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Dee Kay Dental

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 5 May 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

Dee Kay Dental is situated in Kirton Lindsey, Lincolnshire. It offers mainly NHS treatment to patients of all ages but also offers private dental treatments. The services include preventative advice and treatment and routine restorative dental care.

The practice has two surgeries, a decontamination room, a waiting area and a reception area. All facilities were located on the ground floor. There were accessible toilet facilities on the ground floor of the premises.

There was one dentist, a dental hygiene therapist, three dental nurses, one receptionist and a cleaner.

The opening hours are Monday and Tuesday from 9-00am to 5-30pm and Wednesday to Friday from 9-00am to 5-00pm.

The practice owner is registered with the Care Quality Commission (CQC) as an individual. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

During the inspection we spoke with seven patients who used the service and reviewed 26 completed CQC comment cards. The patients were positive about the care and treatment they received at the practice.

Summary of findings

Comments included that the practice was very clean and that staff were polite, helpful, friendly and professional. Patients also commented that they were given very clear explanations about treatment.

Our key findings were:

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

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

- Review the practice's protocol for the storage of dental burs, endodontics files and local anaesthetics.
- Review the procedures in relation to the OPT machine and X-ray machine in the store room and decommission the units if not being used.
- Review the practice's protocols for documenting when risks and benefits have been discussed and also the rationale for particular course of treatment.

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.

There was an effective system in place for reporting of incidents and accidents. These were followed up, analysed and learning was disseminated.

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

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

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

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

Are services effective?

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

Staff were encouraged to complete training relevant to their roles and this was monitored by one of the dental nurses. The clinical staff were up to date with their continuing professional development (CPD).

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

Are services caring?

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

During the inspection we spoke with seven patients who used the service and reviewed 26 completed CQC comment cards. Patients commented that staff were polite, helpful, friendly and professional.

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

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

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

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 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 in a wheelchair or with limited mobility to access treatment.

Are services well-led?

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

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

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

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

They conducted patient satisfaction surveys, were currently undertaking the NHS Friends and Family Test (FFT) and there was a comments box in the waiting room for patients to make suggestions to the practice.

Dee Kay Dental

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 registered provider 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 that we were inspecting the practice; however we did not receive any information of concern from them.

During the inspection we spoke with seven patients who used the service and reviewed 26 completed CQC comment cards. We also spoke with the dentist (the practice owner) and two dental nurses. To assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had clear guidance for staff about how to report incidents and accidents. Staff described an incident which had occurred in the last year and this had been well documented, investigated and reflected upon by the dental practice. We spoke with the patient who was involved in the incident and they told us that they were very happy with how it was dealt with. It was evident that the practice embraced the ethos of significant event analysis in order to continuously improve their service. Any accidents or incidents would be reported to the practice owner and would also be discussed at staff meetings in order to disseminate learning and aim to prevent the incident from occurring again.

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 received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) that affected the dental profession. These were actioned if necessary and were the stored for future reference.

Reliable safety systems and processes (including safeguarding)

The practice had child and vulnerable adult safeguarding policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff. Staff had access to contact details for both child protection and adult safeguarding teams. The practice owner was the safeguarding lead for the practice and all staff had undertaken level two safeguarding training.

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

Rubber dam (this is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth) was used in root canal treatment in line with guidance from the British Endodontic Society.

We saw that patients' clinical records were computerised and password protected to keep people safe and protect them from abuse. Any paper documentation relating to the dental care records were locked away in secure cabinets when the practice was closed.

Medical emergencies

The practice had procedures in place which provided staff with clear guidance about how to deal with medical emergencies. This was in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). Staff were knowledgeable about what to do in a medical emergency and had completed training in emergency resuscitation and basic life support within the last 12 months.

The emergency resuscitation kits and oxygen were stored in the store room and the emergency medicines were stored in one of the surgeries. Staff knew where the emergency kits were kept. The practice had an Automated External Defibrillator (AED). An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Staff had received training in the use of the AED.

Records showed regular checks were carried out on the oxygen cylinder, AED and the emergency drugs. These checks ensured that the oxygen cylinder was full, the AED was fully charged and the emergency medicines were in date.

