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Ise Lodge Dental Centre

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 6 September 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

Ise Lodge Dental Care is located in a quiet residential area of Kettering. The practice is in a converted, modern bungalow with access for disabled people. The practice has a waiting room where up to ten people can be seated and three treatment rooms that are accessed from the reception area.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. 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.

As part of the inspection, we received feedback through 41 CQC comments cards completed by patients, speaking with other patients and staff during the inspection. Patients said that the staff were caring and helpful to them and they received good care and treatment.

Our key findings were:

- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- There were systems to promote the safe operation of the service although the reporting of incidents and significant events required development.

Summary of findings

- The provider had emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice although one medicine was found to be incorrectly stored and out of date.
- Patients told us they were able to get an appointment when they needed one and the staff were kind and helpful.
- Dentists provided dental care in accordance with current guidelines from the Faculty for General Dental Practice guidelines and the National Institute for Care Excellence (NICE).
- Staff had good access to training and were supported to develop their knowledge and maintain their professional development.
- Governance arrangements were in place although these required strengthening to maintain the safety of the service and promote ongoing learning and improvement.

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

- Strengthen systems used to monitor quality and safety in relation to incidents, accidents, significant events, complaints and environmental risks.
- Review the process used to act on the outcomes of clinical and non clinical audits so that actions taken are clearly evidenced and can be monitored.
- Review the storage of dental care products and medicines that may require refrigeration to ensure they are stored in line with the manufacturer's guidance and the fridge temperature is monitored and recorded.
- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society.
- Review staff awareness of Gillick competency and the Mental Capacity Act (2005) to ensure all staff are aware of their responsibilities.
- Review the practice's sharps procedures in relation to the management of sharps injuries giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Review staff records so that records of Hepatitis B immunity are monitored.
- Review ongoing systems to monitor infection control practice in the treatment rooms so that all dental items are hygienically stored, supplies of materials and equipment are checked and records of cleaning completed.

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.

Accidents were recorded although the actions taken were not always recorded and followed up. Although there was no evidence of any incidents or significant events, there was no system to help staff identify and record them so that issues could be investigated and used to promote safety and improvement. The practice received electronic safety alerts and these were shared and actioned appropriately. There were clear guidelines in place for reporting safeguarding concerns and staff had received relevant training. Recruitment procedures were in place although the practice had not recruited any new staff in the last four years.

Emergency medicines and equipment were available although one item was not stored in line with recommended guidelines. The practice had good infection control procedures in place to ensure that patients were protected from potential risks. However, we found some dental instruments and materials in the treatment rooms were not stored appropriately or were out of date. Equipment used in the decontamination process was maintained by a specialist company and regular checks were carried out to ensure equipment was working properly and safely. X-ray equipment was well maintained and record keeping in relation to X-rays clearly documented.

Are services effective?

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

Consultations were carried out in line with best practice guidance from the National Institute for Health and Care Excellence (NICE) and the Faculty of General Dental Practice Guidelines, a professional membership body that supports standards of dentistry practice. Patients received a comprehensive assessment of their dental needs although records to update patients' medical histories were not kept up to date. Explanations were given to patients in a way they understood. Risks, benefits, options and costs were explained. Patients were referred to other services in a timely manner and staff followed appropriate guidelines for obtaining patient consent. However, they needed to review guidelines in relation to Gillick competency as well as the Mental Capacity Act 2005.

The staff were able to access professional training and development appropriate to their roles and an appraisal process was in place. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration

Are services caring?

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

Staff treated patients with dignity and respect and ensured their privacy was maintained. Patient information and data was handled confidentially. Patients told us that staff were very considerate, listened to their needs and put them at ease. Treatment was clearly explained to patients and they were provided with treatment plans and costs. Patients were given time to consider their treatment options and felt involved in their care and treatment.

Are services responsive to people's needs?

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

Appointment times met the needs of patients and staff took steps to ensure that waiting times were kept to a minimum. Information about emergency treatment was made available to patients when they telephoned the practice as part of a recorded message. A practice leaflet was provided to new patients. The service was accessible to

patients with a disability and patients who had difficulty understanding care and treatment options were supported. A complaints policy was in place to deal with complaints in an open and transparent way. We saw that complaints had been managed in accordance with the policy although learning from complaints was not always identified and shared with the team. Patients received an apology when things went wrong.

Are services well-led?

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

Although there were some systems in place to monitor the overall quality of the service, some systems were not fully effective and required strenghtening. For example systems to identify and manage incidents and significant events had not been established. There was no evidence to demonstrate that action had been taken to mitigate legionella risks. Action plans were not recorded in response to fire safety and the management of sharp instruments.

