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London Road Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 13 September 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

London Road Dental Practice is located in Sittingbourne, Kent and offers NHS and private general dentistry services to patients. The practice has three dentists and one hygienist who are supported by a practice manager, four dental nurses and two receptionists. The practice has four treatment rooms, one of which is on the ground floor, a reception, two waiting areas, and staff facilities.

The practice is open: Monday – Friday 9am to 5.30pm and Saturdays by appointment only.

The principal dentist 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.

On the day of inspection we received 28 CQC comment cards providing feedback and spoke to six patients following our inspection. The patients who provided feedback were very positive about the care and attention to treatment they received at the practice. They told us they were involved in all aspects of their care and found the staff to be excellent, great at responding to pain requirements, helpful and they were treated with dignity and respect in a clean and tidy environment.

Our key findings were:

Summary of findings

- Patient care and treatment was planned and delivered in line with evidence based guidelines, best practice and current regulations.
- Patients received clear explanations about their proposed treatment, costs, benefits and risks and were consistently involved in making decisions about it.
- Patients were treated with dignity and respect and confidentiality was maintained.
- The appointment system met patients' needs. Appointments were easy to book and emergency slots were available each day for patients requiring urgent treatment.
- There was a complaints system. Staff recorded complaints and cascaded learning to staff.
- The governance systems were effective.
- The practice sought feedback from staff and patients about the services they provided.
- We found that the practice ethos was to provide patient centred dental care in a relaxed and friendly environment.
- Strong and effective leadership was provided by the principal dentist.
- Infection control procedures were robust and carried out in accordance with current guidance

The practice was clean, spacious and very well maintained.

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 robust arrangements for essential areas such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found that all the equipment used in the dental practice was well maintained. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents. There were sufficient numbers of suitably qualified staff working at the practice. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

No action

Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals. 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.

No action

Are services caring?

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

We collected 28 completed Care Quality Commission patient comment cards and obtained the views of a further six patients. These provided a positive view of the service the practice provided. All of the patients commented that the quality of care was very good. Patients commented on friendliness and helpfulness of the staff and dentists were good at explaining the treatment that was proposed.

No action

Are services responsive to people's needs?

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

The service was aware of the needs of the local population and took these into account in how the practice was run. Patients could access treatment and urgent and emergency care when required. The practice provided patients with written information in language they could understand and had access to telephone interpreter services when required. The practice had ground floor treatment rooms and level access into the building for patients with mobility difficulties and families with prams and pushchairs.

No action

Are services well-led?

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

Strong and effective leadership was provided by the principal dentist. The principal dentist, practice manager and other staff had an open approach to their work and shared a commitment to continually

No action

Summary of findings

improving the service they provided. There was a no blame culture in the practice. The practice had robust clinical governance and risk management structures in place. Staff told us that they felt well supported and could raise any concerns with the principal dentist and practice manager. All the staff we met said that they were happy in their work and the practice was a good place to work.

London Road Dental Practice

Detailed findings

Background to this inspection

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

The inspection was carried out on 13 September 2016 by a CQC inspector who was supported by a specialist dental adviser. Prior to the inspection, we asked the practice to send us some information which 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 on 19 February 2016 and our local Healthwatch that we were inspecting the practice; however, we did not receive any information of concern from them.

During the inspection, we spoke with the principal dentist, a dentist on duty, dental nurses and the receptionist and reviewed policies, procedures and other documents. We also obtained the views of six patients following the day of our visit. We reviewed 28 comment cards that we had left prior to the inspection, for patients to complete, about the services provided at the practice.

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

Staff demonstrated a good awareness of RIDDOR (The reporting of injuries diseases and dangerous occurrences regulations). The practice had an incident reporting system in place when something went wrong; this system also included the reporting of minor injuries/accidents to patients and staff. There had been four incidents to date that required investigation. The records we saw demonstrated that the reporting forms were completed in full with details of how the incidents could be prevented in future.

The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA). Where relevant this information was sent to all members of staff by the principal dentist. Staff explained that relevant alerts would also be discussed during staff meetings to facilitate shared learning these meetings occurred every month. Minutes from practice meetings confirmed this.

Reliable safety systems and processes (including safeguarding)

We spoke to a dental nurse about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current EU directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne diseases. The practice used a system whereby needles were not manually re-sheathed using the hands following administration of a local anaesthetic to a patient. Dentists were also responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps.

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

The principal dentist acted as the safeguarding lead and acted as a point of referral should members of staff encounter a child or adult safeguarding issue. A policy and protocol was in place for staff to refer to in relation to children and adults who may be the victim of abuse or neglect. Training records showed that all staff had received appropriate safeguarding training for both vulnerable adults and children. Information was available in the practice that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. The practice reported that there had been one safeguarding incident that required further investigation by appropriate authorities. We saw that this had been handled in line with the practice policy. The principal dentist told us that this referral had resulted in a positive outcome and records we looked at confirmed this.

