Ivy Cottage Dental Care

# Ivy Cottage Dental Care

## Inspection Report

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## Overall summary

We carried out an announced comprehensive inspection on 9 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.

Ivy cottage Dental Care is situated in Rotherham town centre. It offers NHS and private dental care services to patients of all ages. The services provided include preventative advice and treatment and routine restorative dental care. Treatment and waiting rooms are on the ground and first floor of the premises.

The practice is currently undergoing a full refurbishment as part of a continuous improvement plan.

The practice has five dentists, three which are part time; a dental hygiene therapist, seven dental nurses, two receptionists and a practice manager. One of the principle dentists 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 is open Monday 9-00am to 7-00pm, Tuesday to Friday 8-30am to 5-30pm and Saturday 8-30am to 12-30pm.

We spoke with three patients who used the service on the day of inspection and reviewed 45 completed CQC comment cards. Patients we spoke with and those who completed comment cards were positive about the care

# Summary of findings

they received about the service. They commented that staff were caring, helpful and respectful, treatment was well explained, the practice was clean and that they had no problems getting appointments.

**Our key findings were:**

- The practice had systems in place to assess and manage risks to patients and staff including infection prevention and control, health and safety and the management of medical emergencies.
- Dental care records were detailed and showed that treatment was planned in line with current best practice guidelines, for example Faculty of General Dental Practice (FGDP) and 'The Delivering Better Oral Health Toolkit' (DBOH).
- Patients were treated with care, respect and dignity.
- Patients were able to access appointments in a timely manner.
- There were clearly defined leadership roles within the practice and staff told us that they felt supported, appreciated and comfortable to raise concerns or make suggestions.

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

- Ensure risk assessments were included in policies where action would not be taken.
- Ensure that when responding to a complaint, the complainant receives all relevant contact details of other organisation if they wish to take the complaint further.
- Ensure all single use dental products are disposed of in the correct manner.

# 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.

There were systems in place to help ensure the safety of patients and staff.

Staff felt confident and comfortable about reporting incidents and accidents. We reviewed incidents which had occurred within the last two years and saw that the practice had responded appropriately.

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

Staff were suitably trained and skilled to meet patient's needs and there were sufficient numbers of staff available at all times. There was clear evidence of skill mix within the practice.

Patients' medical histories were obtained before any treatment took place. The dentists were aware of any health or medication issues which could affect the planning of treatment. Staff were trained to deal with medical emergencies. All emergency equipment and medicines were in date and in accordance with the British National Formulary (BNF) and Resuscitation UK guidelines.

**Are services effective?**

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

Patients dental care records provided comprehensive information about their current dental needs and past treatment. The practice monitored any changes to the patients oral health and made referrals for specialist treatment or investigations where indicated.

The practice followed best practice guidelines when delivering dental care. These included Faculty of General Dental Practice (FGDP) and National Institute for Health and Care Excellence (NICE). The practice focused strongly on prevention and the dentists were aware of 'The Delivering Better Oral Health Toolkit' (DBOH) with regards to fluoride application and oral hygiene advice.

Staff were supported by the practice in continuing their professional development (CPD) and were meeting the requirements of their professional registration. Staff were knowledgeable about how to ensure patients had sufficient information in order to give informed consent. Staff had received training on the Mental Capacity Act (MCA) 2005.

**Are services caring?**

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

We reviewed 45 comment cards and spoke with three patients. Common themes were that patients felt they were treated with dignity and respect in a safe and clean environment. Patients also commented that they were involved in treatment options and full explanations of treatment was given. It was also noted that reception staff were always very helpful.

We observed patients' privacy and confidentiality were maintained at all times in the waiting room and reception area.

Staff explained that enough time was allocated in order to ensure that the treatment and care was fully explained to patients in a way which patients understood.

# Summary of findings

**Are services responsive to people's needs?**

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

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

The practice had undertaken a disability access risk assessment and reasonable adjustments had been made to accommodate patients with a disability or limited mobility.

The practice had emergency appointment slots available each day. They also offered extended opening hours on Monday evening and on Saturday morning. Patients commented that they were able to access emergency appointments when required. There were clear instructions available for patients who required emergency treatment outside opening hours.

