Locala Community Partnerships C.I.C.

Dental Clinic, Todmorden Health Centre

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 20 December 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

Dental Clinic, Todmorden Health Centre is situated in Todmorden, West Yorkshire. The practice is a community dental service. It offers treatment to adults and children with special needs. The services include preventative advice and treatment and routine restorative dental care.

The practice is located on the second floor of a large medical centre. There is a lift from the ground floor to the dental clinic. There are two surgeries, an instruments storage room, a recovery room, a preventative dental unit, a waiting area and a reception area.

There is one dentist, three dental hygiene therapists and six dental nurses. They are supported by a management team which includes a quality manager, a customer engagement manager and a head of business.

The opening hours are Monday, Tuesday and Thursday 8:30am to 5:00pm.

The Chief Executive of Locala is the registered manager. A registered manager is a person who is registered with the

Summary of findings

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.

During the inspection we received feedback from three patients. The patients were positive about the care and treatment they received at the practice. Comments included staff were polite, friendly and professional. They also commented they were given very good advice about looking after their teeth.

Our key findings were:

- The practice was visibly clean and uncluttered.
- The practice had systems in place to assess and manage risks to patients and staff including health and safety and the management of medical emergencies.
- Staff were qualified and had received training appropriate to their roles.
- Patients were involved in making decisions about their treatment and were given clear explanations about their proposed treatment including costs, benefits and risks.
- Dental care records showed treatment was planned in line with current best practice guidelines.
- Oral health advice and treatment were provided in-line with the 'Delivering Better Oral Health' toolkit (DBOH).
- We observed patients were treated with kindness and respect by staff.
- The practice used cognitive behavioural therapy to help patients overcome anxiety of dental treatment.
- Reasonable adjustments had been made to enable wheelchair users or patients with limited mobility to access dental treatment.
- Staff ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood.
- The practice had a complaints system in place and there was an openness and transparency in how these were dealt with.
- The governance systems were effective.
- There were clearly defined leadership roles within the practice and staff told us they felt supported, appreciated and comfortable to raise concerns or make suggestions.

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

- Review availability of equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.

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?

No action

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

The practice had an effective process to report incidents and accidents through an electronic patient safety system. Staff felt confident about reporting incidents, accidents and the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

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

Staff were appropriately recruited, suitably trained and skilled for their roles.

Staff were trained to deal with medical emergencies. The practice held two emergency kits so one could be taken on domiciliary visits and one remained in the practice. Some ancillary equipment was missing from the emergency kits. This issue was raised on the day of inspection and we were told this would be addressed.

Decontamination and sterilisation processes were carried out off site. Used instruments were transported in secure rigid boxes. Sterile instruments were stored appropriately.

The practice was following current legislation and guidance in relation to x-rays, to protect patients and staff from unnecessary exposure to radiation.

Are services effective?

No action

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

Patients' dental care records provided comprehensive information about their current dental needs and past treatment. The practice monitored any changes to the patient's oral health and provided treatment when appropriate.

The practice followed best practice guidelines when delivering dental care. These included Faculty of General Dental Practice (FGDP), National Institute for Health and Care Excellence (NICE) and guidance from the British Society of Periodontology (BSP).

The practice provided preventative advice and treatment in line with the 'Delivering Better Oral Health' toolkit (DBOH). This included fluoride application, oral hygiene advice and smoking cessation advice.

Staff had completed training relevant to their roles and were up to date with their continuing professional development (CPD).

There was an effective skill mix within the practice. Several dental nurses had extended duties including oral health education and dental radiography. One of the dental hygiene therapists used cognitive behavioural therapy to help nervous patients overcome their dental anxieties.

There was an effective system in place for receiving referrals from dentists. Referrals were also made to other providers when appropriate.

Summary of findings

Are services caring?

No action

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

During the inspection we received feedback from three patients. Comments included staff were polite, friendly and professional.

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

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

Are services responsive to people's needs?