Medical emergencies

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

The emergency medicines and oxygen we saw were all in date and stored in a central location known to all staff. The practice held training sessions each year for the whole team so that they could maintain their competence in dealing with medical emergencies. Staff we spoke with demonstrated they knew how to respond if a person suddenly became unwell.

Staff recruitment

All of the dentists, the dental therapist, dental hygienists and dental nurses had current registration with the General Dental Council, the dental professionals' regulatory body.

Are services safe?

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 references.

The systems and processes we saw were in line with the information required by regulations. Staff recruitment records were stored securely in a locked cabinet to protect the confidentiality of staff personal information. 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

The practice had arrangements to monitor health and safety and deal with foreseeable emergencies. The practice maintained a comprehensive system of policies and risk assessments which included radiation, fire safety, general health and safety and those pertaining to all the equipment used in the practice. The practice had a business continuity plan to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service.

The practice had a well-maintained comprehensive Control of Substances Hazardous to Health (COSHH) file. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients.

Infection control

There were effective systems to reduce the risk and spread of infection within the practice. The practice had a robust infection control policy that was regularly reviewed. It was demonstrated through direct observation of the cleaning process and a review of practice protocols that HTM 01 05 (national guidance for infection prevention control in dental practices) Essential Quality Requirements for infection control were well executed. It was observed that an audit of infection control processes carried out on 1 September 2016 confirmed compliance with HTM 01 05 guidelines.

We saw that the three dental treatment rooms, waiting areas, reception and toilets were clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available including liquid soap and paper towel dispensers in each of the treatment rooms and toilet. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

The drawers of a treatment rooms were inspected and these were clean, ordered and free from clutter. Each treatment room had plenty of the appropriate routine personal protective equipment available for staff use; this included protective gloves, masks and eye protection.

The dental nurse we spoke with described to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. They demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines. The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings) staff described the method they used which was in line with current HTM 01-05 guidelines.

We saw that a Legionella risk assessment had been carried out at the practice by a competent person in May 2015. The recommended procedures contained in the report were carried out and logged appropriately. These measures ensured that patients' and staff were protected from the risk of infection due to Legionella.

The practice carried out their decontamination for instrument processing using the temporal separation method. This is where instruments are manually cleaned in the treatment room using a process that is carried out when the treatment room is free and no patients are undergoing treatment or consultation. The dental nurse we spoke with demonstrated the process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean. The practice used a system of manual scrubbing for the initial cleaning process, following inspection with an illuminated magnifier before the instruments were placed in an autoclave (a device for

Are services safe?

sterilising dental and medical instruments). When the instruments had been sterilised, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines.

We were shown the systems in place to ensure that the two autoclaves used in the decontamination process were working effectively. It was observed that the data cards used to record the essential daily and weekly validation checks of the sterilisation cycles were complete and up to date.

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 in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. This was stored in a separate locked location adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection. Patients' could be assured that they were protected from the risk of infection from contaminated dental waste.

Environment cleaning was carried out by an external cleaner. We saw an extensive file that contained detailed cleaning plans for each treatment room and other areas of the practice. We saw that the practice carried out a regular audit of these procedures, the audits contained action plans for the cleaner to follow to improve the standard of environmental cleaning.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the two autoclaves had been serviced and calibrated in February 2016. The practices' X-ray machines had been serviced and calibrated as specified under current national regulations. Portable appliance testing (PAT) had been carried out in July 2015.

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 overnight to prevent loss due to theft. The practice also had a prescription logging system to account for the prescriptions issued to prevent inappropriate prescribing or loss of prescriptions. We observed that the practice had equipment to deal with minor first aid problems such as minor eye problems and spill kits to deal with body fluid and mercury spillage.

Radiography (X-rays)

We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 (IRR99) 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 maintenance logs, Health and Safety Executive (HSE) notification and a copy of the local rules.

We saw that a radiological audit for each dentist had been carried out in November 2015. Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured. These findings showed that practice was acting in accordance with national radiological law and patients and staff were protected from unnecessary exposure to radiation.

We saw training records that showed all staff where appropriate had received training for core radiological knowledge under IRMER 2000 and IRR 99 Regulations.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists we spoke with carried out consultations, assessments and treatment in line with recognised general professional guidelines. The dentists described to us how they carried out their assessment of patients for routine care. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer.

Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained in detail. Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Dental care records we reviewed demonstrated that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums).These were carried out where appropriate during a dental health assessment.

