IDH 403 Ltd

Billinge Dental Practice

Inspection Report

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Overall summary

We carried out a comprehensive inspection of Billinge Dental Practice on 7 May 2015.

Billinge Dental Practice is part of Brand IDH, a national organisation which operates 600 dental practices across the United Kingdom. It offers mainly (approximately 80%) NHS dental care services to patients of all ages. The services provided include preventative advice and treatment and routine and restorative dental care. Treatment and waiting rooms are on the ground floor of the premises.

The practice has three dentists, one of whom is part time; seven dental nurses (who also worked as receptionists), a part-time hygienist, a receptionist and a practice manager. The practice manager is applying to be the registered manager for the practice. 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 manager is full time but is also responsible for one other practice.

The practice is open Monday to Wednesday day from 9-00am to 5-30pm, Thursday from 9-00am to 6-30pm and on Friday from 8-00am to 5-00pm

We spoke with two patients who used the service on the day of our inspection and reviewed 29 completed CQC comment cards. Patients we spoke with and 27 patients who completed comment cards were positive about the care they received from the practice. They commented staff were caring, helpful and respectful and that they had confidence in the dental services provided. Two negative comments were made; one regarding the availability of appointments and one about staff attitude.

We found that this practice was providing safe, effective, caring, responsive and well-led care in accordance with the relevant regulations.

Our key findings were:

- The practice had systems to assess and manage risks to patients, including for infection prevention and control, health and safety and the management of medical emergencies.
- Dental care records were detailed and showed on-going monitoring of patients' oral health. Staff had received training appropriate to their roles.
- We reviewed 29 comment cards that had been completed by patients. Common themes were patients felt they were listened to and received very good care in a clean environment.

Summary of findings

- Patients were able to make routine and emergency appointments when needed. There were clear instructions for patients regarding out of hours care.
- There were clearly defined leadership roles supporting the practice and arrangements for sharing information within the practice.

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

- Ensure the dental team is familiar with 'The Delivering Better Oral Health toolkit'.
- Ensure staff are knowledgeable about the Mental Capacity Act (MCA) 2005 and its relevance to dental practice.
- Review how feedback from the IDH patient surveys is shared with practice staff and patients.

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 staff and patients. These included safeguarding children and adults from abuse, maintaining the required standards of infection prevention and control and responding to medical emergencies. The practice carried out and reviewed risk assessments to identify and manage risks.

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 in the patient's oral health and made referrals to specialist services for further investigations or treatment if required. Staff were supported by the practice in continuing their professional development (CPD) and were meeting the requirements of their professional registration.

The practice manager and the dental nurses we spoke with were not familiar with 'The Delivering Better Oral Health toolkit'. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Staff we spoke with described how they involved relatives and carers to help patients who required support with making decisions to ensure the best interests of the patient were met. The practice manager confirmed they would discuss with IDH how they could further improve staff knowledge about the Mental Capacity Act (MCA) 2005 and its relevance to dental practice.

Are services caring?

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

We reviewed 29 comment cards that had been completed by patients. Common themes were patients felt they were listened to and received very good care in a clean environment. Patients we spoke with told us they felt they were treated with respect and were involved with the discussion of their treatment options.

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 guidance. Patients' dental care records were stored electronically and paper records were kept securely in a locked cabinet.

Are services responsive to people's needs?

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

The practice offered routine and emergency appointments each day. There were clear instructions for patients requiring urgent care when the practice was closed. The practice had extended opening hours on a Thursday until 6-30pm and on a Friday from 8-00am. The practice supported patients to attend their forthcoming appointment by having a text reminder system in place. Patients who commented on this service reported this as helpful.

There was a procedure in place for responding to and learning from complaints, concerns and suggestions made by patients.

Summary of findings

Are services well-led?

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

The practice manager was responsible for the day to day running of the service and was supported by IDH's clinical support manager and site manager to monitor the quality of the service. The practice audited areas of their service each year as part of a system of continuous improvement and learning. These included audits of X-rays, patient records and prescription usage. Staff we spoke with told us they felt well supported by the practice manager. There were good arrangements for sharing information across the practice including daily informal meetings and monthly practice meetings which were documented for those staff unable to attend.

IDH had systems in place to seek and act upon feedback from patients using the service, including carrying out continuous patient surveys using their website. However the practice manager was unable to show us the results of the completed surveys for Billinge dental practice during the last 12 months or any changes made as a result of patient feedback. 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.

Billinge Dental Practice

Detailed findings

Background to this inspection

This announced inspection was carried out on the 7 May 2015 by an inspector from the Care Quality Commission (CQC).

Prior to the inspection we reviewed information we held about the provider.