**Are services well-led?**

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

There was a clearly defined management structure in place and staff all felt supported and appreciated in their own particular roles. The practice manager was responsible for the day to day running of the practice and they were supported by a dental practice adviser.

The practice regularly audited clinical and non-clinical areas as part of a system of continuous improvement and learning. They regularly undertook patient satisfaction surveys and were also undertaking the NHS Family and Friends Test.

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

# Ivy Cottage Dental Care

**Detailed findings**

## Background to this inspection

This announced inspection was carried out on 9 June 2015 by two inspectors from the Care Quality Commission (CQC), one of whom was a registered dentist.

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 reviewed information we held about the provider. This included information from NHS England, Healthwatch Rotherham and notifications which we had received.

During the inspection we toured the premises, spoke with one dentist, the dental hygiene/therapist, two dental nurses and the practice manager. To assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

We also reviewed information we asked the provider to send us in advance of the inspection. This included their latest statement of purpose describing their values and their objectives and a record of any complaints received in the last 12 months.

We obtained the views of 45 patients who had filled in CQC comment cards and we spoke with three patients who used the service on the day of our inspection.

# Are services safe?

## Our findings

**Reporting, learning and improvement from incidents**

The practice had a clear and effective process of how to report incidents. Staff were fully aware of this process. We saw evidence that incidents were documented, investigated and reflected on by the practice. Patients were given an apology and informed of any action taken.

The principal dentist understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). There was reference to this in the practice health and safety policy. The practice responded to patient safety alerts issued from the Medicines and Healthcare products Regulatory Authority (MHRA) that affected the dental profession.

**Reliable safety systems and processes (including safeguarding)**

The practice had child protection and vulnerable adult policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff. Staff had access to contact details for both child protection and adult safeguarding teams.

The principal dentist was the safeguarding lead and all staff had received safeguarding training in the last 12 months. Staff we spoke with were aware of the different types and signs of abuse and felt confident about raising any concerns with the safeguarding lead.

The practice had safety systems in place to help ensure the safety of staff and patients. These included clear guidelines about responding to a sharps injury (needles and sharp instruments). The practice had undertaken a sharps risk assessment to reduce the likelihood of sharps injuries. There were adequate supplies of personal protective equipment such as face visors and heavy duty rubber gloves for use when manually cleaning instruments. Rubber dams were used in root canal treatment. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway.

**Medical emergencies**

The practice had a medical emergencies policy which provided staff with clear guidance about how to deal with medical emergencies. This was in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). The emergency resuscitation kits, oxygen and emergency medicines were stored securely with easy access for staff working in any of the treatment rooms. The practice had an Automated External Defibrillator (AED) to support staff in a medical emergency. (An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm).

Records showed weekly and monthly checks were carried out to ensure the equipment and emergency medicines were safe to use. Staff were knowledgeable about what to do in a medical emergency and had received their annual training in emergency resuscitation and basic life support as a team within the last 12 months. Staff had also undertaken a simulator based medical emergency course specifically aimed at medical emergencies which are more likely to occur in a dental practice.

**Staff recruitment**

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

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

**Monitoring health & safety and responding to risks**

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice manager and principal dentist carried out health and safety and checks which involved inspecting the premises and equipment and ensuring maintenance and service documentation was up to date.

# Are services safe?

There were policies and procedures in place to manage risks at the practice. These included infection prevention and control, a pregnant person's risk assessment, fire evacuation procedures and risks associated with Hepatitis B. The majority of processes were in place to monitor and reduce these risks so that staff and patients were safe.

The practice maintained a file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including substances such as disinfectants, blood and saliva. The practice identified how they managed hazardous substances in their health and safety and infection control policies and in specific guidelines for staff, for example in their blood spillage and waste disposal procedures.

The practice had a business continuity plan to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service. Key contact numbers were included and copies of the plan were kept in the practice and by the principal dentist.

