Castle and Costa

Castle & Costa Dental Services

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 23 June 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Castle and Costa is the trading name of a partnership set up by Conrad and Audrey Costa. There is one dentist, a practice manager and two part-time dental nurses.

The practice manager is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

The practice provides domiciliary dental services to over 100 care homes in the Norfolk area, and also to vulnerable people living in their own homes. Referrals come mostly from care homes, GPs, speech and language therapists, and people who refer themselves. All treatment is funded by the NHS. A range of dental services is offered including examination, oral health promotion, the treatment of dental infection and toothache, fillings, and denture provision. Patients requiring x-rays or more complex work are referred to other services, such as the community dental teams. The practice is not commissioned to provide recall services.

Our key findings were:

Summary of findings

- Staff had an excellent understanding of the needs of patients who could not give consent, and had received extensive training in this. We consider this to be of notable practice.
- Staff were clearly committed to providing good dental care to vulnerable people.
- The practice recorded and analysed significant events and complaints, and shared learning with staff.
- Staff had received safeguarding and whistleblowing training and knew the processes to follow to raise any concerns.
- Staff had been trained to handle emergencies, and appropriate medicines and life-saving equipment were readily available.
- Infection control procedures were in place and the practice mostly followed published guidance.
- Patients' care and treatment was planned and delivered in line with evidence based guidelines, best practice and current legislation.
- Patients received clear explanations about their proposed treatment and were involved in making decisions about it.
- Staff had an excellent understanding of the Mental Capacity Act and regularly applied its principles in their everyday work.
- The practice was well-led: staff felt involved and worked as a team.
- Governance systems were effective and there was a range of audits and patient surveys to monitor the quality of services.

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

- Review the practice's infection control procedures and protocols giving due regard to guidelines issued by the Department of Health – (Health Technical Memorandum 01-05: Decontamination in primary care dental practices) in relation to the use of plastic aprons, the use of long handled brushes, monitoring water temperature, emptying the autoclave reservoir each day and keeping dental instruments moist whilst in transit.
- Ensure that amalgam is filtered and disposed of correctly.
- Regularly record the temperature inside the car when transporting medicines to ensure it does not exceed 25 degrees centigrade.
- Improve the security of controlled drugs when stored in the vehicle.
- Ensure that patients' risk scores for gum disease, oral cancer and dental decay are recorded in their dental care records.
- Ensure that all the practice's policies and procedures are dated, and show evidence of regular review.

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.

We found that the practice was safe because there were systems in place in the areas of infection control, clinical waste control and the management of medical emergencies although some of these required a review.

We found that all the equipment used in the dental practice was well maintained and in line with current guidelines. There were systems in place for identifying, investigating and learning from patient safety incidents and an emphasis in the practice to reduce or prevent harm from occurring. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding people.

Are services effective?

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

The dental care provided was effective, evidence based and focussed on the needs of the patients. Appropriate assessments of patients' health risks were carried out although these were not routinely recorded.

Staff were up-to-date and received professional development appropriate to their role and learning needs. Staff who were registered with the General Dental Council (GDC), had frequent continuing professional development 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.

Patients spoke highly of the dental treatment they received, and of the caring and empathetic nature of the practice's staff. This also aligned with the feedback we received from care home managers who knew the service well.

Staff we spoke with were clearly committed to their work, and the specific needs of the patient groups they served.

Are services responsive to people's needs?

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

The service was specifically designed to meet the needs of vulnerable people who could not attend traditional dental services and was able to offer a range of dental procedures and treatments in people's own homes. Telephone access to the service was good and emergency appointments were available to registered patients.

Staff received specific training for their work, and in particular in understanding the needs of older people and those living with dementia.

Patients felt able to raise their concerns and the practice managed complaints well.

Are services well-led?

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

The dental practice was well-led with satisfactory clinical governance and risk management structures in place. Some policies and systems required review to ensure that risks were appropriately identified and managed.

Summary of findings

The dentist and practice manager were very approachable and the culture within the practice was open and transparent. Staff were well supported and told us that it was a good place to work. The practice sought feedback from its patients and used it to improve its service.