Practice policies were reviewed on a regular basis and some audits were in place. However we found that this did not always lead to improvement.

Overall leadership of the practice was clear and staff were aware of their own responsibilities as well as the role of others. However we found the practice did not have a member of staff with overall responsibility for monitoring infection control practice in the treatment rooms as well as in the decontamination room. The practice team aimed to meet on a monthly basis and worked closely as a small team where communication was done informally. Staff told us they felt supported by the dentists and practice manager and they worked well together as a team.

Patient feedback was actively sought and used to help improve the service.

Ise Lodge Dental 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 practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

This inspection took place on 6 September 2016 and was led by a CQC Inspector who was supported by a specialist dental advisor. Before the inspection, we asked the practice to send us some information for review and this included a summary of complaints received.

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

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had a process in place for reporting and recording accidents. An accident book was in use and we reviewed the last three reports which had all occurred within the last two years. We found that one accident involving a patient, had been recorded in their dental records and appropriate action had been taken. Two other accidents reported were staff injuries caused by sharp instruments. We found there were no records to describe the actions taken in response to the injury or any learning that had taken place. We discussed this with the provider who agreed to make further improvement.

The practice had a policy in place for the reporting of RIDDOR (The reporting of injuries diseases and dangerous occurrences regulations). Staff we spoke with understood the basic principles of the reporting procedure.

The practice did not have a significant event/incident policy in place and most staff did not understand how these differed from accident reporting.

The provider had signed up to receive national patient safety alerts such as those relating to medicines or the safety of clinical equipment. Other alerts were cascaded from the local clinical commissioning group and NHS England.

The provider had a broad understanding of the principles of the duty of candour and we saw that patients had received an apology when they experienced a poor service.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for safeguarding vulnerable adults and children which linked to the local guidelines. The principal dentist was the designated lead for safeguarding concerns and had knowledge of the escalation process to the local authority team if it was required. Information on the reporting process was visible and accessible to staff who had received relevant training and were able to demonstrate sufficient knowledge in recognising safeguarding concerns. There had been no referrals made.

We spoke with dentists and dental nurses to ask about the use of rubber dam for root canal treatments. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work. One dentists offered root canal treatments. When we discussed this, we found they did not always use rubber dam and did not complete a written risk assessment to demonstrate their rationale for using high level suction as an alternative.

Medical emergencies

Staff had access to an automated external defibrillator (AED) in line with Resuscitation Council UK guidance and the General Dental Council (GDC) standards for the dental team. An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. However, there was no record to demonstrate this equipment was regularly checked to ensure it was ready for use. Additional equipment for use in medical emergencies included oxygen. Records showed this was checked on a weekly basis to ensure the cylinder was full and within its expiry date.

The practice had emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice. We checked the emergency medicines and saw that most items were within their expiry dates. However, emergency medicine used to treat diabetic patients with a low blood sugar level had not been stored in a refrigerator and as a result, this meant the use by date had expired. The dental nurse agreed to order a replacement the following day.

Staff had received update training in dealing with medical emergencies.

Staff recruitment

All of the employed dental professionals had current registration with the General Dental Council, the dental professionals' regulatory body.The practice had not employed a new member of staff in the last four years. We found they had a detailed recruitment policy that included the checks required to be undertaken before a person started work.For example, proof of identity, a full employment history, evidence of relevant qualifications, adequate medical indemnity cover and references. There was also an induction programme for dental nurses and reception staff which included time with the practice manager to receive training in key issues such as

complaints, NHS regulations and the role of NHS England. We saw that relevant staff had received appropriate checks from the Disclosure and Barring Service (DBS). These are checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice manager led on health and safety issues and there were a number of general risk assessments in place covering all areas of the premises. The assessments were regularly reviewed. Assessment information for the Control of Substances Hazardous to Health (COSHH) was also available although it was not clear when these had last been reviewed. Safety kits were available in the practice for cleaning and disposing of spillages of mercury or body fluids in a safe way. A first aid kit was also available and there was a designated member of staff as a first aider.

The practice had procedures in place to reduce the risk of injuries through the use of sharp instruments. Staff knew how to take appropriate immediate action if an injury occurred. However we found that when a sharps injury had occurred, staff were not advised to seek further follow up through an occupational health team or their own GP and this was not detailed in the policy. A sharps risk assessment had been completed in November 2015 although where action had been identified; there was no record to demonstrate completion. All staff had received immunisation for Hepatitis B although records did not include immunity checks for all staff.

