Dr. Anthony Fagg

Oriel Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 17 December 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Dr. Anthony Fagg provides NHS and private dental treatment. The majority of patients at the practice are private with approximately 35% NHS patients. The practice is situated in South Walls, Stafford, Staffordshire. Dr. Anthony Fagg is co-located with another individual dental provider who share the same premises and staff team. Dr. Anthony Fagg has been working at the practice for 30 years. The practice team includes four dental hygienists/ therapists, four dental nurses and two reception staff. The practice is supported by a practice manager/dental nurse. The practice relocated to its current location in 2010. The practice has been reconfigured to the providers' specification and had been subject to recent refurbishment. The treatment room surgeries are fully equipped and the airy reception area enables patient privacy with distance between the reception desk and the waiting room area on the ground floor. The practice has a further waiting room area on the first floor and both reception and waiting room areas have CCTV monitoring which reception staff manage and was well advertised throughout the practice and within the practice literature. The main entrance to reception is accessible to patients with restricted mobility. The practice has three dental treatment rooms on the first floor accessible via stairs and one to the ground floor. The practice has a separate room which provides an area for the decontamination and cleaning, sterilising and packing of dental instruments.

Before the inspection we sent Care Quality Commission (CQC) comment cards to the practice for patients to use

Summary of findings

to tell us about their experience of the practice. We collected 48 completed cards. These provided extremely positive views of the service the practice provides. Patients told us the practice was excellent and that the dentist was professional, caring, understanding of their anxieties, thorough and helpful and went above and beyond their expectations. Several patients specifically commented that the dentist put them at ease and had allayed their fears. We spoke with four staff members all understood the needs of their patients living with dementia illnesses and those with learning disabilities. They understood their responsibilities under the Mental Capacity Act (2005).

Our key findings were:

- The practice had systems for dealing with significant events and accidents and staff understood their responsibilities for providing a safe service.
- The practice was visibly clean and had processes to help staff manage infection prevention and control effectively.
- The practice had systems, medicines and equipment for the management of medical emergencies and staff were trained to know how to deal with these.
- The practice had safeguarding processes and staff understood their responsibilities for safeguarding adults and children.
- Dental care records included the essential information expected about patients' care and treatment including treatment plans and consent to care and treatment.
- The practice was committed to staff education and development. Staff received training appropriate to their roles and were encouraged and supported in their continued professional development (CPD).
- The practice received very few complaints but had a clear system for handling and responding to these.
- Patients who completed Care Quality Commission comment cards were pleased with the care and treatment they or their family member received and were complimentary about the whole practice team.
- The practice had well organised governance and leadership arrangements and an open door policy which made staff feel valued and listened to.
- The practice had open and supportive leadership and staff were happy in their roles, professional and enthusiastic.

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

• Consider adding further detail regarding the treatment provided to patients' within the care records and consistently update the health promotion advice given to patients.

• Re-evaluate the process in place for dating the pouched instruments and put a protocol in place.

• There should be a safer sharps policy available to all staff and ensure there is a risk assessment in place regarding the disposal of sharps systems the dentist utilised.

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 safe systems for dealing with medical emergencies, carrying out X-rays and for reducing the risk of infection. Patients who completed comments cards told us that they felt the environment was clean and hygienic. Staff were aware of the management of adverse incidents process within the practice and all were clear and consistent about what would happen should an incident occur. Health and safety risks were known and understood by staff and staff took appropriate action when risks were identified. The practice had arrangements to ensure equipment used within the practice was serviced regularly which included equipment used for the sterilisation of instruments. Staff received training in child protection and safeguarding vulnerable adults and understood their responsibilities in terms of responding to any potential abuse. During the inspection the provider informed Care Quality Commission that an annual service contract was put in place for the practice oxygen cylinder.

Are services effective?

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

Patients' individual needs and personal risks were being assessed. Care and treatment was being delivered in a way that ensured patient safety and welfare. Where specialist dental care needs were identified referrals had been made and were followed up to ensure continuity of care.

Patients told us that they felt fully informed about their dental care and were subsequently able to make informed decisions about their proposed treatment. Staff working at the practice were clear about their individual roles and responsibilities and had undertaken appropriate training to support them in their roles and enable them to meet the needs of patients. Information for staff on Mental Capacity Act (2005) and Deprivation of Liberty Safeguards was available to all staff.

