Dr. Andrew Michalcewicz

Ash Villa Dental Practice

Inspection Report

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Overall summary

We carried out this announced inspection on 20 November 2018 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

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 form the framework for the areas we look at during the inspection.

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

Ash Villa Dental is in Sale, Manchester and provides private treatment to adults and children.

There is a ramp to access the premises for people who use wheelchairs and those with pushchairs. A small car park is provided with additional on street parking nearby.

The dental team includes three dentists comprising of the principal dentist and two associate dentists, a clinical practice manager, a business practice manager, three dental nurses, a part time dental hygiene therapist, a receptionist and a reception manager. The practice has three treatment rooms.

Summary of findings

The practice is owned by an individual who is the principal dentist there. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

On the day of inspection, we collected 33 CQC comment cards filled in by patients. Patients were very positive about the service.

During the inspection we spoke with three dentists, two dental nurses, the clinical manager and the business manager. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday 9:00am - 6:00pm

Tuesday 9:00am - 7:00pm

Wednesday and Thursday 9:00am - 5:30pm

Friday 8:40am - 3:00pm

Our key findings were:

- The practice appeared clean and well maintained.
- The provider had infection control procedures which should be reviewed to ensure consistency.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- The practice had systems to help them identify and manage risk to patients and staff. Improvements could be made in relation to safety alerts and radiography.
- The practice staff had suitable safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider had thorough staff recruitment procedures. A DBS check had not been carried out for a recently employed dentist.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The provider was providing preventive care and supporting patients to ensure better oral health. Bespoke resources were used to reinforce good oral health.
- The appointment system met patients' needs.
- The practice had effective leadership and culture of continuous improvement.
- Staff felt involved and worked well as a team.
- The practice asked staff and patients for feedback about the services they provided.
- The provider dealt with complaints positively and efficiently.
- The provider had suitable information governance arrangements.

There were areas where the provider could make improvements. They should:

- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued by the Medicines and Healthcare products Regulatory Agency, the Central Alerting System and other relevant bodies, such as Public Health England.
- Review the practice's protocols and procedures for the use of X-ray equipment in compliance with The Ionising Radiations Regulations 2017 and Ionising Radiation (Medical Exposure) Regulations 2017 and taking into account the guidance for Dental Practitioners on the Safe Use of X-ray Equipment.
- Review the practice's infection control procedures and protocols taking into account the guidelines issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, and having regard to The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance' In particular, ensuring staff follow consistent decontamination procedures.
- Review the practice's protocols for ensuring that all clinical staff have adequate immunity for vaccine preventable infectious diseases.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services. We asked the following question(s).

Are services safe?

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

The practice had systems and processes to provide safe care and treatment. They used learning from incidents and complaints to help them improve.

Staff knew how to recognise the signs of abuse and how to report concerns. They received training in safeguarding people but not always to the correct level.

Staff were qualified for their roles and the practice completed essential recruitment checks, with the exception of one DBS check.

Premises and equipment were clean and properly maintained. The practice broadly followed national guidance for cleaning, sterilising and storing dental instruments. We noticed inconsistencies in the processes in place.

The practice had suitable arrangements for dealing with medical and other emergencies. Action was taken immediately after the inspection to review the location of medical emergency equipment.

No action ✓

Are services effective?

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

The dentists assessed patients' needs and provided care and treatment in line with recognised guidance. Patients described high levels of satisfaction with the treatment they received. The dentists discussed treatment with patients so they could give informed consent and recorded this in their records.

The practice had clear arrangements when patients needed to be referred to other dental or health care professionals.

The practice had developed personalised certificates for children to commemorate their first dental visit. Staff used resources creatively to encourage children to maintain good oral hygiene.

The practice supported staff to complete training relevant to their roles and had systems to help them monitor this.

No action ✓

Are services caring?

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

We received feedback about the practice from 33 people. Patients were positive about all aspects of the service the practice provided. They told us staff were friendly, welcoming and professional.

They said that they were given helpful, honest explanations about dental treatment, and said their dentist listened to them. Patients commented that they made them feel at ease, especially when they were anxious about visiting the dentist.

No action ✓

Summary of findings

We saw that staff protected patients' privacy and were aware of the importance of confidentiality. Patients said staff treated them with dignity and respect.

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's appointment system was efficient and met patients' needs. Patients could get an appointment quickly if in pain.

Staff considered patients' different needs. This included providing facilities for disabled patients and families with children. The practice had access to interpreter services and had arrangements to help patients with sight or hearing loss.

The practice took patients views seriously. They valued compliments from patients and responded to concerns and complaints quickly and constructively.