Castle & Costa Dental Services

Detailed findings

Background to this inspection

The inspection took place on 23 June 2015 and was conducted by a CQC inspector and a dental specialist advisor.

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.

Prior to the inspection we asked the practice to send us some information which we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, the details of their staff members, their qualifications and proof of registration with their professional bodies.

During the inspection we spoke with the dentist, the practice manager and both dental nurses. We also spoke with four patients and five representatives of care homes that the practice visited. We reviewed policies, procedures and other documents. We reviewed 15 comment cards about the quality of the service that patients had completed prior to our inspection.

We received consistently good feedback from patients and care home representatives about the practice. Patients reported that staff were friendly, professional and empathetic. Patients were pleased with the range of treatments that could be provided in their own home which saved them having to attend a more traditional dentist at great inconvenience They particularly appreciated the reliability of the service, stating that staff were never late and always rang ahead of the visit to let them know they were on their way. One patient told us they greatly looked forward to their visits as the practice's staff were so nice and he never felt rushed. Another reported that they only had one tooth left in their mouth and the dentist worked really hard to ensure they didn't lose it.

Patients also reported that the dentist always asked them about their medical conditions and any medicines they took. One patient reported that the dentist had spent considerable time going through each of his many medicines to ensure he recorded them properly.

Representatives from the care homes we spoke with reported that the practice's staff communicated well with their residents with dementia, and always consulted the home's staff about their needs.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had procedures in place to investigate, respond to and learn from significant events and complaints. Staff were aware of the reporting procedures in place and encouraged to bring safety issues to the attention of the dentist or the practice manager.

The practice had an incident reporting policy and a specific reporting form for staff to complete when something went wrong. Significant events were discussed at the staff meetings and we saw evidence of this in the minutes we reviewed.

We looked at three significant events and found that they had been recorded, investigated and learning had been shared to prevent them from happening again. For example, in response to the dentist running out of local anaesthetic during an extraction, a new procedure for inspecting, restocking and checking the local anaesthetic had been implemented. A new IT policy had been introduced in response to a staff member leaving their computer password written on a piece of paper in the office.

The practice received national and local alerts relating to patient safety and safety of medicines. They had a system for logging these and for making sure that all members of the dental team received copies of relevant information. The dentist had good knowledge of recent alerts, even though they did not directly affect the service.

Reliable safety systems and processes (including safeguarding)

The practice had comprehensive information available regarding safeguarding policies, procedures and contact information. We saw that essential contact numbers of agencies involved in protecting people were on the wall of the practice's office, making them easily available to staff. The practice manager told us she had referred to this information on several occasions when the dentist had rung for it, in order to make a referral.

All staff had received safeguarding training provided by Norfolk County Council, and also undertook on-line training to keep their knowledge up to date. Staff we spoke with understood the importance of safeguarding issues and were aware of the role of the dental team in helping to monitor welfare and safety. Staff were able to describe to us specific safeguarding incidents they had come across in their work, and the action they had taken to escalate it. We were given an example of where an allegation of abuse was reported to the dentist who escalated this immediately to the relevant safeguarding agencies.

The practice had a whistleblowing policy in place and staff reported that they felt confident to use it if needed. One dental nurse told us she had raised concerns about a colleague's practices, allowing swift action to be taken, and patients' safety to be protected.

The dentist was always accompanied by a dental nurse at every visit to promote personal and patient safety.

Medical emergencies

The practice had procedures in place for staff to follow in the event of a medical emergency and all staff had received basic life support including the use of the defibrillator (an electrical device that delivers a measured electric current to treat certain cardiac emergencies). The practice manager told us that the training had been specifically designed to meet the needs of staff working in a domiciliary environment, and that further training had been booked the week of our inspection visit.

A first aid box available in the decontamination room and its contents were checked regularly by the practice manager to ensure they were in date and safe for use.

A full portable medical emergency kit was carried in the practice's car, so it was available on all domiciliary visits if needed. This included emergency medicines, a defibrillator and oxygen which were in line with guidelines issued by the British National Formulary and the Resuscitation Council (UK). We checked the emergency medicines and found that they were of the recommended type and were in date Staff told us that they checked medicines and equipment about every three to four weeks.