Are services caring?

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

We found that staff were sensitive to the needs of their patients and aware of the need to ensure patient confidentiality. The patients who completed comment cards spoke very highly of the care they received and told us the team was customer focused and treated them with respect.

Staff told us how they ensured patients were kept informed about their oral health at each visit and how they supported them to make decisions about their care. Patients told us that they felt involved in their treatment and that it was explained fully to them. Results the practice's own surveys echoed these positive views.

Are services responsive to people's needs?

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

We found the practice was aware of patients' needs and in particular those who may have high levels of anxiety or specialist needs. Patients told us that they were able to get appointments when they needed to and that they could get appointments in an emergency. There were arrangements for dealing with any complaints and concerns raised by patients or their carers. We saw that when this had happened any complaints were investigated and responded to appropriately.

Summary of findings

Are services well-led?

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

The practice manager provided day to day support for the staff team as well as dentist. It was evident from discussions with staff that these arrangements worked well. Staff told us they felt supported and were encouraged to extend their learning. We saw that feedback from patients was encouraged and there were systems to capture feedback from patients as they visited the practice and to use the information to improve the service provided.

Oriel 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.

We carried out an announced, comprehensive inspection on 17 December 2015 by a Care Quality Commission (CQC) inspector and a dentist specialist advisor.

Before the inspection we reviewed information we held about the provider and information that we asked them to send us in advance of the inspection. During our inspection visit, we reviewed a range of policies and procedures and other documents including dental care records. We spoke with four members of staff, including the management team. We looked around the premises including the treatment rooms. We looked at the storage arrangements for emergency medicines and equipment. We observed the dental nurse carrying out decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area.

We reviewed 48 CQC comment cards completed by patients and spoke with five patients. Patients gave extremely positive views about the care and experience of 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

The practice had procedures in place to investigate, respond to and learn from significant events and complaints. Staff were aware of the reporting procedures in place and followed them. The practice manager maintained an incident log which held information on both clinical and non-clinical incidents and events. There had been no written complaints recorded in the 12 month period. We saw records which included accidents and incidents were well maintained. We saw records that demonstrated that when a significant event had occurred it was fully investigated, appropriate advice taken and the learning was shared with all staff at the practice meetings. Records showed the patient was fully informed in a timely manner and the practice policy was followed. We saw that practice meetings were held generally every four weeks. We saw that should incidents occur such as sharp instrument or needle stick injuries that these were discussed, recorded and the outcome shared as learning for improvement. The practice responded to national patient safety and medicines alerts that were relevant to the dental profession. Any relevant notices were available for staff to read were discussed at practice meetings and brought to staff attention. Where policies had been updated systems were in place to confirm that staff read these updates. The dentists and staff spoken with had a clear understanding of their responsibilities in Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) and had access to the appropriate recording forms.

Reliable safety systems and processes (including safeguarding)

We discussed child and adult safeguarding with staff at the practice. They were aware of how to recognise potential concerns about the safety and well-being of children, young people and vulnerable adults including older patients living with dementia. The practice had a safeguarding policy for staff to refer to and contact details for the relevant safeguarding professionals. This information was kept on the practice computer system together with staff access to a paper copy which could easily be referred to. We saw documentary evidence that all staff had undertaken safeguarding training. Staff knew who to report concerns to outside of the practice and had access to the contact details for external agencies. Rubber dams were used in root canal treatment. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. The practice had an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. The practice had the emergency medicines set out in the British National Formulary guidance. Oxygen and other related items such as face masks were available in line with the Resuscitation Council UK guidelines. All of the emergency medicines were in date and stored securely. The expiry dates of medicines and equipment were monitored using a monthly check sheet which enabled the staff to replace out of date drugs and equipment promptly. The practice held in-house training sessions for the whole team to maintain their competence in dealing with medical emergencies using an outside provider. Emergency oxygen was in a location known to all staff and was full. The oxygen cylinder however did not have an adequate flow rate to enable sufficient time until the arrival of an ambulance which is considered to be 20 minutes. The provider acted immediately on this information. A company was contacted and a replacement and an annual service contract was arranged.