A fire risk assessment had been completed in November 2014 and recommendations had been made. Although we saw that some of the issues raised such as fire training and the installation of a fire detection alarm had been actioned, there was no record of the actions that had been completed. Firefighting and detection equipment had been serviced. A fire drill had been undertaken in December 2015.

The practice had a business continuity plan in place to deal with any emergencies that could disrupt the safe and smooth running of the service. Copies of the plan were held by two senior members of staff and a further copy was accessible to other staff.

Infection control

The practice had a robust infection control policy that was regularly reviewed. The practice employed a decontamination assistant to complete the decontamination process for used dental instruments three days each week. At other times, this responsibility was allocated to the nurses who were on duty. We met with the decontamination assistant, spoke with other staff and observed the procedures and practice that was being followed. We found that overall the practice was meeting HTM 01 05 (national guidance for infection prevention control in dental practices') Essential Quality Requirements for infection control were being met although some improvements were needed in the treatment rooms.

An infection control audit had been completed in the last six months. This resulted in minimal actions and confirmed to us that staff followed systems to ensure they were compliant with HTM 01 05 guidelines.

We saw that the dental treatment rooms, waiting area, reception and toilet were clean, tidy and clutter free. Hand washing facilities were available including liquid soap and paper towel dispensers in each of the treatment rooms and toilet. Hand washing protocols were also displayed appropriately in various areas of the practice.

The practice had a separate decontamination room for instrument processing. The dental assistant working in the decontamination room demonstrated the process from taking the dirty instruments through the cleaning process to ensure they were fit for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean. Cleaned instruments were date stamped for one year so that any unused instruments could be reprocessed if they exceeded the use by date.

When we looked at the items used in the treatment rooms, we found that some single use items had not been packaged and were kept loose in a drawer. We also found that the matrix band holders used by both dentists were loaded with unsterile bands and placed within the drawers. This meant staff did not know how long they had been there and if they were suitable for patient use.

There were systems in place to ensure that the equipment used in the decontamination process was working effectively. Records showed that regular daily, weekly and monthly validation tests were recorded in an appropriate

log book. Although dental nurses described the method they used to maintain the dental water lines in keeping with current HTM 01 05 guidelines, there were no records to support this. Dental water lines should be maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for a particular bacteria which can contaminate water systems in buildings). A legionella risk assessment report had been completed in October 2014 and had identified several actions to be taken which included monitoring water temperatures, identifying a person with responsibility for monitoring legionella risk and the flushing of a staff shower. There was no written record of the actions taken in response to these recommendations.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. Arrangements were in place to ensure that an approved contractor removed clinical waste from the premises on a weekly basis. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained and stored securely where appropriate. Cleaning equipment for the premises was colour coded for use although the system used did not reflect current guidelines. The general cleaning of the premises was completed by an employed cleaner who completed daily schedules and discussed any issues or concerns with the team to help maintain high standards. The dental nurses were responsible for clinical cleaning although records of this were not maintained.

Equipment and medicines

There were systems in place to check that the equipment had been serviced regularly and in accordance with the manufacturer's instructions. Items included the items used for decontamination of the dental equipment, the dental chairs, electrical items and firefighting equipment. However, when we checked items used in the treatment rooms used by the dentists, there were several that were out of date. For example materials used during fillings, crowns and bridges. When we raised this, the items were removed by the dental nurses.

A refridgerator in the staff kitchen was used to store food as well as some dental materials and products. There were no temperature checks to demonstrate that these items were stored within the appropriate temperature range to ensure their safe and effective use for patients.

An effective system was in place for the prescribing, dispensing, use and stock control of the medicines used in clinical practice such as antibiotics and local anaesthetics. We found that the practice stored prescription pads securely and had a clear tracking system to monitor prescriptions that were issued. The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records.

Radiography (X-rays)

The practice had a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation in relation to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for each X-ray set along with the three yearly maintenance logs and a copy of the local rules. The maintenance logs were within the current recommended interval of three years. We found that training records showed all staff where appropriate, had received training for core radiological knowledge under IRMER 2000.

We saw that radiographic audits were completed regularly for each dentist and actions were taken in response to any findings. We saw that dental care records included information when X-rays had been taken, how these were justified, reported on and quality assured. This showed the practice was acting in accordance with national radiological guidelines to protect both patients and staff from unnecessary exposure to radiation.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists we spoke with carried out consultations, assessments and treatment in line with recognised general professional guidelines. They described how they carried out their assessment of patients for routine care and we saw this evidenced in some dental care records. The assessment began with a verbal discussion about the patient's medical history, health conditions, medicines being taken and any allergies suffered. However, records of medical histories were not maintained. For example one patient record showed their last signed medical history questionnaire was dated in 2011.