**Infection control**

Two of the dental nurses were the infection control lead professionals. They worked together with the practice manager to ensure there was a comprehensive infection control policy and set of procedures to help keep patients safe. These included hand hygiene, health and safety, safe handling of instruments, managing waste products and decontamination guidance. We observed waste was separated into safe containers for disposal by a registered waste carrier and appropriate documentation retained.

The practice had followed the guidance about decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)' and the 'Code of Practice about the prevention and control of infections and related guidance'. These documents and the practice's policy and procedures relating to infection prevention and control were accessible to staff. Posters promoting good hand hygiene and the decontamination procedures were clearly displayed to support staff in following practice procedures. Staff received annual training regarding hand hygiene and infection prevention and control.

We looked around the premises during the inspection and found the treatment rooms and the decontamination room appeared clean and hygienic. They had sealed floors and work surfaces that were free from clutter and could be cleaned and disinfected between patients. Staff we spoke with told us they cleaned the treatment areas and surfaces between each patient and at the end of the morning and afternoon sessions to help maintain infection control standards. There were hand washing facilities in each treatment room and staff had access to good supplies of personal protective equipment (PPE) for patients and staff members. During the inspection of the treatment rooms we found half used capsules of filling material. This was brought to the attention of the practice manager and principal dentists and they took immediate action to ensure that these were disposed of after each patient.

Sharps bins were appropriately located, signed and dated and not overfilled. A clinical waste contract was in place and waste was stored securely until collection.

There were checklists available for staff to follow for the surgeries and the general areas of the practice including daily cleaning schedules. We looked at records dating back several months and found they were completed to a satisfactory standard. Records held reflected that the quality of the cleaning was being monitored and feedback given accordingly.

Decontamination procedures were carried out in a dedicated decontamination room in accordance with HTM 01-05 guidance. An instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which minimised the risk of the spread of infection.

The Local Decontamination Unit (LDU) nurse showed us the procedures involved in cleaning, rinsing, inspecting and decontaminating dirty instruments; packaging and storing clean instruments. The practice routinely manually scrubbed dirty instruments, then examined them visually with an illuminated magnifying glass, then sterilised them in an autoclave. Instruments were packaged and stamped with a use by date. High use instruments (mirrors/probes) were stored in a sealed box and transported back to each surgery. The decontamination room had clearly defined dirty and clean zones in operation to reduce the risk of cross contamination. Staff wore appropriate PPE during the process and these included disposable gloves, aprons and protective eye wear.

# Are services safe?

The practice had systems in place for daily quality testing of the decontamination equipment and we saw records which confirmed these had taken place. There were sufficient instruments available to ensure the services provided to patients were uninterrupted.

The practice had carried out the self- assessment audit in the last six months relating to the Department of Health's guidance on decontamination in dental services (HTM01-05).This is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. The audit showed the practice was meeting the required standards.

Records showed a risk assessment process for Legionella had been carried out in the last 12 months. (Legionella is a term for particular bacteria which can contaminate water systems in buildings). This ensured the risks of Legionella bacteria developing in water systems within the premises had been identified and preventive measures taken to minimise the risk to patients and staff of developing Legionnaires' disease. These included running the water lines in the treatment rooms at the beginning of each session and between patients and monitoring cold and hot water temperatures each month.

**Equipment and medicines**

The practice maintained a comprehensive record of all equipment including dates of when maintenance contracts required renewal. The practice manager told us this helped them check and record that all equipment was in working order. Records showed contracts were in place to ensure annual servicing and routine maintenance work occurred in a timely manner.

The practice had an effective system in place regarding the prescribing, recording, dispensing, use and stock control of the medicines and materials used in clinical practice. The dentists used the British National Formulary to keep up to date about medicines. The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored safely for the protection of patients.

Prescription pads were stored in the surgeries when in use and in a locked cabinet in the office. Prescriptions were stamped only at the point of issue to maintain their safe use. The dentist we spoke with told us they recorded information about any prescription issued within the patient's dental care record.

**Radiography (X-rays)**

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. Records we viewed demonstrated that the X-ray equipment was regularly tested, serviced and repairs undertaken when necessary. A Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure that the equipment was operated safely and by qualified staff only. We found there were suitable arrangements in place to ensure the safety of the equipment. Local rules were available in all surgery's and within the radiation protection folder for staff to reference if needed.