Staff recruitment

We looked at the staff files for four of the current employees and the practice's recruitment policy and procedure. We saw that in general the practice held the required information for each member of staff employed. Not all files contained photographic proof of identity however the practice manager gave assurances that this would be rectified. The recruitment policy reflected the requirements of Regulation 19(3) and Schedule 3 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. It contained clear information about the checks the practice would carry out when appointing new staff. Disclosure and Barring Service (DBS) carries out 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.

Are services safe?

Monitoring health & safety and responding to risks

The practice had a health and safety policies in place. There were a number of health and safety related policies. These included Control of Substances Hazardous to Health (COSHH), sharps, slips, trips and falls and fire safety. We saw that there were fire safety records showing that the practice had carried out regular checks of the fire alarm system, fire extinguishers and a fire risk assessment was in place. The records also showed that staff had taken part in fire drills and regular checks of their emergency lighting. Staff attended fire safety awareness training as part of their induction and staff told us they had received training. The fire risk assessment was also reviewed in 2015.

The practice had a treatment room situated on the ground floor of the building which patients who experienced limited mobility were invited to use. The practice had digital X-ray facilities. Each treatment room had an intra-oral X-ray machine for taking small films which are most commonly used in dentistry.

Infection control

The practice was visibly clean, tidy and uncluttered. An infection control policy was in place, which clearly described how cleaning was to be undertaken at the premises including the treatment rooms and the general areas of the practice. The types of cleaning and frequency were detailed and checklists were available for staff to follow. The dental nurses, dental hygienist and dental therapists had their own responsibilities in the treatment rooms. The practice had systems in place for testing and auditing infection control procedures. We found that there were adequate supplies of liquid soaps and hand towels throughout the premises. Posters describing proper hand washing techniques were displayed in the dental surgeries. Sharps bins were located within a cupboard and were signed, dated and not overfilled. This was discussed with the dentist who assured us that a risk assessment would be completed regarding the location of the sharps bins and that they would ensure there is a risk assessment in place regarding the disposal of sharps systems the dentist used. A clinical waste contract was in place and waste was stored securely until collection.

We looked at the procedures in place for the decontamination of used dental instruments. The practice had a dedicated decontamination room. The decontamination room had clearly defined dirty and clean zones in operation to reduce the risk of cross contamination. Staff wore appropriate personal protective equipment during the process. These included aprons, protective eye wear with a face visor and the practice of double gloving involved wearing disposable gloves with the additional protection of heavy duty gloves to minimise the risk of injury from sharp instruments was used. We found that instruments were being cleaned and sterilised in line with the Department of Health's guidance, Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices published guidance. On the day of our inspection, a dental nurse demonstrated the decontamination process to us and used the correct procedures. The practice first cleaned the instruments which were scrubbed in a sink designated for this purpose. All instruments were then rinsed and examined visually with a magnifying glass before being sterilised in an autoclave. At the end of the sterilising procedure the instruments were correctly packaged, sealed, stored and dated with an expiry date. We looked at the sealed instruments in the surgeries and found that all but one had an expiry date that met the recommendations from the Department of Health. There was one pouched instrument that was undated. The practice removed these instruments.

The equipment used for cleaning and sterilising was checked, maintained and serviced in line with the manufacturer's instructions. Daily, weekly and monthly records were kept of decontamination cycles to ensure that equipment was functioning properly. Records showed that the equipment was in good working order and being effectively maintained. We saw that staff were well presented and wore clean uniforms. We saw that appropriate personal protective equipment was worn by staff and provided for patients when undergoing treatment. Staff files reflected that staff had received inoculations against Hepatitis B and received regular blood tests to check the effectiveness of that inoculation. People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise the risk of blood borne infections. The practice had an up to date legionella risk assessment in place.