Are services well-led?

No action 

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

The practice had arrangements to ensure the smooth running of the service. These included systems for the practice team to discuss the quality and safety of the care and treatment provided. There was a clearly defined management structure and staff felt supported and appreciated.

The systems to assess and manage risks, issues and performance could be improved. In particular, relating to safety alerts, decontamination processes, radiography equipment and carrying out essential checks on staff.

The practice team kept complete patient dental care records which were clearly written or typed and stored securely.

The practice monitored clinical and non-clinical areas of their work to help them improve and learn. This included asking for and listening to the views of patients and staff.

Are services safe?

Our findings

Safety systems and processes, including staff recruitment, equipment & premises and radiography (X-rays)

The practice had clear systems to keep patients safe.

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The practice had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We highlighted that these could be made more available to staff. Immediate action was taken on the day to provide these in several areas throughout the practice. Staff were encouraged to undertake safeguarding training and we saw evidence of this, although this was not always to the appropriate level. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns. We discussed the requirement to ensure all staff completed safeguarding training to the appropriate level for their role and to notify the CQC of any safeguarding referrals as staff were not aware. Evidence of training to the correct level was sent after the inspection.

There was a system to highlight vulnerable patients on records e.g. children with child protection plans, adults where there were safeguarding concerns, people with a learning disability or a mental health condition, or who require other support such as with mobility or communication.

The practice had a whistleblowing policy. Staff felt confident they could raise concerns without fear of recrimination.

The dentists used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment. In instances where the rubber dam was not used, such as for example refusal by the patient, and where other methods were used to protect the airway, this was documented in the dental care record and a risk assessment completed.

The provider had a business continuity plan describing how they would deal with events that could disrupt the normal running of the practice.

The practice subscribed to an online human resources provider which included recruitment policies and procedure to help them employ suitable staff. These reflected the relevant legislation. We looked at three staff recruitment records. These showed the practice followed their recruitment procedure, with the exception of carrying out a Disclosure and Barring Service (DBS) on the most recently employed dentist. DBS checks or an adequate risk assessment should be undertaken at the point of employment to ensure the employee is suitable to work with children and vulnerable adults.

We noted that clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover.

The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions, including electrical and gas appliances. One of the treatment rooms had recently been refurbished to a high standard. The fitters had carried out remedial work to the electrical systems prior to the work being carried out. The practice had not had the five-yearly examination of the fixed electrical wiring of the building. This is recommended to ensure the electrical installations within a building are safe and compliant. The clinical manager took immediate action to arrange this.

Records showed that fire detection equipment, such as smoke detectors and emergency lighting, were regularly tested and firefighting equipment, such as fire extinguishers, were regularly serviced.

The practice had arrangements to ensure the safety of the X-ray equipment and had the required information in their radiation protection file. The practice had an OPG (Orthopantomogram) which is a rotational panoramic dental radiograph that allows the clinician to view the upper and lower jaws and teeth and gives a 2-dimensional representation of these.

We noted the critical examinations carried out when equipment was installed included recommendations which had not been implemented. These included ensuring isolation switches were located outside the surgeries and safety X-ray warning signs were displayed. There were also recommendations to identify whether two walls had the appropriate radiation protection. Informal arrangements were in place to ensure no-one was in the waiting area next to this room or the doorway whilst X-rays were taken, but this information was not made clear to operators, for example in the local rules. We discussed this

with the clinical manager who understood the need to formalise the process, update the local rules, review the availability and positioning of isolation switches and display safety signs. They sent evidence immediately after the inspection that they had displayed the appropriate signage and consulted with their Radiation Protection Adviser (RPA) to ensure that they met current radiation regulations.

We saw evidence that the dentists justified, graded and reported on the radiographs they took. The clinical practice manager had created a specific radiographic reporting template in the clinical records system to prompt staff to record this information correctly. The practice carried out radiography audits every year following current guidance and legislation.

Clinical staff completed continuing professional development (CPD) in respect of dental radiography.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

The practice's health and safety policies, procedures and risk assessments were up to date and reviewed regularly to help manage potential risk. The practice had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The staff followed relevant safety regulation when using needles and other sharp dental items. A comprehensive sharps risk assessment had been undertaken and was updated annually. Safer needle and dental matrices were in place and staff confirmed that only the dentists and the dental therapist were permitted to assemble, re-sheath and dispose of needles where necessary to minimise the risk of inoculation injuries to staff. Protocols were in place to ensure staff accessed appropriate care and advice in the event of a sharps injury and staff were aware of the importance of reporting inoculation injuries.

