# Orthoworld 2000 Limited

# St Ives – Ortho

## Inspection Report

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Date of inspection visit: 13 Janaury 2016
Date of publication: 18/02/2016

## Overall summary

We carried out an announced comprehensive inspection on 13 January 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**

St Ives-Ortho provides mainly private dental treatment to patients and some NHS orthodontic treatment to children. The practice has about 2000 active patients and is part of the Mydentist group, who have a large number of dental practices across the UK.

The practice employs one full-time dentist, one part-time orthodontist and one part-time dental hygienist. A visiting dentist attends the practice every 6- 8 weeks to fit dental implants. They are supported by a part-time practice manager and two dental nurses. The practice opens Monday to Friday from 8am to 5 pm.

At the time of our inspection the registered manager was in the process of deregistering but a new manager had been appointed and had submitted her application to register. She had been in post for only a week. 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 has one treatment room, a decontamination room for cleaning and a very small administrative office. Overall the premises are small, with limited space for staff and patients.

# Summary of findings

We received feedback from 12 patients during the inspection process. They were overwhelmingly positive about the service offered, and made particular reference to the friendliness of the staff team and the effectiveness of their treatment.

**Our key findings were:**

- The practice had systems to help ensure patient safety. These included safeguarding children and adults from abuse, and responding to medical emergencies.
- The practice carried out effective infection control procedures, as described in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' Published by the Department of Health.
- There was enough equipment for staff to undertake their duties, and it was well maintained.
- Staff received good training for their roles and were supported in their continued professional development.
- The practice sought feedback from staff and patients and used it to improve the service provided.
- The practice did not offer extended hours opening and access to appointments with the orthodontist and hygienist were limited.
- Patients' care and treatment was not planned and delivered in line with evidence based guidelines, best practice and current legislation. We found that vital information was missing from dental care records and the recording of the quality of x-rays was inconsistent.

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

- Review the practice's protocols for completion of dental records giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Review the practice's protocols for recording in the patients' dental care records the quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.
- Secure external clinical waste bins kept in the shared lock up to a wall.
- Implement dirty to clean zoning in the treatment room.
- Review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 so that all staff are aware of their responsibilities under the Act as it relates to their role.
- Display information about how to complain in the patient waiting area and ensure that all verbal complaints are recorded centrally for monitoring and analyses.
- Only store clinical items in the clinical fridge.

# 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 and maintaining the required standards of infection prevention and control. The practice carried out and reviewed risk assessments to identify and manage risk. Emergency equipment was available and medicines in use at the practice were stored safely and checked to ensure they did not go beyond their expiry dates. Sufficient quantities of equipment were available to meet patients' needs.

**Are services effective?**

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

Patients were referred to other services appropriately and staff had the skills, knowledge and experience to deliver effective care and treatment. There was evidence of appraisals and personal development plans for all members of staff. A range of clinical audits were completed to ensure patients received effective and safe care. However, the practice did not always assess patients' needs and deliver care in line with current evidence based guidance. Some patients received treatment without the dentist having taken the medical history, and other patients did not receive a basic periodontal examination.

**Are services caring?**

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

Patients spoke highly of the dental treatment they received, and of the caring nature of the practice's staff. Staff often went out their way to accommodate patients' individual needs. Patients told us they were involved in decisions about their treatment, and didn't feel rushed in their appointments.

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

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

There was good information available about the services on offer at the practice and appointments were easy to book. However patients had limited access to dental specialists as the specialists only worked on certain days. The practice had made some adjustments to accommodate patients with a disability.

The practice had systems in place to obtain and learn from patients' experiences, concerns and complaints in order to improve the quality of care, although not all verbal complaints were adequately recorded and managed.

**Are services well-led?**

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

The dentist and practice manager were approachable and the culture within the practice was open and transparent. There was a clear leadership structure and staff were well supported and told us they enjoyed their work. The practice sought feedback from its patients and staff which it acted on. However the provider had failed to take action in response to audits which showed poor record keeping within the practice by some staff.

# St Ives – Ortho

**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

The inspection took place on 13 January 2016 and was conducted by a CQC inspector and a dental specialist advisor.

During the inspection we spoke with one dentist, the practice manager and two dental nurses. We also spoke with two patients. We reviewed 10 comment cards about the quality of the service that patients had completed prior to our inspection. We observed one patient consultation, reviewed policies, procedures and other documents relating to the management of the service.