Staff recruitment

The practice had a policy and a set of procedures for the safe recruitment of staff which included seeking references, proof of identity, checking relevant qualifications and professional registration. We reviewed a sample of recruitment files and found the recruitment procedure had been followed. We were told that they carried out Disclosure and Barring Service (DBS) checks for all newly employed staff. These checks identify whether a person has a criminal record or is on an official list of people barred

from working in roles where they may have contact with children or adults who may be vulnerable. We reviewed records of staff recruitment and these showed that all checks were in place.

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

Monitoring health & safety and responding to risks

A health and safety policy and risk assessment was in place at the practice. This identified the risks to patients and staff who attended the practice. The risks had been identified and control measures put in place to reduce them. We saw that one of the dental nurses had carried out a health and safety self-assessment audit. This included checks for slips, trips and falls, whether there was adequate ventilation and checks of computer monitor screens. This audit was carried out on an annual basis.

There were policies and procedures in place to manage risks at the practice. These included infection prevention and control, fire evacuation procedures and risks associated with Hepatitis B. We saw that one of the dental nurses conducted regular fire checks to ensure that any risks were appropriately managed. They also conducted bi-annual fire drills.

The practice maintained a file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including substances such as disinfectants, and dental materials in use in the practice. The practice identified how they managed hazardous substances in its health and safety and infection control policies and in specific guidelines for staff, for example in its blood spillage and waste disposal procedures. The COSHH folder was reviewed every year by one of the dental nurses to check whether any new hazards had been identified for the substances included in the folder. Any new materials or substances would be added to the COSHH folder and staff would be made aware of any particular precautions associated with it.

Infection control

There was an infection control policy and procedures to keep patients safe. These included hand hygiene, safe handling of instruments, managing waste products and decontamination guidance. The practice followed the guidance about decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 -Decontamination in primary care dental practices (HTM 01-05)'. One of the dental nurses was the infection control lead.

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

We observed the treatment rooms and the decontamination room to be clean and hygienic. Work surfaces were free from clutter. Staff told us they cleaned the treatment areas and surfaces between each patient and at the end of the morning and afternoon sessions to help maintain infection control standards. There was a cleaning schedule which identified and monitored areas to be cleaned. We noted that dental burs and root canal files were stored in the surgery unbagged. HTM 01-05 states that any instruments which are stored in the surgery unbagged should be re-sterilised after one day. This was brought to the attention of the practice owner and we were told that this would be actioned.

There were hand washing facilities in the treatment rooms and staff had access to supplies of personal protective equipment (PPE) for patients and staff members. Posters promoting good hand hygiene and the decontamination procedures were clearly displayed to support staff in following practice procedures. Sharps bins were appropriately located, signed and dated and not overfilled. We observed waste was separated into safe containers for disposal by a registered waste carrier and appropriate documentation retained.

Decontamination procedures were carried out in a dedicated decontamination room in accordance with HTM 01-05 guidance. An instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which minimised the risk of the spread of infection.

One of the dental nurses showed us the procedures involved in disinfecting, inspecting and sterilising dirty instruments; packaging and storing clean instruments. The practice routinely used a washer disinfector to clean the used instruments, examined them visually with an

Are services safe?

illuminated magnifying glass, and then sterilised them in a validated autoclave (a device for sterilising dental and medical instruments). The decontamination room had clearly defined dirty and clean zones in operation to reduce the risk of cross contamination. Staff wore appropriate PPE during the process and these included disposable gloves, aprons and protective eye wear.

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

The practice had been carrying out an Infection Prevention Society (IPS) self- assessment audit every six months relating to the Department of Health's guidance on decontamination in dental services (HTM01-05).This is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. The audit showed the practice was meeting the required standards. We saw that an action plan had been identified and actioned.

Records showed a risk assessment process for Legionella had been carried out in December 2014(Legionella is a term for particular bacteria which can contaminate water systems in buildings). The practice undertook processes to reduce the likelihood of legionella developing which included monitoring cold and hot water temperatures each month and the use of a water conditioning agent in the water lines. The practice used a special piece of equipment which purged the dental unit water lines running the water lines at the beginning and end of each session and between patients.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as X-ray sets, the autoclave and the washer disinfector and the compressor. One of the dental nurses maintained a comprehensive list of all equipment including dates when each piece of equipment required servicing. We saw evidence of validation of the autoclave and the washer disinfector. The practice had had a new compressor fitted in the last year and we saw the appropriate documentation related to the installation.

