Marlborough Medical Practice

Marlborough Medical Practice Dental Services

Inspection Report

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Date of inspection visit: 6 February 2015
Date of publication: 26/03/2015

Overall summary

The inspection took place on 6 February 2015 as part of our national programme of comprehensive inspections. This practice had not previously been inspected.

Marlborough Medical Practice Dental Services provide NHS and private dental treatment to patients of all ages. The practice team consists of two dentists and a part time dental hygienist. The clinical team are supported by three dental nurses and two practice receptionists. Marlborough Medical Practice Dental Services are located in the Maurice Suite of Marlborough Medical Practice. The registered manager of the dental service is one of the GP partners who is also the registered manager of the GP practice. Another GP partner is the lead partner for the dental service.

The practice consists of two treatment rooms, a dedicated decontamination room and a reception and waiting area. All patient areas are on the ground floor with access suitable for all patients. There is flat access to the practice building.

During our inspection we spoke with five patients and reviewed 24 Care Quality Commission (CQC) comments cards, which patients had completed in the week before our visit. The majority of patients commented positively about the care and treatment they had received and the friendly, helpful staff. Some patients felt that due to recent changes in staff they had not always experienced continuity of care and had a longer than acceptable wait for a routine appointment.

Our key findings were:

- The practice provided a clean well equipped environment
- All staff were kind and caring in the way they dealt with patients
- There was a regular schedule of staff meetings which gave staff the opportunity to make suggestions for improving the practice and kept staff up to date with changes to the practice.
- All policies, procedures and protocols had been regularly reviewed and updated as necessary.
- Patients care and treatment was assessed, planned and delivered according to their individual needs.
- Locum dentists had been used regularly in recent months to cover for study leave. This had resulted in some disruption of the service to patients.

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

Summary of findings

- Ensure infection prevention and control procedures are audited every six months to assess compliance with Department of Health guidance and take action when shortfalls are identified.
- Carry out a risk assessment in relation to the decisions of the practice to use an alternative emergency medicine to that listed in current guidance.
- Cary out a risk assessment in relation to the availability of emergency oxygen and where it is kept.
- Ensure that staff are aware of the processes they should use to record incidents and accidents at the practice.

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?

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

The infection prevention and control practices at the practice followed current Department of Health essential quality requirements. All equipment at the practice was regularly maintained, tested and monitored for safety and effectiveness.

The practice had medicines and equipment available to deal with a medical emergency should it occur; staff were trained to deal with such emergencies.

Care and treatment of patients was planned and delivered in a way that ensured their safety and welfare. Patients' medical histories were taken and appropriate alerts were recorded on dental care records.

Are services effective?

The practice ensured that patients were given sufficient information about their proposed treatment to enable them to give informed consent. Staff demonstrated a good knowledge of the requirements of the Mental Capacity Act (2005) and how it should be used if they had reason to believe a patient lacked the capacity to consent to treatment.

Dental care records showed a systematic and structured approach to assessing and planning patient care and treatment. Patient recalls were planned according to National Institute for Health and Care Excellence (NICE) guidelines based on a checklist of risk factors, including oral health, diet, alcohol and tobacco use.Health education for patients was provided by the dentist and dental hygienist. They provided patients with advice to improve and maintain good oral health.

Are services caring?

We found the practice had a caring and sensitive approach to the needs of their patients. Patients commented positively on the friendly professional staff, describing them as caring, kind and respectful.

Patients felt they had been given appropriate information and support regarding their care or treatment. They felt the dentist explained the treatment they needed in a way they could understand. They told us they understood the risks and benefits of each option. Patients with children told us that the dentists presently working at the practice communicated well with their children and gave them time to become acclimatised to dental treatment.

Are services responsive to people's needs?

The practice offered same day appointments for any patient in an emergency. The practice opened in the evening one day a week to meet the needs of patients who were unable to attend during working hours.

The practice had recently experienced difficulty with the recruitment of dentists. Consequently some patients commented on the lack of continuity and difficulty in getting routine appointments.

A number of patients commented on the way in which staff at the practice had helped them to become more relaxed about attending for treatment.

Are services well-led?