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked. The results of these vaccinations were not available for five of the clinical staff. The provider did not have a risk assessment in place in relation to staff working in a clinical environment where the effectiveness of their Hepatitis B vaccination was unknown or where it was ineffective. This was discussed with the clinical manager to obtain results and risk assess as appropriate.

Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support (BLS) every year.

Emergency equipment and medicines were available as described in recognised guidance. Staff kept records of their checks to make sure these were available, within their expiry date, and in working order. We observed that two oxygen masks had expired and Glucagon (which is required in the event of severe low blood sugar), was kept with the emergency drugs kit but the expiry date had not been adjusted in line with the manufacturer's instructions. The Automated External Defibrillator (AED) was kept on the back of the office door. We highlighted this could be subjected to damage against the wall. The clinical manager confirmed after the inspection that expired items had been replaced and the AED had been moved and was now stored with other emergency items.

A dental nurse worked with the dentists and the dental hygiene therapist when they treated patients in line with GDC Standards for the Dental Team.

The provider had completed risk assessments and retained safety data sheets to minimise the risk that can be caused from substances that are hazardous to health. The practice could not be sure that all hazardous cleaning substances had been assessed. The clinical manager confirmed this would be addressed.

The practice had an infection prevention and control policy and procedures. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health and Social Care. Staff completed infection prevention and control training and received updates as required.

The practice had suitable arrangements for transporting and checking instruments in line with HTM01-05. Procedures were not available in the decontamination areas for staff to follow, as a result, we observed differences in the way staff cleaned and sterilised instruments. For example:

Are services safe?

- How the ultrasonic baths were operated and the frequency of solution changes.
- The layout of equipment resulted in instruments being pouched in the area where contaminated instruments were cleaned.
- The two sterilisers had vacuum-assisted cycles, where wrapped instruments can be reprocessed. We observed staff using different cycles on the machines. Steam penetration tests were not carried out, which are required for vacuum-assisted sterilisers.

We also noted that dental burs and ultrasonic scaler tips were stored open in drawers in the treatment rooms. We discussed our observations with the clinical manager, they told us the new sterilisers were installed in November 2017 and April 2018 respectively. They had identified just before the inspection that these devices had vacuum capability but gave assurance the vacuum cycles were not being used. They gave assurance that they would review the processes and provide clear procedures to staff to follow.

The records showed equipment used by staff for cleaning and sterilising instruments were maintained in line with the manufacturers' guidance.

The practice had in place systems and protocols to ensure that any dental laboratory work was disinfected prior to being sent to a dental laboratory and before the dental laboratory work was fitted in a patient's mouth.

The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. All recommendations had been actioned and records of water testing and dental unit water line management were in place. During the inspection we identified a working cold water tap in the cellar that had not been identified in the risk assessment or by staff. The clinical manager made arrangements for this to be removed.

We saw cleaning schedules for the premises. The practice was clean when we inspected and patients confirmed that this was usual. We highlighted that the cleaning schedule should include the cellar steps as staff access this area regularly.

The practice had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance and staff were aware of the importance of this. We noted that clear bin liners were used in household and clinical waste bins. The clinical manager told us this was an oversight and would be addressed immediately.

The practice carried out infection prevention and control audits twice a year. The latest audit did not include an action plan or analysis of the findings. We discussed the need to ensure this is carried out to ensure that any issues are identified and acted upon.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at a sample of dental care records to confirm our findings and noted that individual records were written and managed in a way that kept patients safe. Dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation (GDPR) requirements.

Patient referrals to other service providers contained specific information which allowed appropriate and timely referrals in line with practice protocols and current guidance.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

There was a suitable stock control system of medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required.

The practice stored and kept records of NHS prescriptions as described in current guidance.

The dentists were aware of current guidance with regards to prescribing medicines.

Track record on safety

The practice had a good safety record.

Are services safe?

There were comprehensive risk assessments in relation to safety issues. The practice monitored and reviewed incidents. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Incidents were investigated, documented and discussed with the rest of the dental practice team to prevent such occurrences happening again in the future.

Lessons learned and improvements

The practice learned and made improvements when things went wrong.

The staff were aware of the Serious Incident Framework and recorded, responded to and discussed all incidents to reduce risk and support future learning in line with the framework.

There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons identified themes and acted to improve safety in the practice. For example, providing safer disposable sharps.