Staff recruitment

We checked the employment files for two dental nurses. They contained evidence of their disclosure and barring checks, their immunisation status, their medical indemnity insurance, their professional registration, current training certificates, and job description and employment contract. There were no references for either of these employees. However both these staff had been employed some years

Are services safe?

ago and the previous provider had not taken up references at the time. We viewed the practice's current recruitment policy which assured us that references would be obtained for any new members of staff starting at the practice

Monitoring health & safety and responding to risks

Comprehensive assessments had been completed for many hazards and risks at the practice. We viewed a range of these including those for fire, Legionella, premises, sharps' injuries, hazardous substances and display screen equipment. The likelihood and severity of each risk had been assessed along with the measures that been implanted to reduce them, and keep both staff and patients safe. We noted that one member of staff was pregnant and found that a detailed risk assessment had been undertaken to ensure her safety in the workplace.

A business continuity plan was in place to deal with a range of emergencies that might impact on the daily operation of the practice. Risks identified included power failure, flood, burglary and fuel shortages. The document contained relevant contact details for staff to refer to and could be accessed by staff remotely.

Infection control

The practice had developed its own specific procedures and protocols in relation to maintaining good infection control in the domiciliary care setting. We viewed these which clearly outlined the specific requirements in relation to creating clean and dirty zones within the environment; the management of clinical waste, the use of polystyrene-backed impermeable paper sheets to cover surfaces, and the handling of instrument boxes to transport decontaminated instruments.

Our discussions with both staff and patients demonstrated that these procedures were adhered to. Staff confirmed that they wore appropriate personal protective equipment such as gloves, masks and eye visors when treating patients. Staff wore clean uniforms each day, however, they did not wear any disposable aprons when treating patients. This was a cross infection risk, given they visited up to ten different establishments each day.

Any instruments used during visits were placed in a secure 'dirty box' to be transported back to the practice's decontamination room. However, we noted that used instruments were not kept moist during their journey back, which risked substances hardening on the instruments and making them difficult to clean. Staff reported that all containers used to transport equipment were put through the washer disinfector at the end of each day.

The practice had a dedicated decontamination room that was set out according to the Department of Health's guidance, Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices. The decontamination room had clearly defined dirty and clean zones, with a good air flow in operation to reduce the risk of cross contamination. There was a separate hand washing sink for staff, in addition to two separate sinks for decontamination work. The procedure for cleaning, disinfecting and sterilising the instruments was clearly displayed on the wall to guide staff.

There were adequate supplies of liquid soap and paper hand towels in the room, and a poster describing proper hand washing techniques was displayed above the hand washing sink. The sharps bin was properly assembled signed, dated and not overfilled.

The practice manager demonstrated the decontamination process to us and used the correct procedures. We saw that staff wore appropriate personal protective equipment during the decontamination process including heavy duty gloves, aprons and protective eye wear. However, we noted that the temperature of the water used to clean the instruments manually was not checked to ensure it was less than 45 degrees centigrade (a higher temperature risks coagulating any protein and inhibit its removal). We also noted that some instruments were scrubbed with a nail brush and not kept under water during the cleaning process. Guidance states that instruments should be cleaned with a long handled brush, and under water to prevent unnecessary splashing.

At the end of the sterilising procedure we found that the instruments were correctly packaged, sealed, stored and dated with an expiry date. Packaging had also been initialled to indicate who had cleaned them. There was a rotation system in place to ensure that the instruments with the oldest date were used first.

The practice carried out regular audits of infection control using the tool provided by the Infection Prevention Society. Findings of the audit were discussed with staff so that learning could be shared.

Are services safe?

The practice used an appropriate contractor to remove dental waste from the practice and we saw the necessary waste consignment notices. However, we noted that in a few cases amalgam was not separated from other waste material and was sometimes disposed of in the care home's clinical waste. Amalgam should be filtered from other waste material, captured and returned to the practice's office for proper disposal to prevent contamination.

Equipment and medicines

The equipment used for cleaning and sterilising was checked, maintained and serviced in line with the manufacturer's instructions. Daily, weekly and monthly records were kept of decontamination cycles to ensure that equipment was functioning properly. Records showed that the equipment was in good working order and being effectively maintained. However we noted that the autoclave's water reservoir was only emptied weekly and not at the end of each day as recommended by the guidance. Portable appliance testing was undertaken on all electrical equipment and had last been conducted in November 2014.