Health promotion & prevention

The practice was very focussed on the prevention of dental disease and the maintenance of good oral health. To facilitate this aim the practice appointed a dental hygienist to work alongside of the dentists in delivering preventative dental care. One dentist we spoke with explained that patients at high risk of tooth decay were identified and were offered fluoride varnish applications or the prescription of high concentrated fluoride tooth paste to keep their teeth in a healthy condition.

They also placed fissure sealants (thin coatings on the biting surfaces of permanent back teeth) on patients who were particularly vulnerable to dental decay. Other preventative advice included tooth brushing techniques explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. Dental care records we reviewed demonstrated that dentists and the hygienist had given oral health advice to patients.

The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area. Underpinning this was a range of leaflets explaining how patients could maintain good oral health.

Staffing

The practice had three dentists working different days over the course of a week and were supported by four dental nurses and a dental hygienist. Other staff includes a practice manager, two receptionists and a cleaner. We observed a friendly atmosphere at the practice. Staff we spoke with told us the staffing levels were suitable for the size of the service. The staff appeared to be a very effective and cohesive team; they told us they felt supported by the principal dentist and other dentists. They told us they felt they had acquired the necessary skills to carry out their role and were encouraged to progress. We confirmed that the dental nurses received an annual appraisal and had personal development plans. These appraisals were carried out by the principal dentist. There was effective use of skill mix in the practice. This enabled the dentists to concentrate on providing care to patients whose needs were more complex whilst the dental hygienist provided routine care and advice.

The principal dentist showed us their system or recording training that staff had completed. These contained details of continuing professional development (CPD), confirmation of current General Dental Council (GDC) registration, and current professional indemnity cover

Are services effective?

(for example, treatment is effective)

where applicable. All of the patients we spoke with said they had confidence and trust in the dentists. This was also reflected in the Care Quality Commission comment cards we received

Working with other services

One of the dentists explained how they would work with other services. Dentists were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as oral surgery, special care dentistry and orthodontic providers.

We noted the practice used a referral tracking system to monitor referrals from the practice. This ensured that patients were seen by the right person at the right time.

Consent to care and treatment

We spoke with the dentists about how they implemented the principles of informed consent; all of the dentists had a very clear understanding of consent issues. They explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan and the patients dental care records. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options.

To underpin the consent process the practice had developed bespoke consent forms for more complex treatment including root canal treatment and the surgical removal of teeth. The dentists went onto explain how they would obtain consent from a patient who suffered with any mental impairment that may mean that they might be unable to fully understand the implications of their treatment. If there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed.

They went on to say they would involve relatives and carers if appropriate to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005. Staff were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting areas and we saw that doors were closed at all times when patients were with dentists or the hygienist. Conversations between patients and clinicians could not be heard from outside the treatment rooms which protected patient's privacy.

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 cabinets at various points in the practice. Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality.

Before the inspection, we sent Care Quality Commission (CQC) comment cards so patients could tell us about their experience of the practice. We collected 28 completed CQC patient comment cards and obtained the views of six patients following the day of our visit. These provided a positive view of the service the practice provided. All of the patients commented that the quality of care was very good.

Patients commented that treatment was explained clearly and the staff were caring and put them at ease. They also said that the reception staff were always helpful and efficient. During the inspection, we observed staff in the reception area. We observed that they were polite and helpful towards patients and that the general atmosphere was welcoming and friendly.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. A poster detailing NHS fees was displayed on the patient notice board in the waiting area. Booklets were also available in the waiting area and on the practice website that detailed the costs of both NHS and private treatment.

The dentists we spoke with paid particular attention to patient involvement when drawing up individual treatment plans. We 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. This included information recorded on the standard NHS treatment planning forms for dentistry where applicable.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we looked at the examples of information the practice had available for people. We saw that the practice waiting area displayed a wide variety of information including the practice patient information leaflet and leaflets about the services the practice offered, results of the family and friends test, how to make a complaint, fire procedures for patients to follow and the practices quality assurance policy.

The patient information leaflet explained opening hours, emergency 'out of hours' contact details and arrangements, staff details and how to make a complaint. The practice website also contained useful information to patients such as leaflets about different types of treatments which patients could down load and how to provide feedback on the services provided. We observed that the appointment diaries were not overbooked and that this provided capacity each day for patients with dental pain to be fitted into urgent slots for each dentist. The dentists decided how long a patient's appointment 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 had made reasonable adjustments to help prevent inequity for patients that experienced limited mobility or other issues that would hamper them from accessing services. The building was accessed via a small flight of stairs. We looked at the practice disability access audit conducted in April 2016 by an external company. The results clearly demonstrated that it was not possible to achieve level access. As a result of this the provider had made arrangements with another practice close by to receive any patients that required level access. Staff also checked with all new patients enquiring about joining the practice, if they had any special requirements. Staff told us how they would inform any new patients about the steps and if they would be able to navigate them. Staff informed us that they would refer any patients with mobility problems to a practice nearby. The practice used a translation service, which they arranged if it was clear that a patient had difficulty in understanding information about their treatment

Access to the service

The practice was open 9am - 5.30pm Monday to Friday 9am - 1pm Saturday mornings by appointment. The practice used the NHS Dentaline 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, at the entrance to the practice and on the telephone answering machine when the practice was closed.