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**

Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. All incidents were then reported to the provider's head office where they were monitored and analysed by its health and safety departments for any trends. Information from incidents was regularly shared via the provider's weekly bulletin that was sent to all practice managers in the company for sharing with staff.

The practice responded to national safety alerts and medicines alerts that affected the dental profession. These were sent regularly from the provider's head office to the practice manager for dissemination to staff. The practice manager was able to give us examples of recent alerts that had been received.

Complaints and patient feedback from the practice's own surveys, the Friends and Family test or from NHS Choices was discussed at staff meetings so that learning from them could be shared, and improvements to the service made in their light.

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

Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements. The policies were available to all staff, and clearly outlined who to contact for further guidance if they had concerns about a patient's welfare. Posters were on display in the staff/x-ray room giving the contact details of relevant agencies involved in protecting people.

Staff demonstrated they understood their responsibilities in relation to safeguarding and all had received training relevant to their role. The practice manager was the lead for safeguarding, however she had not undertaken any additional training for this role. Staff were able to give us an example of where they had sought advice from the local safeguarding team as they had concerns about a child whom they suspected was being neglected at home. Children with any safeguarding concerns could be flagged on the practice's computer system to ensure clinicians were aware of them.

The British Endodontic Society uses quality guidance from the European Society of Endodontology recommending the use of rubber dams for endodontic (root canal) treatment. 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. The dentist we spoke with confirmed that they used rubber dams as far as practically possible.

**Medical emergencies**

The practice had arrangements in place to manage emergencies and records showed that all staff had received training in basic life support. Emergency equipment, including oxygen and an automated external defibrillator (AED) (this 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) was available behind the reception desk. Records confirmed that it was checked daily by staff.

Emergency drugs were available to deal with a range of emergencies including angina, asthma, chest pain and epilepsy, and all drugs were within date for safe use.

Emergency medical simulations were rehearsed every month by staff so that they were clear about what to do in the event of an incident at the practice. For example, in November 2015 staff had practiced how to respond to a patient suffering an asthma attack.

**Staff recruitment**

We reviewed three personnel files and found that appropriate recruitment checks had been undertaken for staff prior to their employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). Notes were kept of all interviews and potential employees were scored against set criteria to ensure consistency and fairness in the recruitment process. However, some interview notes had not been completed and the name of the interviewer, interviewee and date was missing, making it difficult to know to whom the records referred. All newly employed staff were given an employee hand book which outlined personnel procedures and policies, and other key information about the provider.

# Are services safe?

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

We looked at a range of policies and risk assessments which described how the practice aimed to provide safe care for patients and staff. These were comprehensive and covered a wide range of areas including display screens, fire, infection control, and the use of dental equipment. We found that these assessments were detailed and kept up to date to ensure their relevance to the practice. Health and safety was a set agenda item at all practice meetings and the provider sent out specific health and safety quarterly bulletins to ensure staff were kept up to date with any relevant issues.

The practice maintained a safe environment for patients within the building. We noted that there was good signage throughout the premises clearly indicating fire exits, first aid equipment and x-ray warning signs to ensure that patients and staff were protected. There were regular fire drills. Fire detection and firefighting equipment such as fire alarms and fire extinguishers were regularly tested, and we saw records to demonstrate this. Regular checks of the building and equipment were completed to ensure both staff and patients were safe. There were comprehensive control of substances hazardous to health folders in place containing chemical safety data sheets for products used within the practice**.** However the practice did not have a business continuity plan in place to deal with a range of emergencies that might impact on the daily operation of the practice such as the loss of premises or utilities. During our inspection the practice experienced a brief power cut.

The practice had minimised risks in relation to used sharps (needles and other sharp objects which may be contaminated) by using a sharps safety system which allowed staff to discard needles without the need to re-sheath them. However, the sharps bin was not securely attached to the wall in the treatment room to ensure their safety.

**Infection control**

Patients who completed our comment cards told us that they were happy with the standards of hygiene and cleanliness at the practice. The practice had a named lead for infection control and also conducted its own infection control audits, evidence of which we viewed. The practice has scored 100% in its most recent audit, indicating that good standards were maintained.

The practice had a comprehensive environmental cleaning and maintenance policy in place and files we viewed showed that staff had received appropriate training in infection prevention and control. The dental nurses took responsibility for the environmental cleaning of the practice and we viewed daily cleaning logs and accountability sheets in place.