We checked the practice's vehicle and found it had appropriate business insurance and an MOT certificate in place. It displayed the correct warning sticker to indicate that oxygen was carried on board. However, a TREM card (traffic emergency card) was not available. This must be carried in the cab of any vehicle that is transporting dangerous goods by road. It contains instructions and information that the driver can refer to in the event of an incident involving the hazardous load. The provider assured us he would order one as soon as possible.

Equipment needed for domiciliary visits had been divided into sub kits (such as those for fillings, extraction, impressions and dirty instruments) and stored in boxes that did not weigh more than 8 kg so it was easy for staff to carry to and from patients' houses. Daily treatment boxes were assembled a week in advance to ensure there was always equipment readily available.

We checked a small sample of equipment in the car including storage boxes, the torch, the oxygen cylinder, portable suction unit and AED and found them to be fit for purpose and in good working order. However we found a number of medical consumables including gauzes, swabs and plastic syringes that were long out of date and no longer fit for use.

Medicines such as local anaesthetic were routinely kept in the car. However the car's temperature was not routinely monitored to ensure it was kept below 25 degrees centigrade. Controlled drugs were not always held securely in the car when unattended.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

During our visit we found that the care and treatment of patients was planned and delivered in a way that ensured their safety and welfare. The dentists' description of the patient journey was detailed, thoughtful and showed considerable expertise in working in sometimes very difficult environments. The dentist was aware of various best practice guidelines and described to us how he used them to inform his treatment of patients, within the limitations of the domiciliary care setting.

Patients told us that the dentist always asked about their medical history and also took time to fully check and record any medicines they took. The dental records we viewed were well structured and contained detailed information about the dental treatment provided to patients. Records contained information about patients' medical histories, and also the condition of their gums. However, the notes did not always include the patients' level of risk for tooth decay or oral cancer, and although we were assured these risk assessments were completed by the dentist, they were not recorded.

We found that NICE (National Institute for Clinical Excellence) guidance was followed in relation to the prescribing of medicines and the dentist had undertaken a specific audit to establish that medicines had been prescribed correctly and that their usage had been recorded in patients' notes.

Patients requiring specialised treatment such as conscious sedation or x-ray were referred to other dental specialists. We viewed a small sample of referral letters which were comprehensive and contained detailed information about patients' needs.

We saw a range of clinical and other audits that the practice carried out to help them monitor the service. These included the quality of clinical record keeping, infection prevention control procedures and prescribing patterns.

Health promotion & prevention

Dental records we viewed contained good evidence that the dentist regularly provided patients with oral hygiene advice, including the use of high fluoride toothpaste, and advice on smoking and alcohol. This advice was also shared with the patients' carers so that they could support them to maintain their oral hygiene.

The dentist had written a specific guide for staff working in nursing and residential care homes. This had been distributed to a number of homes in the region so that care home staff could better support residents with their oral health care.

The practice's web site contained good information for patients on a range of subjects including tooth decay, gum disease, and denture care.

Staffing

The practice employed one full time dentist, supported by a practice manager and two dental nurses. Dental staff were appropriately trained and registered with their professional body. Staff were encouraged to maintain their continuing professional development (CPD) and skill levels. One dental nurse told us she had undertaken courses on a range of topics including suture removal, denture impressions and fluoride application. Another nurse told us that they had undertaken an in-depth, three month dementia course which had greatly improved their understanding of the illness and how better to communicate with patients living with it.

The dentist was registered with the general dental council and had undertaken a range of training in the recommended core subjects. For example, training records we viewed showed that in the previous year to our inspection they had undertaken training in child and adult protection; gerodontology; dementia; radiology and oral cancer.

The practice manager attended a local practice manager's group where the latest dental guidance was discussed. Speakers were also invited to the meetings to share their knowledge. An occupation health specialist had attended the last meeting and the practice manager told us this had improved her knowledge about ways of promoting staff' health and well-being. She was also a member of the association of dental administrators and managers. A national association that provides information, advice and training for dental staff.