The practice did not have a system to receive and act on safety alerts. Staff were not aware of these or their importance. We showed the clinical manager examples of these and carried out checks which confirmed that no devices at the practice had been affected. The clinical manager took immediate action to register to receive and review these in the future.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The practice had systems to keep dental practitioners up to date with current evidence-based practice. We saw that clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

The provider took into account guidelines as set out by the British Society for Disability and Oral Health when providing dental care in domiciliary settings such as care homes or in people's residence. We saw completed risk assessments that were carried out prior to providing domiciliary care.

The staff were involved in quality improvement initiatives as part of their approach in providing high quality care. They were a member of a certification scheme, this included attendance at supported peer review and practice planning meetings. These were used to identify areas to improve and set objectives for the whole team.

Helping patients to live healthier lives

The practice was providing preventive care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentists prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish based on an assessment of the risk of tooth decay.

The dentists where applicable, discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of dental products for sale and provided health promotion leaflets to help patients with their oral health.

The practice was aware of and participated in national oral health campaigns and local schemes available in supporting patients to live healthier lives. For example, local stop smoking services. They directed patients to these schemes when necessary. They used social media to promote healthy living. For example, to raise awareness of mouth cancer.

The dentists described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition. Patients were referred to the dental hygiene therapist as appropriate. The practice had developed personalised certificates for children to commemorate their first dental visit, and when they attended for treatment. Toothbrushing aids were available and the dental nurses had created a song to engage younger children in toothbrushing technique.

Patients with more severe gum disease were recalled at more frequent intervals to review their compliance and to reinforce home care preventative advice.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentists gave patients information about treatment options and the risks and benefits of these so they could make informed decisions. Patients confirmed their dentist listened to them and gave them clear information about their treatment.

The practice's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who may not be able to make informed decisions. The policy also referred to Gillick competence, by which a child under the age of 16 years of age can give consent for themselves. The staff were aware of the need to consider this when treating young people under 16 years of age.

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

The practice kept detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dentists assessed patients' treatment needs in line with recognised guidance. Clinical templates were used to ensure a consistent approach to record keeping.

Effective staffing

Are services effective?

(for example, treatment is effective)

Staff had the skills, knowledge and experience to carry out their roles. For example, dental nurses had completed training in radiography, impression taking and oral hygiene including the application of fluoride varnish.

Staff new to the practice had a period of induction based on a structured programme. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council.

Staff discussed their training needs at one to one meetings and informal discussion. The practice addressed the training requirements of staff by providing a training template which encouraged staff to complete training modules regularly throughout the year.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

Dentists confirmed they referred patients to the dental therapist and a range of specialists in primary and secondary care if they needed treatment the practice did not provide.

The practice had systems to identify, manage, follow up and where required refer patients for specialist care when presenting with bacterial infections.

The practice also had systems for referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist.

The practice monitored all referrals to make sure they were dealt with promptly.

Are services caring?

Our findings

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

Staff were aware of their responsibility to respect people's diversity and human rights.

Patients commented positively that staff were friendly, welcoming and professional.

We saw that staff treated patients respectfully, appropriately and kindly and were friendly towards patients at the reception desk and over the telephone.

Patient comments were overwhelmingly positive. Patients said staff were compassionate and understanding. They described how staff were caring and supportive, particularly when patients were nervous, in pain, distress or discomfort. Several patients praised individual staff members for their care and compassion.

Practice information was available for patients to read.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting areas provided limited privacy when reception staff were dealing with patients. If a patient asked for more privacy they would take them into another room. The reception computer screens were not visible to patients and staff did not leave patients' personal information where other patients might see it.

Staff password protected patients' electronic care records and backed these up to secure storage. They stored paper records securely.

Involving people in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the

requirements under the Equality Act.

The practice did not have access to interpreter services for patients who did not have English as a first language. Staff told us these had never been required. Staff communicated with patients in a way that they could understand and communication aids and easy read materials were available. The clinical system had a facility to read the contents of documents or letters aloud to patients with a hearing impairment.

The practice gave patients clear information to help them make informed choices about their treatment. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. A dentist described the conversations they had with patients to satisfy themselves they understood their treatment options. Patients were provided with written treatment plans. The practice used an individual evidence-based risk assessment tool for patients who were members of the payment plan. A detailed report was provided to the patients to help them understand their current oral health and future disease risk.

The practice's website and information leaflet provided patients with information about the range of treatments available at the practice.

The dentists described to us the methods they used to help patients understand treatment options discussed. These included for example, models, videos, X-ray images and photographs shown to the patient/relative to help them better understand the diagnosis and treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

Staff were clear on the importance of emotional support needed by patients when delivering care.

Patients described high levels of satisfaction with the responsive service provided by the practice.