Portable appliance testing (PAT) had been completed in December 2015 (PAT confirms that portable electrical appliances are routinely checked for safety). One of the dental nurses also conducted bi-annual electrical checks to ensure that the electrical equipment appeared safe to use.

Prescriptions were stamped only at the point of issue and were kept locked away when not needed to ensure their safe use.

Radiography (X-rays)

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

There was an Orthopantomogram (OPG) machine (a panoramic scanning dental X-ray of the upper and lower jaw) and an X-ray machine in a store room. We were told that these were not used. They had not been formally decommissioned. We advised the practice owner to get these machines decommissioned.

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

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

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

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

Records showed patients were generally made aware of the condition of their oral health and whether it had changed since the last appointment. We saw in a dental care record that there was no documentation about why a particular treatment was not done. This was brought to the dentist and we were told that more details about the rationale for treatment would be documented.

Medical history checks were updated by each patient every time they attended for treatment and entered in to their electronic dental care record. This included an update on their health conditions, current medicines being taken and whether they had any allergies.

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

Health promotion & prevention

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

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

The medical history form patients completed included questions about smoking and alcohol consumption. We were told by the dentist and saw in dental care records that smoking cessation advice was given to patients where appropriate. Patients were made aware of the effects of smoking and alcohol with regards to oral cancer.

The practice website provided details about the adverse effects of sugar on oral health and why visiting the dental hygienist is important. There were also health promotion leaflets including smoking cessation advice available in the waiting room to support patients.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. The induction process included getting the new member of staff aware of the location of emergency medicines and arrangements for fire evacuation procedures. We saw evidence of completed induction checklists in the recruitment files.

Staff told us they had good access to on-going training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). The practice organised in house training for medical emergencies to help staff keep up to date with current guidance on treatment of medical emergencies in the dental environment. Records showed professional registration with the GDC was up to date for all staff and we saw evidence of on-going CPD.

The practice used a dental hygiene therapist. Dental hygiene therapists are trained dental care professionals who are qualified to undertake certain treatments, for

Are services effective?

(for example, treatment is effective)

example, fillings, periodontal treatments and the extraction of deciduous teeth. The dentist would refer patients for such treatments to the dental hygiene therapist. This allowed the dentist to focus on more advanced or complicated treatments.

Staff told us they had annual appraisals and training requirements were discussed at these. We saw evidence of completed appraisal documents.

Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. For example, referrals were made to hospitals and specialist dental services for further investigations or specialist treatment including orthodontics, oral surgery and sedation.

The dentist first discussed the patient the reason for the referral and gained consent for the referral to be made. They would then complete a detailed proforma or referral letter to ensure the specialist service had all the relevant information required. A copy of the referral letter was kept in the patient's dental care records. Letters received back relating to the referral were first seen by the referring dentist to see if any action was required and then stored in the patient's dental care records.

The practice had a procedure for the referral of a suspected malignancy. This involved a telephone call to the hospital which was followed up by a referral letter.

Consent to care and treatment

Patients were given appropriate information to support them to make decisions about the treatment they received. The dentist was knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent. The dentist described to us how valid consent was obtained for all care and treatment and the role family members and carers might have in supporting the patient to understand and make decisions.

Staff had received training and had an understanding of the principles of the Mental Capacity Act (MCA) 2005 and how it was relevant to ensuring patients had the capacity to consent to their dental treatment. Staff were due to have a refresher course relating to the MCA.

The dentist ensured patients gave their consent before treatment began and this was recorded in the dental care records. We were told that individual treatment options, risks, benefits and costs were discussed with each patient. A treatment plan was signed by patients which included details of the proposed treatment and the associated costs. Details of the risks and benefits of each treatment option proposed by the dentist were not clear in the dental care records. This was brought to the attention of the dentist and we were told that these would now be documented.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

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

We observed privacy and confidentiality were maintained for patients who used the service on the day of inspection. The reception area and waiting area were conducive for maintain confidentiality as the waiting area was large and a reasonable distance from the reception desk. Dental care records were not visible to the public on the reception desk. We observed staff to be helpful, discreet and respectful to patients. Staff were aware that no personal details should be discussed at the reception desk to ensure the dignity of patients. Staff told us that if a patient wished to speak in private, an empty room would be found to speak with them.