There were sufficient numbers of suitably qualified and skilled staff working at the practice. Staff told us that

Are services effective?

(for example, treatment is effective)

annual leave was organised well in advance so that cover could be provided. One nurse told us that they were about to go maternity leave, and that a replacement nurse for her had already been organised. The practice manager was also a trained dental nurse so was available to cover staff shortages if necessary.

Working with other services

The practice had systems in place to refer patients to other practices or specialists if the treatment could not be provided**,** and regularly referred patients to the community dental teams.

It was clear that the practice had built up good relations with a number of local care homes, and worked closely with staff there to promote residents' oral health.

Consent to care and treatment

The practice had a written consent policy which followed the General Dental Council's guidelines, Principles of Patient Consent and it was clear from the dental records we viewed that patients' capacity to consent was carefully assessed and considered by staff.

Staff we spoke with had a clear and in-depth understanding of patient consent issues. For example, staff spoke knowledgeably about dementia and the extra measures they implemented to communicate with these patients, and also ensure they had their full consent. They described how they involved the patient as much as they were able, and if necessary made best interest decisions in consultation with the patient, their family and care home staff.

One care home representative told us that the dentist worked well with residents with dementia. They reported that if he was unsure of the resident's capacity to make decisions he always involved the care home staff or the person's relatives. She knew this, as the dentist sometimes requested relatives' telephone numbers so he could ring them. Another care home manager told us that the dentist had once declined to provide treatment to someone one as they could not be assured of the patient's ability to consent to it.

The dentist told us of another occasion where they had provided treatment to a patient, despite the protestation of their relatives, as the patient was fully able to consent to it and was in discomfort.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We received many positive comments about the practice's staff from the patients we talked with, and those who completed our comments cards. Staff were described as caring, patient and empathetic. One patient told us they found the dentist very calming and gentle, which allowed them to relax during treatment. Another patient told us that they greatly looked forward to their appointments, something he found remarkable as they had never enjoyed visiting the dentist before. Patients told us that the dentist always rang when they were on their way to let them know a time of arrival; something they appreciated greatly.

Care home representatives we spoke with also talked highly of the practice's staff that they described as professional and friendly. One manager told us that if any follow up treatments or products were required, that the dentist always explained these clearly before leaving. Several care home staff commented that the practice's staff communicated well with residents living with dementia, and had a good understanding their needs.

We found that the staff we interviewed spoke about patients in a respectful and genuine way and were clearly passionate about providing good dental care to vulnerable people.

Involvement in decisions about care and treatment

There was good evidence in the dental records we reviewed which demonstrated the inclusion of the patients, family and care home staff where appropriate in decision making processes**.** People we spoke with also confirmed this and told us the dentist always carefully explained things in a way that they could understand**.**

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The service was specifically designed around the needs of people whose circumstances made it difficult to receive care in a traditional dental setting. The dentist carried suitable portable dental, medical and emergency equipment to enable him to provide a range of dental treatments to people in their own home.

The practice worked with many people living with dementia, and had drawn up specific guidelines for staff in relation to this. The guidance provided many practical and helpful examples of how staff could communicate with patients. For example, if a patient was struggling to remember their social or family history, staff were advised to use photographs in the person's room to help prompt them. It directed staff to explain treatment simply and obtain consent for the proposed treatment at each and every stage of it. It also prompted staff to prioritise their work, with the most beneficial treatment completed first, in case the person became distressed. This showed us that the practice had a genuine understanding of the needs of patients with dementia, and adapted their working practices to meet their specific needs.

Access to the service

The practice operated Monday to Friday and the office hours were 8.30am to 6pm. Patients and their representatives told us getting through on the phone to make an appointment was easy. One patient told us that because the dentist had 'set rounds', they always knew which day the dentist would be in their village, and could book accordingly. New patients were welcome and routine appointments were normally available within four weeks.

During week-ends and bank holiday, the practice offered an out of hours emergency service to registered patients. The dentist reported that if dental emergencies arose they would try and attend the same day. However, sometimes this was not possible given the distance to travel. If so, patients could be seen next day.