Concerns & complaint

The practice had a complaints policy and a procedure that set out how complaints would be addressed, who by, and the time frames for responding. Information for patients about how to make a complaint was seen in the patient leaflet, poster in the waiting area and patient website.

The practice had received one complaint during the last twelve months. We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was an effective system in place which ensured a timely response. We saw that the complaint had been managed according to the practices' policy.

Are services well-led?

Our findings

Governance arrangements

The governance arrangements of the practice were developed through a process of continual learning and improvement. The governance arrangements for the practice were facilitated by the principal dentist who was responsible for the day to day running of the practice. The practice maintained a comprehensive system of policies and procedures and an audit plan. All of the staff we spoke with were aware of the policies and how to access them. We noted all policies and procedures were kept under review by the principal dentist on a regular basis.

Leadership, openness and transparency

Strong and effective leadership was provided by the principal dentist. The practice ethos focussed on providing patient centred dental care in a relaxed and friendly environment. The comment cards we saw reflected this approach. The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said they felt comfortable about raising concerns with the practice manager or the principal dentist. There was a no blame culture within the practice. They felt they were listened to and responded to when they did raise a concern however minor. We found staff to be hard working, caring and committed to the work they did. All of the staff we spoke with demonstrated a firm understanding of the principles of clinical governance in dentistry and the standards for dental professionals and were happy with the practice facilities. Staff reported that the principal dentist was proactive and resolved problems very quickly. As a result, staff were motivated and enjoyed working at the practice and were proud of the service they provided to patients.

Learning and improvement

We saw evidence of systems to identify staff learning needs which were underpinned by an appraisal system and a programme of clinical audit. For example we observed that the dental nurses and receptionists received an annual appraisal; these appraisals were carried out by the principal dentist and were followed up by a mid-year review to check if the staff were on course to meet their appraisal objectives. There was a system of peer review in place to facilitate the learning and development needs of the dentists. Staff meetings were held on a six weekly basis and were chaired by the principal dentist. Subjects discussed at recent meetings included consent, specific dental cases, mouth cancer and the Mental Capacity Act.

The practice used the principle of the 'daily chats' which were carried out by the staff to increase their awareness of the particular needs and risks of patients including issues around their medical, social and clinical needs.

We found there was a rolling programme of clinical and non-clinical audits taking place at the practice. These included infection control, clinical record keeping and X-ray quality. The audits demonstrated a comprehensive process where the practice had analysed the results to discuss and identify where improvement actions may be needed.

Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. Staff told us that the practice ethos was that all staff should receive appropriate training and development. The principle dentist encouraged staff to carry out professional development wherever possible. The practice used a variety of ways to ensure staff development including internal training and staff meetings as well as attendance at external courses and conferences. The practice ensured that all staff underwent regular mandatory training in cardio pulmonary resuscitation (CPR), infection control, child protection and adult safeguarding, dental radiography (X-rays). We saw that the practice maintained a comprehensive record of all staff's training records.

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

The practice had gathered feedback from patients through the NHS Friends and Family test (FFT), NHS Choices, compliments and complaints. We saw that there was a robust complaints procedure in place, with details available for patients in the waiting area, practice leaflet and on the website. Results of the Family and Friends Test (FFT) we saw indicated that 100% of patients who completed the survey were happy with the quality of care provided by the practice and patients were either highly likely or likely to recommend the practice to family and friends. Running in tandem with the FFT was the practices' own patient satisfaction survey programme which had conducted in July 2016. Staff had discussed the content of the patient satisfaction survey at the most recent staff meeting in August.

Are services well-led?

Staff told us that the principal dentist was very approachable and they felt they could give their views about how things were done at the practice. Staff confirmed that they had practice meetings every month; the minutes of these were made available to any member of staff who could not attend. Staff described the meetings as good with the opportunity to discuss successes, changes and improvements. Items discussed at the most recent staff meeting included, the introduction of the digital X-rays, complaints, referrals, health and safety and the fire alarm. Staff we spoke with said they felt listened to by the principal dentist and they enjoyed working at the practice.