Patients received an examination covering the condition of their teeth, gums and soft tissues to check for signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained in detail. Where appropriate a health assessment using the basic periodontal examination (BPE) scores for the soft tissues lining the mouth, was used. BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on the treatment required.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general dental hygiene procedures such as tooth brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was always provided to NHS patients and this included the cost involved. For private and dental plan patients, dentists discussed the treatment plans and costs with them and provided a written plan if the treatment was particularly complex or costly. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Health promotion & prevention

The dentists were focussed on the preventative aspects of their practice and employed two dental hygienists to work alongside of the dentists to deliver preventive dental care. Many patients booked consecutive appointments with the dentists and hygienist. Patients were provided with health advice from dental staff. Adults and children attending the practice were advised during their consultation of the steps to take to maintain healthy teeth. This included tooth brushing techniques, dietary, smoking and alcohol advice where it was appropriate. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'.

The practice sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area. There was limited dental health promotion information available to read or take away in the waiting area.

Staffing

The practice employed two dentists who were supported by a hygienist and a hygienists/therapist. The practice manager was also a registered dental nurse who was supported by four other registered dental nurses (two of whom also acted as receptionists) and a decontamination assistant. The patients we asked on the day of our visit said they had confidence and trust in the dentists and this was also reflected in the Care Quality Commission comment cards we received.

We observed a friendly atmosphere at the practice. The staff appeared to work effectively as a team. They told us they felt supported by the practice manager and owner, they had acquired the necessary skills to carry out their role and were encouraged to maintain their professional development. We saw that staff training records were well maintained and included completion of training which included medical emergencies, safeguarding and infection control.

Working with other services

Dentists referred patients to other specialists in primary and secondary care services if the treatment they required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as oral surgery or special care dentistry. This ensured that patients were seen by the right person at the right time.

Consent to care and treatment

Staff explained how individual treatment options, risks, benefits and costs were discussed with each patient and

Are services effective?

(for example, treatment is effective)

then documented in their dental records. A member of staff we spoke with stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options. They told us they also used pictures and models to help explain treatments to patients who may have limited capacity. This supported their understanding and enabled independent decision making.

The practice had an appropriate consent policy in place. We spoke with the dental staff about how they implemented the principles of informed consent. We found that the knowledge of consent and specifically, the Mental Capacity Act 2005 and Gillick competency, varied among staff. The Mental Capacity Act 2005 provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Gillick competency is a test to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

The principal dentist also discussed with us, an example of a young patient who was not provided with treatment as they did not want to have it.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting areas and we saw that doors were closed at all times when patients were with dentists. This prevented conversations between patients and dentists from being overheard and protected patient's privacy. Patients' dental records were stored electronically and computers were password protected and regularly backed up. The computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality.

Before the inspection, we sent Care Quality Commission (CQC) comment cards to the practice for patients to use to tell us about their experience of the practice. We collected 41 completed CQC comment cards and obtained the views of two patients on the day of our visit. All of the feedback we received provided a very positive view of the service the practice provided. Many patients had been registered with the service a number of years and valued the care, consideration and treatment they received from the staff. Patients commented that treatment was explained clearly, staff were friendly, helpful and put them at ease.

During the inspection, we observed that staff working on the reception desk and those greeting patients were polite and welcoming.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. A poster detailing NHS and private treatment costs was displayed in the waiting area. The practice website also gave details of the cost of treatment for patients who opted to pay for treatments as needed and for those who opted for a monthly dental plan cover. The dentists we spoke with paid particular attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice waiting area had some information on display that referred to the services available at the practice. This included a copy of the previous CQC inspection report, information about treatment costs, the statement of aims of the practice and the complaints process. Health information was limited to teeth whitening treatments and alcohol consumption. Other information included leaflets on NHS dentistry and the NHS 111 service. Information leaflets about the practice were provided to new patients.

We spoke with reception staff about the appointments system and found that there were a sufficient number of available appointments. On the day of the inspection, there were some urgent appointments available if requested. If a patient had called to request a routine check they would have a five week wait to see a dentist. There was capacity to arrange follow up appointments and the dentists advised staff when these were required.

Staff took into account any special circumstances such as whether a patient was very nervous, had a disability and the level of complexity of treatment and booked the length of appointment that was most relevant to the patient's need. Comments we received from patients indicated that they were satisfied with the response they received from staff when they required treatment or an urgent appointment.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to prevent inequity for disadvantaged groups in society. The practice had access to a translation service if a patient had difficulty in understanding information about their treatment. Staff explained they would also help patients on an individual basis if they were partially sighted or hard of hearing to complete dental forms. A hearing loop was also available in the reception area. There was level access into the building and there was an accessible toilet and baby change facility available.

