Oasis Dental Care Limited

Oasis Dental Care - Stamford

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 21 March 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

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

Oasis Dental Care Stamford is part of the Oasis Dental Care network. The service provides a wide range of dental services including specialist treatments such as orthodontic (tooth straightening) and periodontic (specialist gum) treatments. Services are available to NHS and private patients of all ages. The practice is situated close to an NHS community hospital and minor injuries unit. The practice had six dental treatment rooms and a separate decontamination room for cleaning, sterilising and packing dental instruments. Dental care was provided on two floors with a reception and waiting area on the ground floor.

The practice opens 8am to 7pmMonday to Thursday, 8am to 6pm on Friday and Saturday 8am to 1pm. The practice employs three dentists, an orthodontist, a periodontist and two dental hygienist/ therapists. They were supported by a team of seven trained dental nurses, one trainee dental nurse, a practice manager and four reception staff.

The practice manager has applied to be 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.

Summary of findings

We received feedback from ten patients either in person or on CQC comments cards from patients who had visited the practice in the two weeks before our inspection. The cards were all positive and commented about the caring and helpful attitude of the staff. Patients told us they were happy with the care and treatment they had received.

Our key findings were:

- There was appropriate equipment for staff to undertake their duties and the equipment was well maintained.
- Staff had been trained to handle emergencies and life-saving equipment was readily available in accordance with current guidelines. Emergency medicines were available in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- Infection control procedures were in place although evidence of staff immunity for Hepatitis B had not been followed up for all staff.
- Dentists provided dental care in accordance with current professional and National Institute for Health and Care Excellence (NICE) guidelines.
- The practice appeared clean and free from clutter.
- Staff received training and development although the system for annual appraisal was not established.
- Patients told us they were able to get an appointment when they needed one and the staff were kind and helpful.
- Governance arrangements were in place and were being reviewed by the practice manager who had been in post for four months. Recent improvements were being made to ensure the smooth running of the practice. This included the completion of regular audits to help monitor the quality and safety of the service.

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

- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as, Public Health England (PHE).
- Review the protocol for completing accurate, complete and detailed records relating to employment of staff. This includes making appropriate notes of verbal reference taken and ensuring recruitment checks, including references, are suitably obtained and recorded.
- Review the protocols and procedures used for the appraisal of all staff.
- Review the complaints process so that learning points are documented and shared with all relevant staff so that the learning and improvements can be demonstrated.

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 in place for infection control, the management of clinical waste, the management of medical emergencies 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.

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 although they did not all receive an appraisal. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

Are services caring?

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

Staff treated patients with dignity and respect and ensured their privacy was maintained. Patient information and data was handled confidentially. We received feedback from ten patients who used the service. They commented on the friendly and helpful staff, told us they were good at explaining their treatment and costs and provided a service they were happy to receive.

Are services responsive to people's needs?

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

Appointment times met the needs of patients and waiting times were kept to a minimum. Patients could access treatment and urgent and emergency care when required. The practice had made reasonable adjustments to the service to ensure it was accessible and the service could be tailored to individual needs. Information was available to patients and there was access to interpreter services if this was required. The practice was on two levels which included two ground floor treatment rooms for patients with mobility difficulties and families with prams and pushchairs. A complaints process was in place and we saw these had been well managed.

Are services well-led?

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

The practice manager staff had an open approach to their work and worked as a team to continually improve the service. Governance procedures were in place and policies and procedures were regularly updated. A system of quality monitoring checks had been reviewed and action was being taken when improvements were identified. Patient feedback was sought, considered and acted upon. Staff told us that they felt well supported and could raise any concerns with the practice manager or dentists.

Oasis Dental Care - Stamford

Detailed findings

Background to this inspection

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

This inspection took place on 21 March 2016 and was led by a CQC Inspector who was supported by a specialist advisor. Before the inspection, we asked the practice to send us some information for review and this included a summary of complaints received.

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

During the inspection we spoke with three dentists, two dental nurses, a dental hygienist/ therapist and three reception staff. We reviewed policies, procedures and other documents. We also obtained the views of three patients on the day of the inspection and received seven comment cards that we had provided for patients to complete during the two weeks leading up to the inspection.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had a process in place for reporting and recording any accidents or incidents. This included an incident reporting policy and incident form that was reported to the practice manager and sent to the provider's health and safety team. The practice manager was able to show us that one incident had occurred since she commenced her role in November 2015. Records demonstrated that appropriate action had been taken at the time. The practice manager had completed further follow up which was not documented. They agreed to revise the tracking system so that incidents could be monitored at a local level. There was no historical evidence that incidents and accidents were reported and investigated prior to November 2015.