Equipment and medicines

The building was well maintained. The practice had been reconfigured to the providers' specification and had been subject to recent refurbishment. We looked at the maintenance schedules for the equipment used in the

Are services safe?

practice. This showed that equipment was maintained in accordance with the manufacturers' instructions using appropriate dental engineers. This included the equipment used to sterilise instruments, X-ray equipment and equipment for dealing with medical emergencies to ensure they were in working order and easily accessible. Portable electrical appliances had been tested by an electrical contractor in 2015. The practice had a system in place to monitor medicines in use at the practice. Staff checked the medicines regularly and kept records of this. We saw from a sample of clinical records that the dentist recorded the name of the medicines they prescribed together with the dose and timing. The batch numbers and expiry dates for local anaesthetics were recorded in the clinical notes we saw. There was sufficient sterilised equipment available for patients' treatment and these were rotated regularly to ensure they remained in date for use. Prescription storage was secure with serial numbers noted and monitored by the practice manager.

Radiography (X-rays)

We were shown records relating to the Ionising Radiation Regulations 1999 (IRR99) and Ionising Radiation Medical Exposure Regulations 2000 (IRMER).The records included the local rules and the names of the Radiation Protection Advisor and the Radiation Protection Supervisor along with the necessary documentation relating to the maintenance of the X-ray equipment. The maintenance logs were within the current recommended interval of 3 years. We looked at the dentists' continuous professional development (CPD) training records in relation to IRMER requirements; these were within the recommended five year renewal period. We looked at a sample of eight dental care records where X-rays had been taken on the day of our visit. These showed that the dentist had recorded their justification for taking these X-rays. These findings showed that practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. The dentist told us they asked patients to complete a medical history questionnaire to provide the practice with details of health conditions, medicines being taken and any allergies suffered. The dentist described a typical examination which covered the condition of a patient's teeth, gums and soft tissues and detecting the signs of mouth cancer. They explained that they made patients aware of the condition of their oral health and whether it had changed since the last appointment. They gave each patient a treatment plan which included the cost involved where applicable. We were shown a sample of eight dental care records for patients who attended the practice. These confirmed that the findings of the dentist's assessment and details of the treatment carried out were recorded.

We saw details of the condition of patients' gums were recorded using the basic periodontal examination (BPE) scores The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums. The records also confirmed that the dentist had checked the soft tissues lining the mouth which can help to detect early signs of cancer. The records confirmed that each of the dental X-rays taken were justified, reported on and quality assured and contained treatment plans and details of any associated costs. When the patient's treatment was complete, the dentist incorporated a risk based approach to determining the dental recall interval based on the National Institute for Health and Care Excellence (NICE) dental recall guidelines.

Health promotion & prevention

The waiting rooms contained literature in a brochure and in a laminated folder accessible to patients that explained the services offered at the practice. The dentist and dental nurse/therapist advised adults and children of steps to take to maintain healthy teeth. They explained tooth brushing techniques and gave advice on diet, smoking, and alcohol consumption. We found that the practice process was that the dental nurse/hygienist completed one to one health promotion consultations and made a brief record in the patients' notes. We saw that on occasion the notes made were brief and some records did not contain a full record of the health promotion advice. Patients we spoke with specifically mentioned that the dentist gave guidance about oral health care and the dental hygienist also provided nutritional information as they had received specific training in this role. Staff had attended various courses to improve their health promotion and prevention knowledge and skills. For example staff had received training in provide further information on the application of fluoride to help keep children's teeth in a healthy condition, as well as on smoking cessation and oral health.

Staffing

Dr. Anthony Fagg was collocated with another individual dentist and shared practice staff. The practice team included four dental hygienists/ dental therapists, four dental nurses and two reception staff. The practice is supported by a practice manager/dental nurse. Staff we spoke with said they had received an induction on commencement of employment at the practice, this included familiarising themselves with the practices policies and procedures. We saw that the most recently employed staff completed a checklist which was signed and dated once they had read the policies and procedures and/or any changes in policies and procedures. This included a wide range of important and appropriate topics such as emergency medicines arrangements and fire safety. The induction itself was formalised and was altered to reflect the new employee's role requirements. The practice recorded details of the dates on which information or training was provided and the assessment of staff competence. We saw evidence that members of the clinical team had completed appropriate training to maintain the continued professional development required for their registration with the General Dental Council. This included medical emergencies in dental practices, infection control, child and adult safeguarding, dental radiography (X-rays), and varied dental topics. The individual staff records contained details of confirmation of current General Dental Council (GDC) registration, current professional indemnity cover and immunisation status. The practice manager was also considering a simplified spreadsheet for staff training they considered to be essential for staff. This would include the date of the training and how regularly refresher training was required.