During the inspection we toured the premises and spoke with one of the dentists, three dental nurses, a receptionist 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 29 patients who had filled in CQC comment cards and spoke with two patients who used the service on the day of our 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

There was an effective system in place to learn from and make improvements following any accidents or incidents. Staff understood the process for accident and incident reporting including the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). We found incidents were reported, investigated and measures put in place where necessary to prevent recurrence.

The practice manager checked all safety alerts and spoke with staff to ensure they were acted upon.

Reliable safety systems and processes (including safeguarding)

The practice manager was the lead for safeguarding in the practice with support from the IDH patient support manager for the region. The practice had up to date 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 local authority contact details for reporting concerns. Safeguarding was identified as essential training for all staff to undertake every 12 months.

The practice had 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 used dental safety syringes which had a needle guard in place to support staff use and to dispose of needles safely. There were adequate supplies of personal protective equipment such as face visors and heavy duty rubber gloves for use when manually cleaning instruments.

Medical emergencies

The practice had a medical emergencies policy and set of procedures 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 near the reception area 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 daily checks were carried out to ensure the equipment and emergency medicines were safe to use. Staff had attended their annual training in emergency resuscitation and basic life support as a team within the last 12 months. Staff were knowledgeable about what to do in a medical emergency. The practice carried out medical emergency simulations every three months to ensure they were familiar with the procedures. We saw records of the most recent simulation in February 2015.One staff member was the first aid lead and had received training to carry out the role.

Staff recruitment

The practice had a policy and set of procedures for the safe recruitment of staff which included seeking references, proof of identity, checking qualifications and professional registration. We reviewed documentation and found the recruitment procedure had been followed.

The practice manager checked the professional registration for newly employed clinical staff each year to ensure that professional registrations were up to date. Records we looked at confirmed this.

The practice manager told us it was IDH's policy to carry out Disclosure and Barring service (DBS) checks for all 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 these checks were in place.

Newly employed staff had a period of induction to familiarise themselves with practice procedures and complete mandatory training such as health and safety and infection control, before being allowed to work unsupervised. Before commencing work, agency staff signed to confirm they had read and understood the emergency medical procedures within the practice.

Monitoring health & safety and responding to risks

The practice had arrangements in place to deal with foreseeable emergencies. A health and safety policy and a risk management process were in place to ensure the safety of patients and staff. For example, we saw completed

Are services safe?

risk assessments for fire, exposure to hazardous substances and infection control. The assessments were reviewed annually and included the controls and actions to manage risks. The practice had detailed files in each treatment room relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations. The log included substances such as X-ray developer, blood and saliva and disinfectants. They identified the controls they had in place for each one. We saw this had been reviewed by IDH in 2015 and staff told us they were in the process of updating the files and familiarising themselves with the revised documents.

The practice manager told us IDH had a business continuity plan in place for all practices. They were unable to locate it on the day of the inspection but told us they would ensure this was in place as soon as possible. We found the practice had clear procedures in place to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service. This included key IDH contact numbers for IT and facilities support. The practice manager described the actions taken by the practice and IDH in the last six months when the telephone lines were not working. These included providing the practice with an emergency mobile phone and using their website to advise patients of the fault and provide alternative contact details. The practice manager told us they had felt well supported to manage the incident.

Infection control

One of the dental nurses was the infection control lead professional and they worked 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, environmental cleaning, health and safety, 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 infection prevention and control and updates were provided at staff meetings.

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. We observed that a wall in one of the treatment rooms was damaged, with an area of dislodged paint work. The practice manager confirmed it had been identified as an infection control risk and was included in a schedule of building work to be completed within the next three months.

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 protective equipment for patients and staff members Staff and patients we spoke with confirmed that protective aprons, gloves and masks were worn during assessment and treatment in accordance with infection control procedures

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 infection control lead professional showed us the procedures involved in cleaning, rinsing, inspecting and decontaminating dirty instruments; packaging and storing clean instruments. The practice used an ultrasonic cleaner or washer-disinfectant machine to clean the used instruments. They examined the instruments visually with an illuminated magnifying glass, to check for any debris or damage, then sterilised them in an autoclave. The decontamination room had clearly defined dirty and clean zones in operation to reduce the risk of cross contamination. Staff wore appropriate personal protective equipment during the process and these included disposable gloves, aprons and protective eye wear.

Are services safe?

The practice had systems for daily quality testing 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 November 2014 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 practice also carried out staff observations and assessments in November 2014 as part of IDH's infection prevention and control monitoring procedures. Results were shared with staff. Both assessments showed the practice was meeting the required standards.

Records showed a risk assessment for Legionella had been carried out in 2013 and was scheduled for re-assessment in 2015 (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. Records showed these procedures were being carried out.