The dentist described to us how they dealt with nervous patients. This included spending more time with them and talking through what to expect during the treatment. They also told us that the nurses were very good at helping to deal with nervous patients as they would offer support and hold their hand during treatment.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients commented they felt involved in their treatment and it was fully explained to them. Staff described to us how they involved patients' relatives or carers when required and ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood. For example the dentist told us that they would use animation son the computer to assist in describing treatments to patients and use models to describe crowns and bridges.

Patients were also informed of the range of treatments available in leaflets in the waiting room and on the practice website. These included details about crowns, veneers, root canal treatment and gum disease.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

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

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

Tackling inequity and promoting equality

The practice had equality and diversity, and disability policies to support staff in understanding and meeting the needs of patients. Reasonable adjustments had been made to the premises to accommodate patients with mobility difficulties. These included step free access to the building and an accessible toilet. The ground floor surgeries were large enough to accommodate a wheelchair or a pram. An audit had been completed to check whether the practice was compliant with the Disability Discrimination Act 2005.

Access to the service

The practice displayed its opening hours in the premises and on the practice website. The opening hours are Monday and Tuesday from 9-00am to 5-30pm and Wednesday to Friday from 9-00am to 5-00pm.

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

Concerns & complaints

The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. There were details of how patients could make a complaint displayed in the waiting room and in the practice information leaflet. One of the dental nurses was the complaints manager and was responsible for dealing with complaints when they arose. Staff told us they raised any formal or informal comments or concerns with the complaints manager to ensure responses were made in a timely manner. We reviewed complaints which had been received in the past 12 months and found that they had been responded to in line with the practices policy.

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

Are services well-led?

Our findings

Governance arrangements

The practice owner was in charge of the day to day running of the service. They were well supported by the two qualified dental nurses.

There was a range of policies and procedures in use at the practice. We saw they had systems in place to monitor the quality of the service and to make improvements. The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately.

The practice had an effective approach for identifying where quality or safety was being affected and addressing any issues**.** Health and safety and risk management policies were in place and we saw a risk management process to ensure the safety of patients and staff members. For example, we saw risk assessments relating to fire safety, the use of equipment and infection control.

There was an effective management structure in place to ensure that responsibilities of staff were clear. We saw that within each of the staff's files that there was a list of duties which they had been delegated. It was clear that the practice owner effectively delegated work to members of staff to ensure tasks were completed.

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 confident to raise any issues at any time. There was a whistleblowing policy which included details of external organisations to contact if the member of staff did not feel confident to raise the issue within the practice.

The practice held monthly staff meetings. These meetings were minuted for those who were unable to attend. During these staff meetings topics such as training requirements, waiting times, significant events and complaints, comments and compliments were discussed.

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. One of the dental nurses was responsible for the audit processes. This included audits such as dental care records, X-rays, hand hygiene, waiting times, health and safety and infection control. We looked at the audits and saw that the practice was performing well. However, where improvements could be made these were identified and followed up by a repeat audit. We saw evidence that as a result of a dental care record audit that improvements had been made.

Staff told us they had access to training and this was monitored by one of the dental nurses to ensure essential training was completed each year; 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.

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

The practice had systems in place to involve, seek and act upon feedback from people using the service including carrying out annual patient satisfaction surveys and a comment box in the waiting room. The satisfaction survey included questions about the friendliness of the staff, how easy it was to contact the practice, whether the dentist listened to their concerns and whether they were aware of the out of hours emergency arrangements. The most recent patient survey showed a high level of satisfaction with the quality of the service provided. The results of the patient satisfaction survey were very well analysed in order to improve the service being provided. We were told that as a result of feedback from patients that dedicated emergency slots had now been implemented to prevent emergency appointments being squeezed in and therefore reducing the likelihood of the dentist from running late.

The practice also undertook the NHS Friends and Family Test (FFT). The FFT is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. The latest results showed that 90% of patients asked said that they would recommend the practice to friends and family.