The practice was well led by one of the medical practice's GP partners and the practice manager. One of the dentists provided clinical leadership to the dental staff and was responsible for clinical governance. The practice had audited some aspects of the service in order to monitor the quality of the service and to identify areas for improvement.

Summary of findings

Staff were given opportunities to make suggestions for the improvement of the practice and felt comfortable doing so. There was a culture of openness and transparency. Staff at the practice were supported to complete training for the benefit of patient care and for their continuous professional development.

Marlborough Medical Practice Dental Services

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 and to pilot a new inspection process being introduced by the CQC.

- This inspection was carried out on 6 February 2015. Our inspection team was led by a CQC Lead Inspector and included a specialist dental advisor.
- Before the inspection we reviewed information we held about the provider. We also viewed information that we asked the provider to send us in advance of the inspection.
- During the inspection we spoke with one of the dentists working at the practice that day, two dental nurses and the practice receptionist. We also spoke with the GP lead for dental services the practice manager and patient services manager.
- We observed staff interaction with patients and looked around the premises and the treatment rooms.
- We spoke with five patients and reviewed 24comment cards to obtain their views about the staff and the services provided.
- We reviewed a range of policies and procedures and other documents.
- The specialist dental advisor reviewed a sample of clinical records to assess their quality and structure.

We informed the local Healthwatch that we were inspecting the practice; we did not receive any information of note from them.

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

Learning and improvement from incidents

There was a system for recording incidents and accidents with guidance for how they should be investigated and reflected upon. Staff told us they were confident about reporting incidents and accidents to the practice manager, although they were not clear about where they should record any incidents or accidents and were not aware of an incident or accident book available within the dental practice. The practice manager understood their responsibilities in Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR).

Reliable safety systems and processes (including safeguarding)

The dentist, dental hygienist and dental nurses had all completed training in safeguarding children and vulnerable adults in November 2013. The practice training register recommended annual training in this subject however this was yet to be arranged. All staff were clear about their responsibilities to raise any concerns they may have and felt they could recognise signs of abuse. One of the GP partners was the lead professional for safeguarding and staff were aware of this lead role.

Care and treatment of patients was planned and delivered in a way that ensured their safety and welfare. Patients told us, and the dental care records we saw confirmed that patients were always asked to complete a medical history at the start of each course of treatment. These were rechecked at each subsequent appointment. The dentist was aware of any health or medicines issues which could affect the planning of a patient's treatment. For examples an allergy, any long term condition or the need for any blood thinning medicines. All health alerts were flagged up to staff when patients' electronic care records were opened.

The dentist we spoke with ensured that clinical practices reflected current guidance in relation to safety. For example, they routinely used rubber dam for certain procedures to ensure their patents safety and to increase the effectiveness of treatment. (Rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth).

Infection control

In November 2009, and updated in March 2013, the Department of Health published a document called 'Health Technical Memorandum 01-05 Decontamination in primary care dental practices' (HTM 01-05). This document describes in detail the processes and practices essential to prevent the transmission of infections and promote clean safe care. It is used by dental practices to guide them to deliver an expected standard of decontamination.

We saw there were effective systems in place to reduce the risk and spread of infection. During our visit we spoke with the dental nurse who took the lead for infection prevention and control. They were able to demonstrate they were aware of the safe practices required to meet the essential standards of HTM 01-05. They were aware of the need for personal protective equipment (PPE). We observed PPE being used appropriately.

The practice had a dedicated decontamination room where the instruments from both treatment rooms were cleaned and sterilised. The dental nurse explained accurately the processes and procedures in place to decontaminate instruments. They also described the checks they carried out to ensure the decontamination equipment was functioning properly. We saw records of the checks that were made by staff. Staff also checked the water used for manual cleaning was at the optimum temperature. Visual checks were made of instruments following manual cleaning using an illuminated magnifier.

The practice followed the guidelines in HTM 01-05 for the manual cleaning of equipment which meets essential quality requirements. The practice was able to show us detailed plans for the refurbishment and improvement to the decontamination room which was due to begin in March 2015; this would enable the practice to install an ultrasonic bath which could provide a validated cleaning process.