Concerns & complaints

Information about how to complain was clearly outlined in the patient information leaflet. This included the timescales in which the complaint would be dealt with, and how to escalate concerns if patients were unhappy with the response received. There was also information on the practice's web site.

Patients we spoke with told us they had never needed to complain, however felt confident that the dentist would take their concerns seriously.

A record of complaints was held and those we reviewed had been managed well and responded to in a timely way. The dentist often sought external advice to ensure his responses were appropriate.

Staff told us that patients' complaints were discussed with them, so that any learning or improvement resulting from them could be shared. We saw that two complaints had been used as a training tool with staff to discuss the complexities of the Mental Capacity Act.

Are services well-led?

Our findings

Governance arrangements

There was a full range of policies and procedures in use at the practice. These included health and safety, infection prevention control, patient confidentiality and recruitment. Staff were aware of the policies and they were readily available for them to access. Staff had also signed to indicate they had read them and understood their contents. Many of the policies had been written specifically for the service and offered good guidance for staff on dealing with patients with dementia, and managing infection control in the domiciliary environment. However we noted that some polices and documentation were not dated, making it hard to know if they were the most up to date version and still relevant. Some also needed to be updated to ensure they provided further guidance around the use of plastic aprons, the use of long handled brushes when cleaning instruments, monitoring the temperature of the water in which instruments were cleaned, monitoring the car's temperature and emptying the autoclave reservoir at the end of each day.

Each member of staff had been given a handbook that provided them with information on a range HR issues including their employment rights, the practice's grievance procedures, holiday entitlement and the working time directive. Staff meetings took place where important information was shared and practice issues discussed. We viewed minutes which showed a wide range of topics were discussed with staff including accident reporting, dealing with medical emergencies, significant events and disaster planning. Meetings were minuted and made available for all to read.

Regular audits were conducted to assess the quality of service provided to patients. These included those for infection control, prescribing and record keeping. We saw that the results of audits were discussed at staff meetings to ensure learning was shared with all. A range of health and risk assessments were also in place to protect staff and patients.

Leadership, openness and transparency

Staff we spoke with clearly enjoyed their job and were enthusiastic about their work. They described an inclusive, open and supportive environment in which their suggestions were valued by the dentist and practice manager. Staff told us that they felt part of a team and worked well together. The staff were proud of the service they provided to patients.

Staff told us there were meetings where they felt able to raise concerns and were consulted beforehand for their agenda items. They particularly appreciated these meetings as they had not taken place under the previous owner of the practice, and felt they were a good forum in which to discuss practice issues.

Staff were aware of the practice's whistle blowing policy and felt confident to raise concerns if a clinician was working in a way that put patients at risk. We found specific evidence that staff had acted upon this policy appropriately, ensuring that patients were protected.

We noted that all staff were actively involved in our inspection, one of whom had attended, despite it being their day off. All staff were present for our feedback at the end of the inspection, demonstrating that the practice had an open and transparent culture.

Management lead through learning and improvement

Staff appraisals were used to identify training and development needs and staff told us there were good opportunities for learning and development. One staff member told us she found her annual appraisal useful as it gave her the opportunity to reflect on what she was good at, and what she needed to improve.

The practice had received two complaints from patients' family members about the dentist's decision to provide treatment to their relative. The dentist had shared these complaints with staff and used them as a training tool to highlight complex issues around patient consent and mental capacity. As a result of these complaints the dentist had also organised additional training for staff in the Mental Capacity Act to ensure they had a robust understanding of it.

The dentist was keen to improve their service and we noted that they had implemented many of our suggestions by the end of our inspection.

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

The practice regularly sought feedback from its patients about the quality of care provided**.** It had sent

Are services well-led?

questionnaires to all of the care homes it visited, asking for their opinion on a range of matters including the accessibility of the service, staff conduct and the quality of the treatment provided: 49 responses had been received. As a direct result of patients' feedback, the staff's uniforms had been redesigned, and now displayed the practice's logo. This was to help residents and care home staff identify the practice's staff more easily.

The practice had just implemented the NHS's friends and family test, and had begun giving the cards to patients' after each visit. Five responses had been received at the time of our inspection, all of which indicated people would be likely or very likely to recommend the service.