X-rays were digital and images were stored within the patient's dental care record. Those authorised to carry out X-ray procedures were clearly named in all documentation and records showed they had attended the relevant training. This protected patients who required X-rays to be taken as part of their treatment.

X-ray audits were carried out at least every six months. This included assessing the quality of the X-ray and also checked that they had been justified and reported on. The results of the audits confirmed they were meeting the required standards which reduced the risk of patients being subjected to further unnecessary X-rays.

# Are services effective?

(for example, treatment is effective)

## Our findings

**Monitoring and improving outcomes for patients**

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

We reviewed with the dentist and the hygiene/therapist the information recorded in five patient care records regarding the oral health assessments, treatment and advice given to patients. Clinical records were comprehensive and included details of the condition of the teeth, soft tissue lining the mouth, gums and any signs of mouth cancer. Records showed patients were made aware of the condition of their oral health and whether it had changed since the last appointment. Medical history checks were updated by each patient every time they attended for treatment and entered in to their electronic dental care record. This included an update on their health conditions, current medicines being taken and whether they had any allergies.

The practice used current guidelines and research in order to continually develop and improve their system of clinical risk management. For example following clinical assessment, the dentists followed the guidance from the FGDP before taking X-rays to ensure they were required and necessary. Justification for the taking of an x-ray was recorded in the patient's care record and these were reviewed in the practice's programme of audits.

Records showed a diagnosis was discussed with the patient and treatment options explained.

Patients were given a copy of their treatment plan, including any fees involved. Treatment plans were signed by the patient before treatment and saved into the patient's electronic record.

Patients spoken with and comments received on CQC comment cards reflected that patients were very satisfied with the assessments, explanations, the quality of the dentistry and outcomes.

**Health promotion & prevention**

The practice had a strong focus on preventative care and supporting patients to ensure better oral health in line with 'The Delivering Better Oral Health Toolkit' (an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting). For example, the practice recalled patients at high risk of tooth decay to receive fluoride applications and fissure sealants to their teeth. The practice had a selection of dental products on sale in the reception area to assist patients with their oral health. Patients were given advice regarding maintaining good oral health and if appropriate were referred to the dental hygiene/therapist for more support regarding general dental hygiene procedures. Where required high fluoride toothpastes were prescribed.

The medical history form patients completed included questions about smoking and alcohol consumption. The dentists we spoke with told us patients were given advice appropriate to their individual needs such as smoking cessation, alcohol consumption or dietary advice. There were health promotion leaflets available in the waiting room to support patients. The practice also used social media to promote good oral health.

**Staffing**

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. Staff we spoke with confirmed they had been fully supported during their induction programme.

Staff told us they had good access to on-going training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). Records showed professional registration with the GDC was up to date for all staff and we saw evidence of on-going CPD. Mandatory training included basic life support and infection prevention and control. They had developed a staff training matrix which showed when staff members were due to complete mandatory training. This ensured that staff were all up to date with current training.

# Are services effective?

## (for example, treatment is effective)

The practice manager and principal dentists monitored staffing levels and planned for staff absences to ensure the service was uninterrupted. They had a procedure in place for the staff to contact the surgery before the surgery opened if they were unable to attend so that cover could be arranged.

Dental nurses were supervised by the dentists and supported on a day to day basis by the practice manager. Staff told us the manager and the principal dentist were readily available to speak to at all times for support and advice. Staff had computer access where they could view policies which contained information that further supported them in the workplace. Staff told us they had received appraisals and reviews of their professional development within the last year.

**Working with other services**

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. For example, referrals were made to hospitals and specialist dental services for further investigations or specialist treatment. The practice completed detailed proformas or referral letters to ensure the specialist service had all the relevant information required. Dental care records contained details of the referrals made and the outcome of the specialist advice.

**Consent to care and treatment**

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

Staff we spoke with had undertaken training on the principles of the Mental Capacity Act (MCA) 2005 and how it was relevant to ensuring patients had the capacity to consent to dental treatment.