Working with other services

We saw records that demonstrated that the dentists referred patients who required any specialised treatment to other dental specialists as necessary. The care and

Are services effective?

(for example, treatment is effective)

treatment required was explained to the patient and they were given a choice of other dentists who were experienced in undertaking the type of treatment required. A referral letter was then prepared with full details of the consultation and the type of treatment required. This was then sent to the specialist who would provide the treatment so they were aware of the details of the treatment required. When the patient had received their treatment they would be discharged back to the practice for further follow-up and monitoring. Where patients had complex dental issues, such as oral cancer, the practice referred them to other healthcare professionals using their referral process.

Consent to care and treatment

The dentist and staff we spoke with were aware of the need to gain valid consent from patients and understood the use of Gillick competency in young persons. Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. The dentists had a clear understanding of consent issues. We found that verbal consent was recorded in the patient's records. They stressed the importance of communication skills when explaining care and treatment to patients. They understood that consent was an ongoing process and a patient could withdraw consent at any time. The dentist explained that they gave patients a detailed verbal explanation of the type of treatment required, including the risks, benefits and options. The comment cards reviewed reflected that patients were offered treatment options where applicable, felt fully informed of their choices and consented to treatment.

The practice had a consent policy and had Department of Health guidance available about the Mental Capacity Act 2005. 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 dentist explained how they would approach the issue of consent with patients who may not fully understand the implications of their treatment. Staff we spoke with assured us that if there was any doubt about a patient's ability to understand or consent to the treatment, then they would postpone treatment. They said they would involve relatives and carers in discussions to ensure that the best interests of the patient were served as part of the process. The spoken with had received training on Deprivation of Liberty safeguards (DoLs) and understood their responsibilities under the MCA. Staff had received training on the MCA. Staff said they would take advice where appropriate to do so to help ensure people's best interests were considered and choice maintained.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Before the inspection we sent Care Quality Commission (CQC) comment cards to the practice for patients to use to tell us about their experience of the practice. We collected 48 completed cards. These provided a very positive view of the service the practice provides. Patients told us the practice was welcoming and that the dentist was professional, considerate, thorough and helpful. Several patients specifically commented that the dentist put them at ease and that this had helped them overcome their fear of going to the dentist. The majority had made additional positive comments about the dentists and staff. The practice as an example placed water outside the practice for patients who attended with dogs when required. Staff knew their patients well, had a stable staff team which enabled good patient rapport and the development of continuity of care. The comments echoed those in the CQC comment cards in that patients described how the practice staff were always caring and many travelled some distance to remain a patient the practice.

Involvement in decisions about care and treatment

Patients commented they felt involved in their treatment and it was fully explained to them. Responses in the CQC comment cards and from patients we spoke with said that treatment was explained and communicated clearly to them. They said that results, examinations and treatment options were discussed with them. Patients said that they were given the time needed to consider their treatment options. The practice provided patients with information to enable them to make informed choices about their dental treatment. Patients were informed about the range of treatments available in information leaflets, and notices in the practice. 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. We looked at a sample of patient records and saw that these included a brief summary of treatment explanations given to patients.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice brochure and information displayed in the waiting area described the range of services offered to patients, the complaints procedure, information about patient confidentiality and record keeping. The practice offered predominately private treatment but had some NHS patients. costs and fee information leaflets were available. Appointment times and availability met the needs of patients. Patients with emergencies such as those in pain were within 24 hours of contacting the practice, sooner if possible. The practice's answering machine informed patients which service they should contact in an emergency when the practice was closed.

Tackling inequity and promoting equality

The practice had a range of policies around anti-discrimination and promoting equality and diversity. Staff we spoke with were aware of these policies. Staff told us although they had no patients requiring the use of an interpreter they could access this service for patients whose first language was not English and who needed support to understand the treatment they needed. The practice building had its own small free car park and was on a local bus route. The premises had been a dental practice for a number of years and had been refurbished and designed to the providers' specifications. The reception and waiting room, patient toilet and a treatment room were on the ground floor with a further waiting room and three treatment rooms on the first floor accessible via stairs. The practice had considered the needs of patients who may have difficulty accessing services due to mobility or physical issues. The dentist described and we saw that the dental treatment rooms chair arms lowered to enable easier transfer for patients who were wheelchair users.