The dental nurse was able to describe the decontamination procedures in operation within the treatment room. They ensured clinical areas were appropriately cleaned between patients and explained the clean and dirty areas in the treatment room to ensure the prevention of cross contamination. The practice used single use equipment wherever possible.Cleaning equipment at the practice followed the national guidelines for colour coding. Therefore the equipment could be identified for use in different areas of the practice.

Are services safe?

Environmental cleaning was carried out by the cleaning contractor as part of the medical practice building. Equipment used in high risk areas was stored separately from that used for general and non-clinical areas. There had been a Legionella risk assessment carried out by a specialist company (Legionella is a bacterium that can grow in contaminated water). There was a written scheme for the monitoring and management of the water system for the premises and for the dental unit water lines. This included the flushing of dental unit water lines at the beginning and end of the day and between patients. Dental unit water lines were maintained in accordance with current guidelines.

The practice had an infection control policy. They had carried out a recent audit of their decontamination process and procedures to identify any shortfalls or areas they could improve, and to work towards best practice. Recommendations were recorded, some of which would be met by the planned refurbishment of the decontamination room. Others, such as periodic hand hygiene training and annual infection control training for all staff were to be implemented by the practice. There was no record of previous audits of the decontamination process having taken place. It is a recommendation of the HTM 01-05 that these audits are completed by each dental practice every six months.

The practice infection control policy contained 19 protocols. These covered all aspects of infection prevention and control such as hand washing, instrument decontamination and storage of instruments, laundry and clinical waste disposal. The policy covered minimising blood borne virus transmission and included details of who to contact should a needle stick injury occur. We saw that staff were working in accordance with the processes described in these protocols.

Equipment and medicines

There was a system in place to ensure that all equipment was regularly maintained and serviced. The maintenance file contained details of all the equipment showing the service intervals and contractors responsible. This included equipment such as autoclaves (equipment used in the sterilising of instruments), the compressor, X-ray machines and portable appliance testing (PAT). Records showed servicing; maintenance and validation of equipment had taken place in accordance with manufacturer's instructions and to meet regulations such as pressure systems regulations.

The practice kept a supply of emergency medicines and equipment. We found these were in date and monitored regularly by staff to ensure they remained safe to use.

The patient records we reviewed showed the prescribing of medicines was recorded. Records showed that quantities, batch numbers and expiry dates of local anaesthetics were always recorded. Medicines kept at the practice were stored securely.

Monitoring health & safety and responding to risks

The practice had carried out a risk assessment in relation to fire safety. There was a record of the annual fire drills that had been carried out. The maintenance of fire extinguishers was up to date with the next check due in December 2015.

Staff were aware of their responsibilities in relation to the control of substances hazardous to health (COSHH). The dental receptionist was responsible for maintaining a COSHH folder which gave information on 61 items used in the dental practice. These information sheets had been regularly reviewed. This ensured that staff had correct information about how to manage these substances safely.

The practice had minimised risks in relation to used sharps (needles and other sharp objects which may be contaminated) by ensuring that sharps bins were securely attached to the wall in the treatment room. Staff and patients were protected from these items being accidentally knocked over.

Medical emergencies

There were arrangements in place to deal with foreseeable emergencies. We checked that the practice had the necessary emergency medicines and equipment as listed in the British National Formulary (BNF) and in the Resuscitation Council (UK) guidelines. The practice checked the emergency medicines to ensure they were in date and ready for use should they be needed. The practice did not have a medicine that is recommended for the management of epileptic seizures. An alternative medicine was available but this did not follow the guidance in the BNF. The practice had access to oxygen and an automatic external defibrillator (AED) 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; these were stored in the medical practice, which shared the premises.

All staff had taken part in annual basic life support training which included medical emergencies and cardio pulmonary resuscitation (CPR). Reception staff were only required by the practice to carry out this training every three years. Practice staff had not trained as a team to manage any medical emergency scenarios which they may encounter.

Staff recruitment

The provider kept comprehensive staff files which contained evidence of the checks they had carried out to ensure that staff working at the practice were suitable for their role. The provider ensured they had satisfactory documentary evidence of the suitability of all the staff.