No action

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

The practice had an efficient appointment system in place to respond to patients' needs. There were vacant appointments slots for urgent or emergency appointments each day. There were clear instructions for patients requiring urgent care when the practice was closed.

There was a procedure in place for responding to patients' complaints. This involved acknowledging, investigating and responding to individual complaints or concerns. Staff were familiar with the complaints procedure.

The provider had taken into account the needs of different groups of people and put adjustments in place. For example, the practice used a platform designed specifically to enable wheelchair users to receive treatment whilst in their wheelchair. They also had access to a dental nurse who could use sign language.

Are services well-led?

No action

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

There was a clearly defined management structure in place and staff felt supported and appreciated in their own particular roles.

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

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

The practice had a system in place to seek feedback from patients.

Dental Clinic, Todmorden Health Centre

Detailed findings

Background to this inspection

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

The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

We informed the local NHS England area team that we were inspecting the practice. We did not receive any information of concern from them. We also reviewed information held by CQC about the practice and no concerns were identified.

During the inspection we received feedback from three patients. We also spoke with the dentist, two dental nurses and members of the managerial team. To assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had clear guidance for staff about how to report incidents and accidents. Staff were familiar with the importance of reporting significant events. Significant events were recorded through an electronic patient safety system. We discussed significant events which had occurred; these had been analysed and action taken to prevent reoccurrence. Actions resulting from a significant event were shared to other locations to disseminate learning. Information was also disseminated to all staff via weekly and monthly newsletters.

Staff understood the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There was guidance about what types of incidents need to be referred to RIDDOR in the electronic patient safety system. Staff were also aware of notifications required by the CQC.

Staff told us they were aware of the need to be open, honest and apologetic to patients if anything was to go wrong; this is in accordance with the Duty of Candour principle.

The provider had implemented a system to avoid wrong site surgery. This was called the "Local safety standards for invasive procedures". This was a document which had to be completed prior to any extractions and signed by both the dentist and dental nurse. The use of this form was audited on a regular basis.

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

Reliable safety systems and processes (including safeguarding)

The practice had child and adult safeguarding policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff. Staff had access to contact details for both child protection and adult safeguarding teams. Staff had a good understanding of the signs and symptoms of abuse and neglect. All staff had undertaken safeguarding training appropriate to their roles and had regular updates. There was a dedicated safeguarding team who were readily available for advice.

The provider had a whistleblowing policy in place with an associated procedure to enable staff to raise issues and concerns.

We spoke to with staff about the use of safer sharps in dentistry as per the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. A safer sharps system was in use at the practice. We were told that the clinicians were responsible for handling local anaesthetic syringes.

The dentist told us they routinely used a rubber dam when providing root canal treatment to patients in line with guidance from the British Endodontic Society. 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. Rubber dams should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons is recorded in the patient's dental care records giving details as to how the patient's safety was assured.

We saw patients' clinical records were computerised and password protected to keep personal details safe. Passwords were regularly changed.

Medical emergencies

The practice had procedures in place which provided staff with clear guidance about how to deal with medical emergencies. Staff were knowledgeable about what to do in a medical emergency and had completed training in emergency resuscitation and basic life support within the last 12 months. Refresher training was also completed bi-annually.

The practice held two sets of emergency resuscitation kit, medical emergency oxygen and emergency medicines. One set was available to take on domiciliary visits. Staff knew where the emergency kits were kept.

We checked the emergency equipment and medicines and found them to be in date and in line with the Resuscitation Council UK guidelines and the BNF. However, some items were not available, namely, a child sized mask for the self-inflating bag in the surgery kit and an oxygen face mask in the domiciliary kit. This was raised on the day of inspection and we were assured this would be addressed.

Are services safe?

The practice had an Automated External Defibrillator (AED) to support staff in a medical emergency. (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). If the AED had been taken on a domiciliary visit a spare one was available within the GP surgery located on the same floor.

Records showed weekly checks were carried out on the AED, emergency medicines and the oxygen cylinder. These checks ensured the oxygen cylinder was full and in good working order, the AED battery was charged and the emergency medicines were in date.