Staff ensured patients gave their consent before treatment began. Staff confirmed individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. Patients were given time to consider and make informed decisions about which option they preferred. We saw evidence of this documented in the dental care records.

# Are services caring?

## Our findings

**Respect, dignity, compassion & empathy**

We looked at 45 CQC comment cards patients had completed prior to the inspection and spoke with three patients on the day of the inspection. Patients were positive about the care they received from the practice. They commented they were treated with respect and dignity.

We discussed with staff how they ensured patient confidentiality was maintained within the reception/ waiting area. Staff were aware of the importance of providing patients with privacy and told us there was a room available if patients wished to discuss something with them away from the reception area. The practice also had a radio playing to provide some background noise to support patient confidentiality. We observed that the computer screens were situated so that patients could not view them. Staff were helpful, discreet and respectful to patients in the practice and on the telephone. Staff would inform patients if there would be a delay in the dentist seeing them and offer an apology.

During the inspection we observed staff interacting with patients in a respectful and dignified manner.

**Involvement in decisions about care and treatment**

The practice provided patients with information to enable them to make informed choices. Patients commented they felt involved in their treatment and it was fully explained to them. Staff described to us how they involved patients' relatives or carers when required and ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood. All staff had received training in the Mental Capacity Act (MCA) 2005.

Patients were also informed of the range of treatments available and their cost in information leaflets, on notices in the practice and on the practice website.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting patients' needs**

The practice provided patients with information about the services they offered in leaflets and on their website. The services provided include preventative advice and treatment and routine and restorative dental care**.** We found the practice had an efficient appointment system in place to respond to patients' needs. Staff told us the majority of patients who requested an urgent appointment would be seen within 24 hours. A patient who we spoke with confirmed they had been given an emergency appointment that day. Staff told us each dentist had blocked off emergency appointment slots each day. If the emergency slots had already been taken the patients were offered to come down and "sit and wait" for an emergency appointment.

The hygiene/therapist we spoke with told us the appointment system gave them sufficient time to meet patient needs and they could determine the length of the appointment times. Patients commented they had sufficient time during their appointment and they were not rushed. We observed the clinics ran smoothly on the day of the inspection and patients were not kept waiting.

Patients we spoke with told us (and comments cards confirmed) they had flexibility and choice to arrange appointments in line with other commitments. Patients also commented that they were offered cancellation appointments if these were available.

**Tackling inequity and promoting equality**

The practice had equality and diversity and disability policies to support staff in understanding and meeting the needs of patients. The practice made adjustments to meet the needs of patients, including having a hearing loop system available on the reception counter for patients with a hearing impairment. The practice had access to an interpreter service for patients whose first language was not English.

The practice is a converted cottage and they had carried out a Disability Discrimination Act (DDA) access audit. Wheelchair access was possible through the front door however there was a slight slope down to the door which may be difficult for some patients with limited mobility. They had made it possible for patients who had limited mobility to access the practice from the back door directly from the car park at the rear of the practice. Patients were advised to call the practice when they were about to arrive so the staff were aware to let them in.

The practice had treatment rooms on the ground and first floor of the premises. The practice had made reasonable adjustments to accommodate patients with a disability or lack of mobility. There were sufficient treatment rooms on the ground floor to always be able to accommodate patients who were unable to use the stairs. There were disabled toilet facilities on the ground floor.

Patients told us that they received information on treatment options to help them understand and make an informed decision on their preference of treatment.

**Access to the service**

The practice displayed its opening hours on the premises, on the practice website and in their practice leaflet. Opening hours were Monday 9-00am to 7-00pm, Tuesday to Friday 8-30am to 5-30pm and Saturday 8-30am to 12-30pm. The practice had clear instructions in the practice, via the practice's answer machine, on their website and in the practice leaflet for patients requiring urgent dental care when the practice was closed. CQC comment cards reflected patients felt they had good access to routine and urgent dental care.

**Concerns & complaints**

The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. Staff told us they raised any formal or informal comments or concerns with the practice manager to ensure responses were made in a timely manner.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients. We found there was an effective system in place which helped ensure a timely response. Information for patients about how to raise a concern or offer suggestions was available in the waiting room, on the practice website and in the practice leaflet.