We observed that all areas of the practice were visibly clean and hygienic, including the waiting area, toilet, x-ray room, staff kitchen and treatment room. The treatment room's surfaces including walls, and cupboard doors were free from dust and visible dirt. Sealed flooring was in good condition. However, there was no clear 'dirty' to 'clean' zoning in the room.

There were posters providing prompts above sinks reminding staff of the correct way to wash their hands. We saw that sharps boxes had been assembled and labelled correctly, but were not wall mounted to ensure their safety. There were foot operated bins and personal protective equipment available to reduce the risk of cross infection.

Staff uniforms were clean, long hair was tied back and dental nurses' arms were bare below the elbows to reduce the risk of cross infection. However we noted that the dentist wore his watch whilst delivering treatment to patients, thereby compromising good infection control. We saw both the dentist and dental nurse wore appropriate personal protective equipment such as masks and gloves, and patients were given eye protection to wear during their treatment.

The practice had a dedicated decontamination room that was set out according to the Department of Health's guidance, Health Technical Memorandum 01- 05 (HTM 01-05), decontamination in primary care dental practices. This room was well organised clean, tidy and clutter free. Protocols were displayed on the wall to remind staff of the decontamination process. The dental nurse demonstrated to us the decontamination process from taking the dirty instruments through to clean and ready for use again and used the correct procedures.

When instruments had been sterilized they were pouched and stored appropriately until required. All pouches were dated with an expiry date in accordance with current guidelines. The nurse also demonstrated that systems were in place to ensure that the autoclave and ultrasonic cleaning bath used were working effectively. These

# Are services safe?

included the automatic control test and steam penetration tests. Data sheets used to record the essential daily validation checks of the sterilisation cycles were complete and up to date.

A legionella risk assessment had been carried out and we saw that staff carried out regular checks of water temperatures in the building as a precaution against the development of legionella. Regular flushing of the water lines was carried out in accordance with current guidelines. The practice used an appropriate contractor to remove dental waste from the practice and we saw the necessary waste consignment notices. Clinical waste was stored prior to removal in locked bins in a communally shared lock up with other local residents. The bins themselves were not secured to a wall and could therefore be easily removed.

All dental staff had been immunised against Hepatitis B.

**Equipment and medicines**

The equipment used for cleaning and sterilising was checked, maintained and serviced in line with the manufacturer's instructions. All equipment was tested and serviced regularly and we saw maintenance logs and other records that confirmed this.

Staff we spoke with told us they had equipment to enable them to carry out their work and the condition of all equipment was assessed each day by staff as part of their daily surgery checklist to ensure it was fit for purpose. Staff told us that request for repairs or replacement were responded to quickly by the provider. For example, one staff member told us that problems with the computer server crashing on the morning of our visit and been resolved with immediately.

We checked a number of medical consumables stored in the treatment room drawers and found they were appropriately packaged and in date for safe use.

There was a system in place to ensure that staff received safety alerts from the Medicines and Health Care products Regulatory Agency and the practice manager was aware of recent alerts.

**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 had been regularly tested and serviced.

A Radiation Protection Advisors and Radiation Protection Supervisor 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 the radiation protection folder and in the x-ray room for staff to reference if needed. Those authorised to carry out X-ray procedures were clearly named in all documentation and records showed they had attended the relevant training.

We checked a number of dental care records and found that multiple radiographs had been graded as three (unacceptable), but had been recorded in patients' notes as grade one (excellent). Radiograph audits completed by the practice had failed to pick these discrepancies up.

# Are services effective?

(for example, treatment is effective)

## Our findings

**Monitoring and improving outcomes for patients**

The practice was not following guidelines from National Institute for Heath and Care Excellence (NICE) and the Faculty of General Dental Practice about best practice in dental care and treatment. For example, we reviewed five sets of dental care records and found instances where basic periodontal assessments for patients had not been completed. This is a screening tool that identifies concerns with gum health and triggers further examination or treatment if necessary. We also found instances where patients had received treatment without a medical history having been obtained beforehand. Records indicating patients' overall general oral health had not been completed. We were told that all patients' dental care records were typed up contemporaneously; however we found that this was not always the case. For example the visiting implant specialist kept his own hand written notes. These were then entered by a dental nurse, under the login details of another dentist, sometimes two to three days later. These notes were not always checked by the specialist who delivered the treatment for accuracy.

The practice regularly undertook audits of its clinical record keeping, to ensure that accurate contemporaneous records were maintained for all patients at the practice. Despite these audits identifying some serious shortfalls in the quality of recording, little action had been taken by managers to improve it.