Access to the service

Patients told us that they could access care and treatment in a timely way and the appointment system met their needs. Staff told us that where treatment was urgent patients would be seen on the same day, where possible and within 24 hours or as soon as an emergency appointment could be identified. The practice opening hours were between 8.30am and 12.45pm and 2 pm to 5pm.

Information in CQC comment cards described a responsive service where patients found it easy to get appointments, particularly when experiencing pain. We looked more generally at appointments on the system and saw that the lengths of appointments varied according to the type of treatment being provided to meet patient's needs.

Concerns & complaints

The practice had a complaint procedure that explained to patients the process to follow, the timescales involved for investigation and the person responsible for handling the concern. The practice website included access to practice complaints procedure. Staff we spoke with were aware of the procedure to follow if they received a complaint. The practice manager and records showed that there had been no written complaints made within the last 12 months. Verbal comments/complaints had been resolved quickly; to the patient's satisfaction and any learning derived from this had been appropriately shared with practice staff. There were reviews from patients posted on the NHS Choices website since 2011.

Are services well-led?

Our findings

Governance arrangements

The practice had robust governance arrangements with an effective management structure. There were arrangements for monitoring the quality of most processes within the practice. They had a well-defined management structure which all the staff were aware of and understood. All staff members had defined roles and were all involved in areas of clinical governance.

There were a number of policies and procedures in place which underpinned staff practices. There was a process that the practice manager was in the process of setting up which included ensuring that all policies and procedures were kept up to date and reviewed. The practice had systems in place for monitoring and managing risks to staff and patients. Risks associated with dental treatments including risks of infection control and unsafe or inappropriate treatments, premises and fire had been recognised and there were plans in place to minimise and mitigate these risks.

Staff told us that they held daily regular informal discussions and monthly formal whole practice meetings. These formal meetings were all minuted and provided the opportunity to discuss any issues, updates, training, health promotion and key governance issues. For example, we saw minutes from meetings where issues such as infection control, information governance and complaints had been discussed. This facilitated an environment where improvement and continuous learning were supported.

The practice had undertaken audits to ensure their procedures and protocols were being carried out and were effective. These included audits of X-rays and infection control. The audits supported the practice to identify and manage risks and ensured information was shared with all team members. Where areas for improvement had been identified action had been taken.

Care and treatment records were kept electronically and we found them to be complete, legible accurate and kept secure. Patients' care records were stored electronically; password protected and regularly backed up to secure storage. The practice had policies and procedures and training which supported staff to maintain patient confidentiality and understand how patients could access their records.

Leadership, openness and transparency

The staff group at the practice was small and on the day of the inspection we observed that the team worked together well and supported each other. They discussed any suggestions for improvements with the dentist who they felt were open to their advice and suggestions. The culture of the practice encouraged candour, openness and honesty. Staff told us that they would approach the practice manager or dentist if they had any concerns. Staff said they could also speak with other staff members. Staff said they were comfortable about raising concerns and felt they were listened to and responded to when they did so. They were aware that they could escalate concerns to external agencies, such as the Care Quality Commission (CQC), if necessary.

The staff we spoke with all told us they enjoyed their work, gained job satisfaction and that they had a good team of staff who supported each other. There was a system of staff appraisals to support staff in carrying out their roles effectively and safely. Staff were aware of their rights in respect of raising concerns about their place of work under whistleblowing legislation. We saw that the practice had a whistleblowing policy in place.

Learning and improvement

Staff told us they had good access to training and personal development. Staff were regularly supervised and had an annual appraisal of their performance from which learning and development needs and aspirations were identified and planned for. The practice audited areas of their practise each year as part of a system of continuous improvement and learning. A number of clinical and non-clinical audits had taken place where improvement areas had been identified. The outcome and actions arising from audits were cascaded and discussed with staff to ensure any identified improvements were made.

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

The practice had records of the patients' views gathered from compliments and comments made. The practice also carried out their own ongoing patient surveys feedback from patients was that they were happy with the treatment they received and confident about the quality of treatment. Patients we spoke with travelled to attend the dental practice despite not living in the area as they valued the dental practice team.