Access to the service

The practice opened from 9.00am to 5.00pmMonday to Friday with the exception of Mondays when it opened until 8pm. When the practice was closed, a recorded message on the practice telephone system advised patients where to go to seek urgent care advice. This information was not displayed in the practice or on their website.

Concerns & complaints

The practice had a complaints policy and a procedure that set out how complaints would be addressed. This included the person with overall responsibility for dealing with a complaint and the timeframes for responding. Information for patients about how to make a complaint was displayed in the waiting area but was not included on the practice website. None of the patients who gave us comments about the practice had needed to make a complaint.

We spoke with staff about complaints and they told us they always tried to resolve the issue at the time if possible. If not, the concerns were referred to the practice manager who dealt with them or they passed clinical complaints to the relevant dentist to consider and provide a response.

The practice had received three complaints in the last twelve months. We reviewed the management of the complaints which all had a complaints action summary sheet to monitor the detail and response. These did not contain any information about learning points identified and the records had not been signed off once the issue was completed. We saw that responses had been provided in a timely way and an apology had been provided to the patient. Staff had received training in the management of concerns and complaints.

Are services well-led?

Our findings

Governance arrangements

The principal dentist and the practice manager shared responsibility for monitoring the quality of the service. We found that the governance arrangements could be further strengthened.

The practice had a number of policies and procedures in place and we saw these covered a wide range of topics. For example, control of infection and health and safety and the management of information. We noted these were kept under review by the practice manager and principal dentist. Staff was aware of where policies and procedures were held and we saw these were easily accessible.

Monthly practice meetings were in place and these were led by the principal dentist and practice manager. When we reviewed minutes of these meetings we found that some had included issues such as patient feedback, significant events, health and safety and training. We noted there were no standing agenda items to promote continuity for discussing quality issues. In addition, there were no clear action points to enable further review.

The practice manager monitored the systems used to manage the safety of the environment which included fire safety and health and safety risk assessments. However we found there was no record of the actions taken following risk assessments for legionella, fire safety and sharp instruments.

Systems were in place to ensure that the maintenance of equipment such as machinery used in the decontamination process and other electrical equipment was checked and serviced regularly.

Some quality monitoring checks were not in place or were not being recorded. For example checks of the medical equipment and dental materials kept in the treatment rooms.

Leadership, openness and transparency

The principal dentist and practice manager had overall leadership and divided most of the lead roles between them for example complaints and the safeguarding lead. Although the practice employed an effective decontamination assistant, they did not have a clinical background and worked only in the decontamination room. There was no professional lead to guide staff in infection control practice while working in the treatment rooms.

Staff we spoke with told us that they worked well as a team and they were supported to raise any issues about the safety and quality of the service, share their ideas and learning. There was a well established team with low turnover of staff who fostered an open and transparent culture.

Providing a quality service and positive patient experience was a high priority. We found through our discussions with staff, that they were caring and committed to the work they did. All staff knew how to raise any issues or concerns and were confident that action would be taken by the practice manager. All staff had signed the policy to say they would follow the duty of candour by being open and honest in their work roles.

Learning and improvement

We found the practice did not always use opportunities to learn from audit findings, complaints and accidents in order to improve the service.

Key audits were taking place on a regular basis for infection control, dental records and X-rays in accordance with current guidelines. However the internal auditing process was limited and did not always drive improvement. For example an external quality audit had been completed early this year and had identified that patient medical histories were not being updated. Records showed this had been identified by the practice prior to the audit. Dental records we reviewed showed that the issue had not been addressed.

Although a system was in place for managing complaints and reporting accidents, we found that any actions taken to promote improvement or learning were not well used. A process to identify, report and learn from significant events or incidents had not been established.

Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. They also received annual appraisals with the exception of the practice manager whose last recorded appraisal was in 2011. Training was

Are services well-led?

completed through a variety of resources and media provision and records of training were maintained. The principal dentist also included training updates as part of staff meetings.

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

The practice had gathered feedback from patients through a patient survey in November 2015. This survey was repeated every 18 months. Results showed that patients rated a high level of satisfaction with the service they received. The results were considered by the practice team and as a result, the practice had introduced extended hours opening one evening a week. Although the results were discussed at a practice meeting there was no record made of the actions agreed in response to the survey and the feedback was not shared with patients.

The practice had participated in the NHS Family and Friends Test but had very limited responses that were helpful to them. At the time of the inspection, there were no feedback forms available with the feedback box. The principal dentist told us they planned to reinstate this.

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