spoke with told us that they worked well as a team and they were supported to raise any issues about the safety and quality of the service and share their learning. We were told that there was a no blame culture at the practice and that the delivery of high quality care was a high priority. Through our discussions with the dentists and nurses we found that staff adopted a holistic approach to patient care with an emphasis on the prevention of dental problems. We found staff were hard working, caring and committed to the work they did. All staff knew how to raise any issues or concerns and were confident that action would be taken by the practice manager without fear of discrimination.

Learning and improvement

Systems were in place to identify staff learning needs through an appraisal system and staff were supported to develop their knowledge and skills by accessing a range of training. Annual core training programmes were available to staff online through the provider. The dentists also received performance reviews with the provider's clinical lead for the area. This ensured that staff registered with the General Dental Council, maintained the requirement to keep up to date.

We found there were a number of clinical and non-clinical audits taking place at the practice. These included clinical record keeping, oral cancer risk factors, infection control, prescribing audits and X-ray quality audits. There was evidence of repeat audits at appropriate intervals and these reflected standards and improvements were being addressed. For example infection control audits were undertaken every six months and X-ray audits were carried out in accordance with current guidelines.

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

The practice gathered feedback from patients through patient surveys, feedback cards in the waiting areas, compliments and complaints. The data for the survey was checked by the practice manager and any relevant comments were shared with staff at the practice meetings. The manager told us there was no formal process to interpret the survey outcomes as they did not generate detailed information. The practice could not give any clear examples of improvements made to services but could demonstrate that all feedback was reviewed. All of the staff told us they felt included in the running of the practice and the practice manager listened to their opinions and respected their knowledge and input at meetings. Staff told

Are services well-led?

us they felt valued and were proud to be part of the team. The results of the NHS Family and Friends Test showed that patients were either highly likely or likely to recommend the service to family and friends.