Staff files contained evidence of continuous employment with an explanation of any gaps. Criminal record checks by the Disclosure and Barring Service (DBS) had been carried out for all staff and photographic ID was also available. All clinical staff at this practice were qualified and registered with the General Dental Council (GDC). The practice had carried out checks to ensure they remained registered with the council.

Locum dentists had been used regularly in recent months to cover for study leave. We saw that the practice staff received copies of checks carried out by the locum agency. The practice also conducted their own checks on the suitability of each locum dentist which included further written references.

Radiography (X-rays)

The practice had a well maintained radiation protection file. This contained all the information required to satisfy the requirements of the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) and The Ionising Radiation Regulations 1999(IRR99). This file contained details of the radiation protection advisor, the radiation protection supervisor, evidence of the maintenance and critical testing of the X-ray unit. There was a copy of the local rules displayed beside the X-ray set which gave staff guidance about the safe use of radiography within the practice.

The dentists at the practice continually assessed the quality of X-ray images. The dentists graded the radiographs (X-rays) they took to monitor their quality and ensure they did not have to be repeated, which could pose a risk to patients. The practice used digital X-rays and aiming devices (these are devices used to ensure the X-ray film and machine are correctly placed) which improved the quality of images. This reduced the number that had to be retaken which protected patients from excess exposure to radiation. There had also been a clinical audit which found that X-ray quality met the Faculty of General Dental Practice (FGDP) criteria. The audit had suggested that should any X-rays be graded as unacceptable a reason should be recorded.

We looked at a sample of dental care records which documented when X-rays had been taken These records showed the reason why X-rays were necessary and recorded any findings.

Are services effective?

(for example, treatment is effective)

Our findings

Consent to care and treatment

We found patients were given sufficient information about their proposed treatment to enable them to give informed consent.

Staff told us how they explained treatment options with their patients including the risks and benefits of each option; this was confirmed by other patients we spoke with. We saw these discussions were recorded in dental care records and that patients were provided with a written treatment plan which ensured they were aware of the treatment that had been agreed. Patients were asked to sign a copy of the treatment plan to confirm their understanding and to consent to the proposed treatment. All written consent documents were scanned into the electronic record. Verbal consent to treatment was also recorded on the electronic dental care record.

The majority of patients told us they felt fully informed about their treatment and they were given time to consider their options before giving their consent to treatment.

Staff were aware of their responsibilities in relation to the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. They were clear about the action they would take if they had reason to believe a patient lacked the capacity to consent to treatment. Staff were also knowledgeable about Gillick competency and its significance in relation to consent. (The Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Monitoring and improving outcomes for people using best practice

Patients' care and treatment was assessed, planned and delivered according to their individual needs. We looked at a selection of dental care records completed by staff. These showed a systematic and structured approach to assessing and planning care and treatment.

All patients had a current medical history recorded when they attended for examination, and these were updated at each visit. Patients told us the dentist always asked if there had been any changes to medical conditions or any medicines they were taking. This information was recorded in the dental care record with any relevant medical condition highlighted for the dentist by symbols or alerts on the electronic care record. The dentist was then aware of any medical issues which could affect the planning of a patient's treatment.

We looked at a sample of dental care records to see the information clinical staff recorded for each examination. We found that dentists kept a record of their examination of soft tissues, teeth and other relevant observations. We saw checks of patients' gum health were followed up with more in depth assessments for those who would require specialist treatment. Diagnostic tests, such as radiographs (X-rays), were carried out if they were clinically necessary. The results were discussed with the patient. Patients told us they were aware of the dentist carrying out an examination of their whole mouth. They said the dentist explained what they were doing and why.

The dentist explained how they scheduled patient recalls according to National Institute for Health and Care Excellence (NICE) guidelines based on a risk assessment taking into account factors such dental decay, diet and oral hygiene.

Working with other services

The practice referred patients for secondary (hospital) care when necessary. For example for assessment or treatment by oral surgeons. We saw that referral letters contained detailed information regarding patients' medical and dental history.

The dentist explained the system and route they would follow for urgent referrals if they detected any problems during the examination of a patient's soft tissues.

The practice had experienced recent recruitment difficulties which meant there had been times when no dentist was available at the practice. There were arrangements in place with another practice to refer patients who needed emergency treatment.