**Health promotion & prevention**

The provider had an informative website which provided information about a wide range of dental health topics and a number of oral health care products were available for sale to patients including interdental brushes, toothpaste and mouthwash. One dental nurse told us she regularly ran oral health training to local St John's Ambulance cadets and that the practice planned to provide oral health care advice at local primary and secondary schools.

During our inspection we observed the dental nurses giving one patient encouragement and advice about how to stop smoking.

**Staffing**

Staff told us there were enough of them to maintain the smooth running of the practice. They reported that they were rarely short staffed and could borrow other staff from local sister practices within the company. There was always a dentist and a minimum of two dental nurses on duty each day. Annual leave was well planned to ensure it was taken at different times by staff. One nurse told us she was allocated a day each week dedicated to co-ordinating patients' treatment and ensuring that referrals were followed up, correspondence attended to and courses of treatment planned.

We looked at a sample of staff personnel files, training records and revalidation logs. We saw evidence that all staff were appropriately qualified, trained and had current professional validation Professional registration and insurance checks were undertaken each year to ensure dental clinicians were still fit to practice for their professional development. Staff told us the training provided was excellent, and they were supported to develop their knowledge and skills. There was a structured system for providing staff in all roles with regular one to one supervision and a yearly appraisal. Staff told us they found these useful.

The practice had an up to date Employer's liability insurance in place.

**Working with other services**

The practice had a system in place for referring, recording and monitoring patients for dental treatment and specialist procedures. It held a list of other dental specialists to whom it could refer patients, and referrals were tracked on its computer system which alerted staff if referrals needed to be followed up. We viewed a number of referrals that had been made and noted they had been completed in detail. However patients did not routinely get a copy of their referral letter to provide them with information about it.

**Consent to care and treatment**

Patients told us that they were provided with sufficient information during their consultation and that they always had the opportunity to ask questions to ensure they understood before agreeing to a particular treatment. Staff told us that all patients were given a treatment plan, which they then signed to show that they were happy for the treatment to be given. During our inspection we observed that the dental nurse went through a patient's treatment

# Are services effective?

## (for example, treatment is effective)

plan and costs with them thoroughly before asking them to sign it. The nurse also gave us a detailed account of how patients' valid and informed consent was obtained from those having dental implants.

The Mental Capacity Act 2005 (MCA) provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. We noted good information about the MCA in the practice. There was a specific MCA file which contained a copy of the Act itself and outlined staff's responsibilities and a poster was on display in the staff/ x-ray room outlining the Act's five key principals. Training records we viewed showed that the dental nurses had received recent training. One dental nurse described this training as an 'eye opener', and it had raised her awareness about the status of legal guardians and also the need to always assume patients had mental capacity unless proven otherwise. However one dentist had a limited understanding of the MCA and did not know how to support and assess patients who might not have the mental capacity to agree to their treatment.

# Are services caring?

## Our findings

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# Are services caring?

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# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting patients' needs**

The practice offered a range of services in additional to general dentistry including orthodontics, periodontics, teeth whitening and dental implants. 'Smile checks' were also offered to find out how patients felt about their smile and so that a range treatment options could be discussed with them.

The patient waiting area displayed a variety of information that explained NHS/private and hygienist charges, opening hours, and emergency 'out of hours' contact details and arrangements. The provider's web site also contained useful information for patients such as how to book appointments, details of the staff team and how to provide feedback on the services provided.

Appointments could be booked in person or by telephone. Although no emergency slots were scheduled, staff reported there were always gaps in the appointment schedule where patients could be fitted in and a sit and wait service was also available. However we noted that one patient who wanted an urgent orthodontic appointment could not be seen until two days later, as the orthodontist only worked on a Friday.

Text messages were sent to remind patients of their appointment and some patients were also telephoned the day before their appointment.

**Tackling inequity and promoting equality**

Staff told us that translation services were available for patients who did not have English as a first language. One of the dental nurses spoke Polish, as did some of the patients, and another nurse was able to sign so could communicate with hearing impaired patients.

The practice had an accessible toilet, and the treatment room was on the ground floor to assist patients with mobility problems. The reception desk was lowered at one end to allow better communication with wheelchair users. However, the practice's front doors were not automatic and there was no call bell in place to alert staff that a wheelchair user might be trying to access the building. There were no easy riser chairs, or wide seating available to accommodate patients with mobility needs; we were told that these would be purchased as part of the practice's forthcoming refurbishment.