Equipment and medicines

The practice maintained a comprehensive list of all equipment including dates when maintenance contracts were renewed. The practice manager told us they used a tracker system to ensure maintenance contracts and routine checks were completed, for example for portable appliance testing. (PAT- this is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use). The practice manager told us the tracker system 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 systems in place regarding the prescribing, recording, use and stock control of the medicines 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 then in a locked cabinet overnight. Prescriptions were stamped only at the point of issue to maintain their safe use. The practice kept a detailed log of all prescriptions issued by each dentist, which provided a clear audit trail to ensure safe usage and prescribing. The dentists recorded information about any prescription issued within the patient's dental care record.

Radiography (X-rays)

X-rays were developed in the practice and stored within the patient's paper records. We checked four sets of patient care records and found both paper and electronic records were up to date and included the justification for taking the X-ray. We looked at the most recent audit of 50 X-rays which was carried out in January 2015 and found they were of the required standard. This reduced the risk of patients being subjected to further unnecessary X-rays.

We found there were suitable arrangements in place to ensure the safety of the equipment. 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 and a radiation protection supervisor had been identified, to ensure that the equipment was operated safely and by qualified staff only. Those authorised to carry out X-ray procedures were clearly named in all documentation and records showed they had attended training. This protected patients who required X-rays to be taken as part of their treatment.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept detailed electronic and paper records of the care given to patients. We reviewed the information recorded in four patient records (electronic and paper) about the oral health assessments, treatment and advice given to patients. Dental care records provided comprehensive information about patients' oral health assessments, treatment and advice given. They included details about the condition of the teeth, soft tissues lining the mouth and gums which were reviewed at each examination in order to monitor any changes in the patient's oral health. The dentists used current National Institute for Health and Care Excellence (NICE) guidelines to assess each patient's risks and needs and determine how frequently to recall them. NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment.

X-rays were taken at appropriate intervals, as informed by guidance issued by the Faculty of General Dental Practice (FGDP). Medical history checks were updated at every visit and the paper and electronic records we looked at confirmed this. This included an update on their health conditions, current medicines being taken and whether they had any allergies.

Patients were given a copy of their treatment plan, including any fees involved. Treatment plans were signed before treatment began.

Health promotion & prevention

The practice manager and the dental nurses we spoke with were not familiar with 'The Delivering Better Oral Health toolkit'. (DBOH-This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting). However it was evident the practice provided patients with preventative care and advice during appointments. The practice recalled patients, as appropriate, to receive fluoride applications to their teeth to help ensure better oral health. A selection of dental products were on sale to assist patients with their oral health and there was a range of literature about effective dental hygiene.

Patients completed a medical questionnaire which included questions about smoking and alcohol intake to support the dentists provide advice according to patient's individual needs.

Staffing

Staff we spoke with 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 required for registration with the General Dental Council (GDC).The GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians and dental technicians. Records showed professional registration with the GDC was up to date for all staff and we saw evidence of on-going continuous professional development. Mandatory training included basic life support, health and safety, safeguarding and infection prevention and control. Records showed staff had completed these in the last 12 months.

The practice manager monitored staffing levels and planned for staff absences to ensure the service was uninterrupted. They told us they had the flexibility of bringing staff from the other practice they managed and to arrange for staff from an agency to support Billinge Dental Practice if required.

Dental nurses were supervised by the dentists and supported on a day to day basis by the practice manager. Staff told us the manager was available to speak to at all times for support and advice.

The practice had a system of annual appraisals and six monthly reviews in place to support staff. However, the practice manager acknowledged that dental nurses/ receptionists in the practice had not had their appraisal which was due in 2014. They confirmed this would be addressed by the end of May 2015.

Working with other services

The practice worked with other services to meet the needs of patients. For example referrals were made to hospitals and specialist dental services for further investigations and orthodontic 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.

Are services effective?

(for example, treatment is effective)

The practice provided emergency services with medical information in the event a patient needed to be taken to hospital by completing patient transfer forms. These were stored with the medical emergency equipment and medicines and easily accessible staff.

Consent to care and treatment

Patients were given appropriate verbal and written information to support them to make decisions about the treatment they received. The practice's consent policy provided staff with guidance and information about when consent was required and how it should be recorded.

Staff described how they involved relatives and carers to help patients who required support with making decisions to ensure the best interests of the patient were met. Following discussion, the practice manager confirmed they would discuss with IDH how they could further improve staff knowledge about the Mental Capacity Act (MCA) 2005 and its relevance to dental practice.

Staff ensured patients gave their consent to care and treatment 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. This was reflected in comments patients made on CQC comment cards and in patient records.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

29 of the 31 patients spoken with or who completed the CQC comment cards were positive about the care they received from the practice. They commented they were treated with respect and dignity. One patient commented negatively about staff attitude on occasions.