Health promotion & prevention

A dental hygienist worked at the practice, on a part time basis. The dentists and dental hygienist provided patients with advice to improve and maintain good oral health. Details of discussions between the clinician and their patient were recorded in dental care records. These included diet advice, the use of fluoride paste and rinses and smoking cessation advice.

Are services effective?

(for example, treatment is effective)

The dental hygienist focused on treating gum disease and giving advice about the prevention of decay and gum disease. This included giving advice on tooth brushing techniques and oral hygiene products. Information leaflets about oral health and various treatments were available for patients.

The dentist told us they prescribed high fluoride tooth paste to patients at high risk of dental caries (tooth decay). We saw that this information was recorded in patients' dental care records. This is in accordance with the Public Health England document 'Delivering better oral health'.

Staffing

The practice had systems to support staff to be suitably skilled to meet patients' needs. The practice kept a record of all training attended to ensure staff had the right skills to carry out their work. The staff carried out annual medical emergencies and basic life support training. However staff sourced their own training in this topic to meet the requirements of their General Dental Council registration. They had not trained together at the practice to ensure they knew their roles and responsibilities should an emergency arise.

All people registered with the GDC have to carry out a specified number of hours of continuing professional development (CPD) to maintain their registration. Records showed staff were up to date with their CPD. Staff records showed professional registration was up to date for all staff.

The practice provided dental implants which were placed by an implantologist. They only worked at the practice when needed for individual patients. This dentist worked with their own dental nurse who was trained in this specialist area.

Staffing levels were monitored and staff absences planned wherever possible to ensure the service was uninterrupted. The practice had relied heavily on the use of locum dentists in recent months but was actively recruiting for a permanent associate dentist which would also increase the number of appointments available for patients.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

During and our visit we spoke with five patients about their care and treatment, we also reviewed 24 comment cards. Patients commented positively about the kind and caring staff, describing them as friendly and professional.

Patients told us they felt listened to by all staff. We observed reception staff interacting with patients before and after their treatment and speaking with patients on the telephone. Although we were able to hear appointment arrangements being made we did not hear any personal information discussed during our observations in the waiting room. Reception staff were polite and friendly in all situations.

On the day of our visit two dentists were working at the practice. All treatment was carried out with the treatment room doors closed. People's privacy and confidentiality was maintained.

Involvement in decisions about care and treatment

The majority of patients told us the dentist they saw discussed the treatment options that were available to them. They felt that their dentist explained the treatment they needed in a way they could understand. They told us they understood the risks and benefits of each option. Patients were given written treatment plans which clearly documented the proposed treatment and related costs. We looked at a selection of dental care records. The dentist had documented conversations with their patient when treatment options had been decided. Records showed that, when necessary, patients had been given relevant information including the risks and benefits of complex treatment. However one patient told us they were not sure what their appointment was for. With their permission we looked at their dental care record and the information recorded at their previous emergency appointment with a locum dentist. This did not contain a record of discussion between the patient and their dentist.

We saw patients were given verbal and written information about their treatment.

A number of patients who completed comment cards told us that they had been given advice about maintaining good oral health.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to the needs of their patients. This included the provision of general dentistry as well as specialist treatments. Patients were informed of the treatments available through the practice website and by their initial consultation at the practice. Specialist treatment was provided by staff with the appropriate qualifications and experience or the practice referred patients to specialists. Appointment times varied in length according to the proposed treatment and to ensure patients and staff were not rushed. The dentists were supported by a dental hygienist who met the needs of those patients who needed treatment and support to maintain good oral health.

The practice had responded to the needs of those patients who found dental treatment stressful. Patients told us the practice had met their needs in this respect and had made their dental treatment more relaxing. We spoke with the parents of a young child who described how the practice had structured the appointments for their child to slowly acclimatise them to treatment.

This practice was contracted to provide to patients with NHS dental treatment. Patients could choose to receive treatment privately, including treatments that were not available on the NHS.

Staff told us the majority of patients who requested an urgent appointment would be seen within 24 hours. Patients we spoke with confirmed this.

Tackling inequity and promoting equality

All the practice facilities were on the ground floor. The waiting room, treatment rooms and toilets were accessible to patients who had mobility difficulties. However we found the reception desk at a high level which could present a barrier to those patients who used a wheelchair. Access to the treatment rooms was difficult for large wheelchairs due to the positioning of the reception desk.