The practice had received one complaint in the last 12 months which had been responded to but which was still on going. Steps had been taken to resolve the issue to the patient's satisfaction and a suitable apology and an explanation had been provided. It was evident from these

# Are services responsive to people's needs?

## (for example, to feedback?)

records that the practice had been open and transparent and where action was required it had been taken. We noted that the response letter did not have the contact details of the NHS Health Service Ombudsman. We made the practice aware of this and they informed us that this was unknowingly omitted and they showed us that the letter template in their policy does have the full contact details available.

# Are services well-led?

## Our findings

**Governance arrangements**

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

The practice was currently undertaking a total refurbishment of the building as part of continuous improvement plan.

The practice manager and principal dentists shared the day to day running of the service. We saw they had systems in place to monitor the quality of the service. These were used to make improvements to the service.

We looked in detail at how the practice identified, assessed and managed clinical and environmental risks related to the service provided. We saw risk assessments and the control measures in place to manage those risks; for example, for use of equipment in the dental practice, fire and infection control.

The practice had undertaken audits to ensure their procedures and protocols were being carried out and were effective. These included audits of infection control and X-rays. Lead roles, for example in infection control, radiography and safeguarding supported the practice to identify and manage risks and helped ensure information was shared with all team members. Where areas for improvement had been identified action had been taken. There was evidence of repeat audits to evidence that improvements had been maintained.

The practice had a well-defined management structure which all the staff were aware of and understood. All staff members had defined roles and were all involved in areas of clinical governance.

There was a full range of policies and procedures in use at the practice and accessible to staff on the practice computers and in paper files. These included guidance about confidentiality, record keeping, incident reporting and data protection. There was a process in place to ensure that all policies and procedures were kept up to date.

Care and treatment records were kept electronically and we found them to be complete, legible accurate and kept secure.

The practice had policies and procedures to support staff maintain patient confidentiality and understand how patients could access their records. These included confidentiality and information governance policies and record management guidance. Patients' care records were stored electronically, password protected and regularly backed up to secure storage. Paper records were kept behind the reception desk. The keys for the cabinets had been lost and the practice could not find replacement keys. As part of their refurbishment plan they were arranging to move the cabinets into the locked and secure cellar.

**Leadership, openness and transparency**

The culture of the practice encouraged candour, openness and honesty. Staff told us there was an open culture at the practice and they felt valued and well supported. They reported the practice manager and dentists were very approachable. The dental nurses who we spoke with told us they had good support to carry out their individual roles within the practice.

The principal dentists and practice manager provided clearly defined leadership roles within the practice. Staff told us there were informal and monthly practice meetings which were documented for those staff unable to attend. Staff told us this helped them keep up to date with new developments, to make suggestions and provide feedback to the practice manager and principal dentists. Staff were encouraged to write down on the notice board any topics they wished to discuss during a staff meeting.

**Management lead through learning and improvement**

Staff told us they had good access to training and the practice manager monitored staff training to ensure essential training was completed each year, this included emergency resuscitation and basic life support and infection control. Staff working at the practice were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC).

The practice audited areas of their practice each year as part of a system of continuous improvement and learning. These included audits of radiography-both the quality of X-ray images and compliance with the Faculty of General

# Are services well-led?

Dental Practice (FGDP) regarding appropriate selection criteria, patient records and consent. The audits included the outcome and actions arising from them to ensure improvements were made.

The practice had monthly staff meeting where significant events were discussed and learning was disseminated. The principle dentists and the practice manager had a weekly meeting to discuss and immediate issues. All staff had annual appraisals where learning needs and aspirations are discussed.

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

The practice had systems in place to seek and act upon feedback from patients using the service and staff, including carrying out annual surveys. The most recent patient survey in 2014 showed a high level of satisfaction with the quality of service provided. The practice gave patients the opportunity to complete the NHS family and friends test, which is a national programme to allow patients to provide feedback on the services provided. The practice also used social media to allow patients to give feedback.