Staff recruitment

The practice had a policy and a set of procedures for the safe recruitment of staff which included seeking references, proof of identity, checking relevant qualifications and professional registration. We reviewed a sample of staff files and found the recruitment procedure had been followed. We were told the practice carried out Disclosure and Barring Service (DBS) checks for all newly employed staff. These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. We reviewed records of staff recruitment and these showed all checks were in place.

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

Monitoring health & safety and responding to risks

A health and safety policy, and risk assessments were in place at the practice. This identified the risks to patients and staff who attended the practice. The risks had been identified and control measures put in place to reduce them. An annual risk assessment was carried out on the premises by the dedicated health and safety team.

A fire risk assessment had been carried out on the premises and was reviewed on an annual basis. Weekly fire alarm tests were carried out by the maintenance team.

The practice maintained an electronic folder relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including substances such as disinfectants, and dental materials in use in the practice. This folder was easily accessible to all staff. The practice identified how it managed hazardous substances in its health and safety and infection control policies, and in specific guidelines for staff, for example in its blood spillage and waste disposal procedures.

Infection control

There was an infection control policy and procedures to keep patients safe. These included hand hygiene, safe handling of instruments and managing waste products. There was a dedicated infection control lead who provided support and guidance for staff.

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

We observed the treatment rooms to be clean and hygienic. Work surfaces were free from clutter. Staff told us they cleaned the treatment areas and surfaces between each patient and at the end of the morning and afternoon sessions to help maintain infection control standards. There was a cleaning schedule which identified and monitored areas to be cleaned. There were hand washing facilities in the treatment rooms and staff had access to supplies of personal protective equipment (PPE) for patients and staff members. Posters promoting good hand hygiene were clearly displayed to support staff in following practice procedures. Sharps bins were appropriately located, signed and dated and not overfilled. We observed waste was separated into safe containers for disposal by a registered waste carrier and appropriate documentation retained.

Decontamination procedures were carried out off site. An instrument transportation system had been implemented to ensure the safe movement of instruments between the location and the decontamination facility, which minimised the risk of the spread of infection. This involved the use of rigid containers. Sterile instruments were bagged at the decontamination facility and stored appropriately at the location. There was a monthly check is place to identify if any bagged instruments had passed their use by date.

An infection prevention and control audit had been completed in September 2016. This showed the practice was meeting the required standards.

Are services safe?

Records showed a risk assessment process for Legionella had been carried out (Legionella is a term for particular bacteria which can contaminate water systems in buildings). The practice undertook processes to reduce the likelihood of legionella developing which included running the water lines in the treatment rooms at the beginning and end of each session and between patients, monitoring cold and hot water temperatures each month and tests on the water quality to ensure Legionella was not developing.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as x-ray sets and the compressor. The maintenance team were responsible for arranging the regular servicing of equipment. We saw evidence of validation of the compressor. Portable appliance testing (PAT) had been completed in February 2016 (PAT confirms that portable electrical appliances are routinely checked for safety).

We saw the practice was storing NHS prescription pads securely in accordance with current guidance and operated a system for checking deliveries of blank NHS prescription pads. Prescriptions were stamped only at the point of issue. A log of which antibiotics had been prescribed was kept.

A process was in place to check that materials and local anaesthetics were in date. However, we identified one cartridge of local anaesthetic in a surgery which was out of date. There was no evidence to suggest that this batch of local anaesthetic had been used as the dentist advised us they would always check the expiry date prior to administering the local anaesthetic. The practice should review the process for checking expiry dates.

Radiography (X-rays)

The practice had a radiation protection file and a record of all x-ray equipment including service and maintenance history. Records we viewed demonstrated the x-ray equipment was regularly tested and serviced. A Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure the equipment was operated safely and by qualified staff only. We found there were suitable arrangements in place to ensure the safety of the equipment. Local rules were available in both surgeries and within the radiation protection folder for staff to reference if needed. The local rules did not reflect the fact there were two entrances to each surgery. This was highlighted on the day of inspection and we were told the local rules would be reviewed.