Several patients named members of staff who they felt had provided exceptional service.

A Disability Access audit had been completed and the practice had made reasonable adjustments for patients with disabilities. These included the provision of a ramp at the front entrance, reading glasses at reception and the facility to read aloud any documents that patients struggled to read. Wheelchair users may struggle to use the toilets. Grab rails could not be installed due to the narrow width of the room. Staff informed any new patients who may be affected. A wall had been removed from the car park to provide a wide parking space for patients with a disability but this was not marked.

Patients could choose to receive text message and email reminders for upcoming appointments. Staff telephoned some patients before their appointment to make sure they could get to the practice. Staff also telephoned patients after complex treatment to check on their well-being and recovery.

Timely access to services

Patients could access care and treatment from the practice within an acceptable timescale for their needs.

The practice displayed its opening hours in the premises, and included it in their information leaflet and on their website.

The practice had an efficient appointment system to respond to patients' needs. Patients who requested urgent advice or care were offered an appointment the same day. Patients had enough time during their appointment and did not feel rushed. Appointments ran smoothly on the day of the inspection and patients were not kept waiting. Several patients commented that they found it easy to arrange routine and urgent appointments at a convenient time, and were rarely kept waiting for their appointment.

The practices' website, information leaflet and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

The practice had a policy providing guidance to staff on how to handle a complaint. The practice information leaflet explained how to make a complaint.

The clinical manager was responsible for dealing with these. Staff would tell the manager about any formal or informal comments or concerns straight away so patients received a quick response.

They aimed to settle complaints in-house and invited patients to speak with them in person to discuss these. Information was available about organisations patients could contact if not satisfied with the way the practice dealt with their concerns.

We looked at comments, compliments and complaints the practice received in the last 12 months.

These showed the practice responded to concerns appropriately and discussed outcomes with staff to share learning and improve the service.

Are services well-led?

Our findings

Leadership capacity and capability

The principal dentist and managers had the capacity and skills to deliver high-quality, sustainable care.

They had the experience, capacity and skills to deliver the practice strategy and address risks to it.

They were knowledgeable about issues and priorities relating to the quality and future of services. They welcomed the inspection and were open to discussion and feedback. They understood the challenges and were keen to act on any findings. Evidence of improvements were sent immediately after the inspection.

The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Culture

The practice had a culture of high-quality sustainable care.

Staff stated they felt respected, supported and valued. They were proud to work in the practice.

The practice focused on the needs of patients.

They had processes in place to deal with poor performance.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

Staff could raise concerns and were encouraged to do so. They had confidence that these would be addressed.

Governance and management

There were clear responsibilities, roles and systems of accountability to support good governance and management.

The principal dentist had overall responsibility for the management and clinical leadership of the practice. The two managers were responsible for the day to day running of the service. Staff knew the management arrangements and their roles and responsibilities.

The provider had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff and were reviewed on a regular basis.

The processes for managing risks, issues and performance could be improved. In particular, ensuring that safety alerts are received and acted upon, ensuring staff follow decontamination processes consistently, and ensuring that recommendations made in critical examinations of radiography equipment are acted upon.

The practice had carried out essential checks on newly employed staff with the exception of a DBS check for the most recently appointed dentist. The practice did not have a system to obtain evidence that vaccinations against Hepatitis B were effective.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.

The practice had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

The practice used patient surveys and verbal comments to obtain patients' views about the service.

The practice gathered feedback from staff through meetings and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on. An ideas tree and a suggestion box were displayed in the staff kitchen, staff were encouraged to submit ideas for consideration. For example, a staff member had suggested sending 'we've missed you' cards to patients who had not returned to the practice. Staff received a small reward when their idea was implemented.

Continuous improvement and innovation

Are services well-led?

There were systems and processes for learning, continuous improvement and innovation.

The practice had quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records and radiographs. They had clear records of the results of these audits and the resulting action plans and improvements. We noted the infection prevention and control audit did not include any evidence of the results being analysed or an action plan to address any issues.

The team showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff.

The dental nurses had annual appraisals. They discussed learning needs, general wellbeing and aims for future professional development. We saw evidence of completed appraisals in the staff folders.

Staff completed 'highly recommended' training as per General Dental Council professional standards. This included undertaking medical emergencies and basic life support training annually. Staff were provided with a training matrix to help them to keep up with training deemed as essential by the practice, and their continuing professional development. We discussed how the practice could provide clearer information to staff on the level and frequency of safeguarding training.

The General Dental Council also requires clinical staff to complete continuing professional development. The practice provided support and encouragement for them to do so.