The waiting area was compact and adjacent to the reception desk. The waiting area was very busy throughout the day of the inspection as all three dentists were treating patients. 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 television in place to provide some background noise to support patient confidentiality. We observed there were sufficient treatment rooms available and used for all discussions with patients. Staff were helpful, discreet and respectful to patients in the practice and on the telephone.

Patients' clinical records were stored electronically; password protected and regularly backed up to secure storage. Paper records were kept securely in two locked cabinets. 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 guidance.

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.

Patients were also informed of the range of treatments available and their cost in information leaflets and 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 patient's needs

The practice provided patients with information about the services they offered in leaflets and on their website. One patient who completed a CQC comment card reported they sometimes had difficulty making an appointment. We looked at the practice's electronic appointment system and found each dentist had two vacant appointment slots each day for urgent or emergency appointments. Staff told us patients were seen as soon as possible for emergency care and this was normally within 24 hours.

Tackling inequity and promoting equality

The practice manager was in the process of re-assessing disability access for the premises and told us this would be included in the IDH review of the building currently taking place. The practice was at ground floor level with step free access; two of the three treatment rooms were sufficiently spacious to accommodate a wheelchair or pushchair. Patient records included an alert for staff, for example regarding patients using a wheelchair; to ensure they were seen in an appropriate treatment room. We observed the practice had a small patient waiting area and did not have disabled toilet facilities**.** The premises were located near shops with some car parking nearby.

Staff told us any patients who had English as their second language attended with relatives who interpreted for them. The practice manager was knowledgeable about how to arrange an interpreter if required.

Access to the service

The practice displayed its opening hours in their premises and on the practice website. Opening hours were Monday to Wednesday from 9.00am to 5.30pm with extended opening hours on a Thursday until 6-30pm and on a Friday from 8-00am. There were clear instructions in the practice and via the practice's answer machine for patients requiring urgent dental care when the practice was closed.

The practice supported patients to attend their forthcoming appointment by having a text reminder system in place. Patients who commented on this service reported this as helpful. The practice was introducing an online appointment booking service to provide increased flexibility and choice for patients.

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 these were responded to.

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

We saw a summary of the three complaints received by the practice in the last 12 months, including the outcome of the investigations and communication with the patients concerned. The complaints had been discussed with staff and learning had taken place; for example to help ensure patient concerns were brought to the attention of the practice manager as soon as possible.

Are services well-led?

Our findings

Governance arrangements

The practice manager was responsible for the day to day running of the service. The practice manager told us they were supported by the IDH clinical support manager and site manager to monitor the quality of the service. The practice manager led on the individual aspects of governance such as complaints, risk management and audits within the practice.

We looked in detail at how the practice identified, assessed and managed clinical and environmental risks related to the service provided. We saw detailed risk assessments and the control measures in place to manage those risks, for example regarding lone workers, manual handling and the use of sharp dental hand instruments. The site manager carried out compliance checks every six months and practice support visits every 4-6 weeks to ensure quality standards were being met. These included checks about patient experience, radiography (X-rays), infection control and buildings, maintenance and health and safety. The practice manager ensured actions arising from the visits were addressed within agreed timescales.

Leadership, openness and transparency

The practice was part of Brand IDH, a national organisation and there were clearly defined leadership roles in place. IDH had a clinical support manager who was the lead dentist for a defined area and set of practices in the country. They provided clinical leadership including meeting with the dentists in the practice and providing clinical support as required.

The practice manager told us they were supported to do their work through monthly practice manager meetings and weekly telephone contact with the site manager. The practice manager ensured IDH's human resource and clinical policies and procedures were up to date and staff were aware of any changes to them. These included guidance about confidentiality, incident reporting, infection control and consent to treatment.

Staff we spoke with told us they felt well supported by the practice manager. There were good arrangements for sharing information across the practice including daily informal meetings 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 and policies. It also gave them an opportunity to make suggestions and provide feedback to the practice manager.

Management lead through learning and improvement

Staff working at the practice were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC). The dentists, dental nurses and hygienist working at the practice were registered with the GDC. The GDC registers all dental care professionals to make sure they are appropriately qualified and competent to work in the United Kingdom. The practice manager kept a record to evidence staff were up to date with their professional registration.

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

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

IDH had systems in place to seek and act upon feedback from patients using the service, including carrying out continuous patient surveys using their website and following up on any comments made on the NHS choices website. The practice manager told us they would be kept up to date with any comments made or actions required from the surveys. However they were unable to show us the results of the completed surveys for Billinge dental practice during the last 12 months or any changes made as a result of patient feedback.

Reception staff told us any suggestions or comments patients made directly to them were reported to the practice manager. 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.