We saw a justification, grade and a report was documented in the dental care records for all x-rays which had been taken.

The practice used an automated x-ray developer. We saw that regular tests ensured the quality of the developing was optimal.

Monthly x-ray audits were carried out. These included an assessment of the quality of the x-rays. The results of the most recent audit confirmed that they were compliant with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

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

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

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

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

Health promotion & prevention

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

Some of the dental nurses had completed training in oral health education. There was a dedicated room where they could provide this service. We were told that every new patient received this service from one of the trained dental nurses. This included diet advice and tooth brushing instruction.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. New staff completed a corporate induction and a location specific induction. The location specific induction process included the fire evacuation process and the location of the medical emergency kits. The whole induction process took three months and new staff members had regular progress reviews to identify areas where assistance was needed.

Staff told us they had good access to on-going training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). The practice organised in house training for medical emergencies. Staff also had access to an on-line training system which covered topics such as fire safety, safeguarding and infection prevention and control. Records showed evidence of on-going CPD.

The provider employed two dental hygiene therapists. Dental hygiene therapists are trained dental care professionals who are qualified to undertake certain treatments, for example, fillings, periodontal treatments and the extraction of deciduous teeth. The dentist could refer patients to the dental hygiene therapist. One of the dental hygiene therapists was qualified to provide cognitive behavioural therapy (CBT). CBT is a therapy that can help manage problems by changing the way patients think and behave. This was used to help patients overcome their anxieties in relation to dental treatment and avoid the need for sedation or general anaesthetic.

Staff told us they had annual appraisals and training requirements were discussed at these. We saw evidence of completed appraisal documents. Staff could also apply for additional courses. These would be considered by a panel and if appropriate would be funded by the provider.

Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interest of the

Are services effective?

(for example, treatment is effective)

patient and in line with current guidance. For example, referrals were made to hospitals and specialist dental services for further investigations or specialist treatment including orthodontics, oral surgery and general anaesthetic. We reviewed referral letters and found they were detailed appropriately and there was clear evidence of a multidisciplinary approach involving both GPs and other dentists.

The practice also ensured any urgent referrals were dealt with promptly such as referring for suspicious lesions under the two-week rule. The two-week rule was initiated by NICE in 2005 to enable patients with suspected cancer lesions to be seen within two weeks.

The practice had a system in place to receive referrals from other dentists. We were told new patients could get an appointment within two weeks for an initial consultation.

Consent to care and treatment

Patients were given appropriate verbal and written information to support them to make decisions about the treatment they received. Staff were knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent. The dentist described to us how valid consent was obtained for all care and treatment and the role family members and carers might have in supporting the patient to understand and make decisions. The dentist was familiar of the concept of Gillick competency clear about involving children in decision making and ensuring their wishes were respected regarding treatment.

Staff had completed training and had a good understanding of the principles of the Mental Capacity Act (MCA) 2005 and how it was relevant to ensuring patients had the capacity to consent to their dental treatment. We saw evidence of documented best interest meetings having taken place when patients lack capacity and required invasive treatment.

Staff ensured patients gave their consent before treatment began. We were told that individual treatment options, risks, benefits and costs (where appropriate) were discussed with each patient. Consent forms were used which outlined the type of treatment which had been proposed. These were signed by the dentist and also the patient, parent or carer. This indicated the patient had been informed of the treatments and the associated risks. Patients were given time to consider and make informed decisions about which option they preferred. The dentist was aware that a patient could withdraw consent at any time.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Feedback from patients was positive and they commented they were treated with care, respect and dignity. Staff told us they always interacted with patients in a respectful, appropriate and kind manner. We observed staff to be friendly and respectful towards patients during interactions at the reception desk and over the telephone. All staff had completed a dementia friend course. This gave them a greater understanding of issues relating to persons living with dementia.