**Access to the service**

The practice was open Monday to Friday 8am to 5pm.However, not all dental clinicians were available each day. For example, the dentist only worked four days a week, the orthodontist one day a week and the hygienist one day a month. During our inspection we noted that one patient requested a late appointment, but the last one was at 4.40pm. The patient also requested that she see the hygienist the same day, but this could not be accommodated by the practice.

**Concerns & complaints**

The practice had a complaints' policy and a procedure that set out how complaints would be addressed, who by, and the timeframes for responding. There was also information on the provider's website. However there was no information in the waiting area informing patients of how they could raise their concerns.

Patients' complaints were logged centrally and monitored by the provider's complaints' officers. Timescales for responding were tracked to ensure patients received a timely response to their concerns. We viewed the paperwork in relation to the one formal complaint the practice had received in the last year and saw that it had been investigated thoroughly and managed well. However, one of the dental nurses told us of two complaints that had been made verbally by patients. However, these had been recorded in patients' notes, rather than logged centrally, so that they could be monitored and analysed.

# Are services well-led?

## Our findings

**Governance arrangements**

The practice had policies and procedures in place to support the management of the service, and these were readily available both on the practice's computer system and in hard copy form. Staff were required to confirm that they had read and understood them.

There was a practice manager who worked three days a week who was responsible for the day to day running of the practice. She was supported by an area manager and clinical support manager who visited regularly to assist her and oversee the running of the practice. Staff also had access to the provider's national help desk which could provide advice and support on a range of dental and administrative matters.

Staff received a weekly bulletin from the provider's central operations team outlining any actions they had to take in response to policy updates, operational changes, and health and safety requirements. Staff told us they found this newsletter useful and it helped keep them up to date with what was happening within the company.

There was a monthly practice meeting attended by all staff. There were standing agenda items such as the practice's performance, patients' feedback, quality assurance, and health and safety. Minutes of these minutes were kept and shared with those were not able to attend.

The provider regularly used 'mystery callers' to ring its practices and ensure that reception staff were providing accurate and comprehensive information to patients. Feedback from these calls was shared with practice staff.

The practice completed an information governance tool each year to assess whether or not it met its legal responsibilities in managing information.

**Leadership, openness and transparency**

Staff told us they enjoyed their work and s that there was an open culture within the practice. They were aware of the whistle blowing policy and understood when it was appropriate to use. Staff we spoke with had an adequate understanding of their responsibilities under the duty of candour, and there was an information folder available which contained guidance for staff and examples of incidents that might trigger the thresholds for reporting under this duty.

Feedback from patient surveys and the Friends and Family test (FFT) was regularly discussed at practice meetings, evidence of which we viewed.

**Learning and improvement**

Staff working at the practice were supported to maintain their continuous professional development as required by the General Dental Council. We reviewed training files which showed they had undertaken a wide range of training for their role. One nurse told us she had just completed her Orthodontic Dental Nursing Certificate. Another nurse reported that training in dental implants and fluoride application had been agreed for her. Both nurses told us that the training available to them was excellent.

Regular audits were undertaken to ensure standards were maintained in radiography, infection control, the quality of clinical notes and antimicrobial prescribing. The provider had recently introduced a wide ranging 'CQC compliance audit' to ensure that practices met all the legal requirements of the Health and Social Care Act 2008. However, audits which had identified inadequate dental care records and been ineffective in implementing improvement in the standard of recording.

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

The practice encouraged and valued feedback from patients. A comments book was available on reception desk and we saw that patients regularly wrote in it, mostly to express their satisfaction with the service. Patients were also able to leave feedback about their experience on the practice's website and details of the provider's patient support team were also available for them to contact.

We were given examples of where the practice had responded to patients' concerns. For example, in response to numerous patients' questions about tooth whitening, one of the nurses had compiled a specific practice information leaflet about this.

# Are services well-led?

The practice had introduced the NHS Friends and Family test as another way for patients to let them know how well they were doing. Results of these were then shared at staff meetings. Results for November 2015 showed that 128 of 131 patients were likely to recommend the practice.

The practice manager told us the provider monitored patients' comments received on the NHS Choices web site, and emailed her to respond to any if required.

The practice had gathered feedback from staff through surveys, staff meetings, appraisals and one to ones. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. We were given examples from staff where managers had listened to them, and implemented their suggestions to improve the service. For example, one nurse had implemented the idea of a monthly 'star buy', where patients could buy reduced dental care products, and medical emergency simulations were now rehearsed monthly after another nurse suggested this.