The practice manager described a good awareness of RIDDOR (The reporting of injuries diseases and dangerous occurrences regulations) and knew when to report any of these injuries. The practice received national patient safety alerts such as those relating to medicines or the safety of clinical equipment. The practice manager received the alerts and raised them with a senior dentist to help identify when they required cascading to the team. There were no records kept to demonstrate the alerts had been shared and actioned.

The practice manager understood the principles of the duty of candour and we saw that patients had received an apology when they experienced a poor service.

Reliable safety systems and processes (including safeguarding)

The practice manager was the designated lead for safeguarding concerns to advise staff and liaise with outside agencies if required. Information on the reporting process was visible and accessible to staff who had received relevant training and were able to demonstrate sufficient knowledge in recognising safeguarding concerns. No referrals had been made.

We spoke with dentists and dental nurses to ask about the use of rubber dam for root canal treatments. 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. Staff told us they had increased their use of rubber dam in recent months in line with guidance issued by the British Endodontic Society. This had occurred in response to an internal quality monitoring visit. Staff were able to describe their assessment of the risk and the importance of documenting this in the patient's dental care record.

Medical emergencies

Staff had access to an automated external defibrillator (AED) in line with Resuscitation Council UK guidance and the General Dental Council (GDC) standards for the dental team. An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. Additional equipment for use in medical emergencies was available. This included oxygen which was checked on a weekly basis to ensure the cylinder was full and within its expiry date. The practice also held medicines and equipment used for managing medical emergencies for diabetic patients with a low blood sugar level. Staff had received training in dealing with medical emergencies.

The practice had emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice. We checked the emergency medicines and saw that the items were all within their expiry dates. There was a system in place to ensure that the dental nurses checked the expiry dates of medicines on a weekly basis.

Staff recruitment

All of the employed dental professionals had current registration with the General Dental Council, the dental professionals' regulatory body.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 and references. We reviewed the recruitment files for two staff who had joined the practice within the last eighteen months. Most of the information was in place although we found there was no evidence of any references or of the interview process that had taken place. The practice manager could not confirm the process used as she had not been in post at the time. The policy also referred to a 12 week induction process for all newly recruited staff with

Are services safe?

formal reviews at monthly intervals. We did not see records to support this. One new member of staff told us they had received an induction and were provided with support although the details of what she had received, and was recorded on the recruitment file did not follow the process in the recruitment policy. Staff recruitment records were stored securely in a locked cabinet to protect the confidentiality of staff personal information. We saw that relevant staff had received appropriate checks from the Disclosure and Barring 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 in place to monitor health and safety and deal with foreseeable emergencies. There were a number of general risk assessments in place that had recently been reviewed. These included the Control of Substances Hazardous to Health (COSHH), lone working, latex allergy and slips, trips and falls. The practice also had safety kits to deal with mercury spillage and body fluids to enable staff to clean and dispose of these hazards in a safe way. A first aid kit, including an eye wash kit was also available.

The practice had procedures in place to reduce the risk of injuries through the use of sharp instruments. Staff knew how to take appropriate action if an injury occurred although no such injuries had been recorded during the last year. Relevant staff had received immunisation for Hepatitis B, although records of their immunity were not complete. The practice manager was already addressing this.

A fire risk assessment had been completed in March 2016. This included a list of recommended actions which the practice manager planned to address. A fire drill had also been recently completed and one minor action was identified to improve the process.

Other assessments included radiation, health and safety and water quality risk assessments.

The practice had a business continuity plan in place to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The practice had a robust infection control policy that was regularly reviewed. Each day a dental nurse was designated to carry out the infection control procedures in the decontamination room. 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 being met. An infection control audit was last completed in February 2016. This had identified two areas that required improvement and we found these actions had been implemented and established. For example a system was in place to record any dental instruments that staff were unable to reprocess because they could not remove debris such as cement residue. This confirmed to us that staff followed systems to ensure they were compliant with HTM 01 05 guidelines.

We saw that the dental treatment rooms, waiting area, reception and toilet were clean, tidy and clutter free. In the treatment rooms, there were clearly marked areas to separate the clean from dirty areas to prevent any cross contamination. 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.

The practice had a separate decontamination room for instrument processing.The dental nurse working in the decontamination room demonstrated the process from taking the dirty instruments through the cleaning process to ensure they were fit 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 the instruments then following inspection with an illuminated magnifier, they were placed in a washer disinfector machine. Finally they were sterilised in an autoclave. This is a device for sterilising dental and medical instruments. Once sterilised, instruments were placed in pouches and dated to indicate when they should be reprocessed if left unused in line with current guidelines.

We were shown the systems in place to ensure that the washer disinfectors and autoclaves used in the decontamination process were working effectively. Records

showed that regular daily, weekly and monthly validation tests were recorded in an appropriate log book. On the day of the inspection, one autoclave was out of use and awaiting repair as the print out was not working therefore staff could not be assured that it was working correctly.