We observed privacy and confidentiality were maintained for patients who used the service on the day of inspection. This included ensuring dental care records were not visible to patients and keeping surgery doors shut during consultations and treatment.

We observed staff to be helpful, discreet and respectful to patients. Staff told us if a patient wished to speak in private an empty room would be found to speak with them.

Involvement in decisions about care and treatment

Patients were provided with information to enable them to make informed choices. 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.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We found the practice had an efficient appointment system in place to respond to patients' needs. Staff told us patients who requested an urgent appointment would be seen the same day. If there was not capacity to see a patient that day then they would be offered an appointment at a sister practice.

We observed the clinics ran smoothly on the day of the inspection and patients were not kept waiting.

Tackling inequity and promoting equality

The practice had equality and diversity, and disability policies to support staff in understanding and meeting the needs of patients. Reasonable adjustments had been made to the premises to accommodate patients with mobility difficulties. These included step free access to the premises, automatic doors, a lowered reception desk and accessible toilet facilities. The surgeries were large enough to accommodate a wheelchair or a pram. They also had access to a platform designed specifically to allow wheelchair users to receive treatment whilst in their wheelchair.

The practice offered interpretation services to patients whose first language was not English. We were told they had access to a dental nurse who could use sign language.

Access to the service

Patients could access care and treatment in a timely way and the appointment system met their needs. Staff were aware of the long waiting list for treatment to be provided. The practice used dental hygiene therapists in order to reduce the waiting list. Where treatment was urgent patients would be seen the same day. The practice had a system in place for patients requiring urgent dental care when the practice was closed. Patients were signposted to the NHS 111 service. Information about the out of hours emergency dental service was available on the telephone answering service and displayed in the waiting area.

Concerns & complaints

The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. There were details of how patients could make a complaint displayed in the waiting room. Complaints were dealt with by the customer engagement manager. Staff told us they aimed to resolve complaints in-house initially. The practice had received one complaint in the past 12 months and we found it had been dealt with in line with the practices policy and to the patient's satisfaction. A detailed complaints log was maintained. This included the nature of the complaint, the date it had been acknowledged, the date a response had been provided and a conclusion including actions taken as a result. Complaints would be discussed at monthly management meetings to determine if any improvements could be made to the service.

Are services well-led?

Our findings

Governance arrangements

The practice was a member of a 'Good Practice' accreditation scheme. This is a quality assurance scheme that demonstrates a visible commitment to providing quality dental care to nationally recognised standards.

There was an effective management structure in place to ensure responsibilities of staff were clear. Staff told us they felt supported and were clear about their roles and responsibilities.

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

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

Leadership, openness and transparency

The culture of the practice encouraged candour, openness and honesty to promote the delivery of high quality care and to challenge poor practice.

Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. These would be discussed openly where relevant and it was evident the practice worked as a team and dealt with any issue in a professional manner.

The practice held bi-annual staff meetings where topics such as safeguarding, medical emergencies and staff recruitment were discussed. These meetings were minuted for those who were unable to attend

The provider also held monthly management meetings where significant events, health and safety and complaints were discussed.

Learning and improvement

Quality assurance processes were used at the practice to encourage continuous improvement. The practice audited areas of their practice as part of a system of continuous improvement and learning. This included audits of dental care records, x-rays, infection prevention and control and failed appointments. We looked at the audits and saw the practice was performing well. We saw actions taken following an audit of failed appointments had reduced the patient failure rate from 13% to 7%.

Staff told us they had access to training and this was monitored to ensure essential training was completed each year; this included medical emergencies and basic life support. Staff working at the practice were supported to maintain their continuous professional development as required by the General Dental Council. Staff were allowed time to complete mandatory training.

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

The practice had systems in place to involve, seek and act upon feedback from people using the service including carrying out annual patient satisfaction surveys and an on-line feedback system. The satisfaction survey included questions about how long they had to wait before their appointment, whether they were happy with the treatment provided and whether they felt involved in decision making.