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). Dental nurses 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 2011. The recommended procedures contained in the report were carried out and logged appropriately. This included regular testing of the water temperatures in the building, descaling shower heads and scaler tips. The practice manager planned to designate the responsibility for monitoring legionella risks to a member of staff. These measures ensured that patients' and staff were protected from the risk of infection due to legionella.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained and was 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. Cleaning schedules were in place and these were monitored by the practice manager. Cleaning equipment for the premises was stored in line with current guidelines.

Equipment and medicines

There were systems in place to check that the equipment had been serviced regularly and in accordance with the manufacturer's instructions. Items included the autoclaves, firefighting equipment, oxygen cylinders and the X-ray equipment. We were shown the annual servicing certificates.

An effective system was in place for the prescribing, dispensing, use and stock control of the medicines used in clinical practice such as antibiotics and local anaesthetics. We found that the practice stored prescription pads securely and had a robust tracking system. 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.

Radiography (X-rays)

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

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

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The 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 outcomes were discussed with the patient and treatment options explained to them if relevant.

Patients were provided with preventative dental information in order to improve the outcome for the patient. This included dietary advice and general dental hygiene procedures such as tooth brushing techniques or recommended tooth care products. The patient's 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.

Staff we spoke with described ways they assessed the condition of patient's gums and soft tissues of the mouth using the basic periodontal examination (BPE) scores. The BPE score is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need. These were carried out where appropriate during a dental health assessment.

The practice did not offer conscious sedation to anxious patients who required it and referred them to other dental specialists. Their treatment was then monitored after being referred back to the practice once it had taken place to ensure they received a satisfactory outcome and all necessary post procedure care.

Health promotion & prevention

The dentists focussed on the preventative aspects of their practice to promote better oral health and dental hygiene. Two dental hygienist/ therapists worked alongside the dentists to deliver preventive dental care. Appropriate internal referrals were made and patients could also self-refer. Adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. Clinical staff told us this was recorded in their dental record. Tooth brushing techniques were explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate and patients we spoke with confirmed this. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'.

The waiting room and reception area contained leaflets that explained the services offered at the practice. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area.

Staffing

The practice employed three dentists, an orthodontist, a periodontist and two dental hygienist/ therapists. They were supported by a team of seven trained dental nurses and one trainee dental nurse. In addition there was a practice manager and four reception staff. The staff were further supported by a corporate management and advisory team.

All of the patients we asked on the day of our visit said they had confidence and trust in the dentists. This was also reflected in the Care Quality Commission comment cards and the compliment cards that were displayed in the practice. 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.

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

An appraisal system had not been established for all staff at the practice. However, the practice manager had this under review to ensure that all staff received an appraisal and a

Are services effective?

(for example, treatment is effective)

personal development plan that identified their training and development needs. Staff we spoke with told us they had completed some informal discussion with the practice manager about their training and development needs.

Working with other services

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

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

Consent to care and treatment

The practice sought valid consent from patients for all care and treatment. Staff confirmed individual treatment options, risks and benefits were discussed with each patient who then received a detailed treatment plan and an estimate of costs. Recently, the practice had implemented dental record templates that included issues such as consent. This helped to ensure that staff completed records in sufficient detail. Staff described the importance of ensuring that patients were given time to consider and make informed decisions about their treatment options which were then recorded in their dental records. There were very few patients with limited English language skills registered at the practice. In the event that staff were unable to communicate information to a patient, access to an interpretation service was available.

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. We spoke to two dentists who were able to demonstrate their understanding of the MCA and how this applied to patients and their capacity to consent to dental treatment. This included assessing a patient's capacity to consent and when making decisions in a patient's best interests. They were also familiar with the Gillick principles to help them judge when children and young people were able to make their own decisions about their treatment.

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. Conversations between patients and dentists could not be heard from outside the treatment rooms which protected patient's privacy. Patients' clinical records were stored electronically and computers were password protected. 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 to the practice for patients to share their experience of the practice. We collected seven completed CQC patient comment cards and obtained the views of three patients on 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 staff treated them with respect, were friendly and understanding. During the inspection we observed that practice staff 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 and private treatment costs was displayed in the waiting area and similar information could be found on the practice website. The dentists we spoke with paid particular attention to patient involvement when drawing up individual care plans. Dental nurses we spoke with confirmed this. We found 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

The practice waiting area contained an information folder for patients about the practice. This included opening times, access to urgent care out of hours, Oasis code of practice and how to raise any concerns about the service. Other information displayed included costs for NHS and private dental care, basic dental health information and a copy of the standards for dentistry care issued by the General Dental Council outlining what patients can expect from their dentist.

We observed the appointment system and spoke with reception staff and found that there were a sufficient number of available appointments. This included access for patients with dental pain who required urgent appointments.

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. Comments we received from patients indicated that they were satisfied with the response they received from staff when they required treatment or an urgent appointment.

Tackling inequity and promoting equality

The practice was situated across two floors and was very accessible to patients with disabilities. There were accessible toilets and baby change facilities on the ground floor. The practice manager told us that a high number of registered patients were elderly and they ensured that they were seen in the ground floor treatment rooms as there was no lift to the first floor.

A hearing loop was available in the reception area. The staff explained they would also help patients to complete NHS and other forms if they were partially sighted or hard of hearing. We observed staff supporting people with limited mobility to access the treatment rooms. Patients were treated with respect and compassion.

Staff told us they rarely met patients with limited English language skills although access to translation services were available if needed.

Access to the service

The practice was open 8am to 7pmMonday to Thursday, 8am to 6pm Friday and Saturday 9am to 1pm. The practice used the NHS 111 service to give advice in case of a dental emergency for NHS patients when the practice was closed. This information was available on the telephone answering service when the practice was closed which also advised private patients on how to access emergency care.

Patients could make online appointments or call the practice direct. Patients that we spoke with told us they had no difficulties arranging convenient appointments.

Concerns & complaints

The practice had a complaints policy and a procedure that set out how complaints would be addressed, who by, and the timeframes for responding. Information for patients about how to make a complaint was seen in the patient leaflet and in the waiting area. None of the patients who gave us comments about the practice had needed to make a complaint. They all told us the staff they had contact with were approachable and they would not hesitate to raise any concerns with them.

The practice had received four complaints since the current practice manager had been in post. There were no records to demonstrate that a complaints process was in place prior to this time. We reviewed the management of the complaints which were recorded on an electronic tracker and shared with the head office team. We saw these had been managed in a timely way and opportunities to improve the safety and the quality of the service had been taken although records to demonstrate what learning had taken place were not completed. The staff received training in the management of concerns and complaints as part of their induction programme. Staff told us they would always attempt to resolve the issue raised at the time or would refer it to a dentist or practice manager if they could not. Patients received an apology when things had not gone well.

Are services well-led?

Our findings

Governance arrangements

It was the responsibility of the practice manager to lead on governance and quality monitoring issues. The practice shared business support services and policies issued by the provider which aimed to support a common approach. A range of policies and procedures were in use at the practice. These included health and safety, infection prevention and control, patient confidentiality and recruitment. Staff we spoke with were aware of the policies and further improvement was planned by the practice manager to increase awareness through team meetings. Monthly practice meetings had been established within the last three months and these included issues such as patient feedback, health and safety and complaints.

The practice manager had reviewed the systems used to ensure the safety of the environment and of equipment such as machinery used in the decontamination process and fire safety equipment. Risk assessments were in place. Records we reviewed demonstrated that audits had been taking place for infection control, radiography and dental care records.

Leadership, openness and transparency

There was a clear leadership structure in place and staff understood their roles and responsibilities within the practice. For example there was a lead dental nurse, a lead receptionist, fire marshals, first aiders and a safeguarding lead. The practice manager had been reviewing standards in the last four months and working with the team to ensure that improvement was maintained.

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

Learning and improvement

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

A member of the team also works as an advisor in dentistry for Health Education England and as an advisory member of the board at Oasis Dental Care Limited. They have used their knowledge and skills to share learning and improve services across the practice. For example, they recently provided Mental Capacity Act training and are involved in peer review.

It was not evident that a structured audit programme was embedded at the practice. However, we found there were a number of clinical and non-clinical audits that had taken place at the practice in the last six months. These included clinical record keeping, infection control, antibiotic prescribing audits and X-ray quality audits. The audits we reviewed demonstrated the practice was focused on improving the service. For example, a recent records audit had identified that dental records were not being fully completed. The regional clinical advisor met with the dentists who agreed to use a template record card to ensure that improvement was made. A further audit was planned in the near future. The practice manager informed us that the range and frequency of audits would continue to be used as a tool to help strengthen the service.

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

The practice gathered feedback from patients on a monthly basis by sending out their own feedback forms and asking patients to provide online feedback. We saw the practice had taken action this in recent months because some patients had said they did not understand their treatment options and costs. Staff had discussed this in a practice meeting and taken action to improve it. The subsequent

Are services well-led?

monthly feedback had improved and they were continuing to monitor this. We saw that 100% patients aid the quality of their treatment was good and 99% patients who completed the survey would recommend the practice to others. Other changes actioned included improved heating in the waiting area.

The practice also participated in the NHS Friends and Family test. A display in the waiting area showed that in January 2016, 94% of patients who completed the survey would recommend the practice. This compared to 95% of patients who completed feedback to say they would recommend the service in February 2016.

All of the staff told us they felt involved in the running of the practice and the practice manager listened to their opinions and respected their knowledge and input at meetings. Staff told us they felt valued and were proud to be part of the team.