The practice had a portable hearing loop which could be used if required by patients who used hearing aids. The practice leaflet was available in large print.

Access to the service

The practice displayed its opening hours at the entrance to the building, in the patient leaflet and on the practice website. Opening hours were Monday to Friday 9am to 5pm and closed for lunch between 1pm and 2pm. There were extended hours opening each Thursday between 5.30pm and 7pm to meet the needs of those patients who were not able to attend during the day.

The practice had clear instructions in the practice and via the practice's answer machine for patients requiring urgent dental care when the practice was closed. Information about how to access out of hours treatment was displayed on the entrance door. Staff told us patients were seen as soon as possible for emergency care and in most cases on the same day.

Concerns & complaints

The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. Staff told us how they would raise any comments or concerns immediately with the practice manager or patient services manager to ensure a timely response was given.

Complaints leaflets were prominently displayed at reception. This leaflet gave patients clear information about how to make a complaint, raise a concern or compliment or provide other feedback both verbally or in writing. The complaints leaflet provided patients with a complaints form should they need it.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions should they be made by patients. We found that all complaints received, including feedback on the NHS choices website had been acknowledged promptly by the practice manager or patient services manager. The complaints summary recorded the action taking following any complaint and any learning that had been implemented.

Are services well-led?

Our findings

Leadership, openness and transparency

There was clear leadership in the practice. The practice was led by a GP partner as this service was provided by the medical practice. The practice manager and patient services manager ensured that human resource and clinical policies and procedures were reviewed and updated to support the safe running of the service. They had also delegated lead roles to suitably qualified and experienced members of staff such as clinical governance, radiography and infection control.

There were informal and formal arrangements for sharing information across the practice including general discussions amongst the small staff team. There were formal team meetings held approximately every six to eight weeks. Staff told us the system of staff meetings within the practice helped them keep up to date with new developments, to make suggestions and to provide feedback to improve patient care.

Governance arrangements

The practice manager was responsible for the day to day running of the service. They had systems in place to monitor the quality of the service. These were used to make improvements to the service. The practice manager led on the individual aspects of governance such as complaints and risk management. One of the dentists was responsible for clinical governance and clinical audit within the practice.

The practice had audited aspects of the service to monitor the quality of the service and to identify areas for improvement. For example through audits of their X-rays and infection control procedures.

The practice had commissioned an operational review early in 2014. Following this review an action plan had been devised to make improvements to the service. The practice could show their progress towards completing this plan. This included refurbishment of the decontamination room and a change to staffing levels and the services they would offer in the future. We saw minutes of staff meetings which showed that staff were kept informed of the progress of the action plan.

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

Patients who used the service were offered a number of ways of providing feedback about the practice. There were patient feedback forms available in the complaints leaflet intended for use not only for complaints but for compliments and concerns as well. The provider had introduced the Friends and Family test to the dental service. There were forms available at the dental reception and there was a link to the test on the practice website. At the time of our inspection there were no results available from this test for the practice to use or act upon. The practice manager responded to any comments made about the practice on the NHS Choices website. They had either thanked patients for their positive comments or encouraged them to approach the practice to allow them to address their concerns. Feedback from patients about continuity of care had been addressed by the provider. They had been more proactive in their recruitment to find a permanent member of staff with the intention of making more patient appointments available.

Staff told us they were involved in discussions about changes to the practice and felt able to make suggestions for improvements at any time, although some staff commented their suggestions were sometimes not implemented. Staff meetings were every six to eight weeks. These meetings were recorded and gave staff the opportunity to make suggestions for improvements to the practice. Meeting records showed that staff had made requests for equipment, which had been provided by the provider

Management lead through learning and improvement

Staff told us they had good access to training and the practice monitored staff training to ensure essential training was completed each year. Staff working at the practice were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC). It is a requirement of the GDC that all people registered with them complete a specified number of hours of CPD, including training in medical emergencies, to maintain their registration.

The dentists, dental nurses and dental hygienist working at the practice were registered with the GDC. The GDC registers all dental care professionals to make sure they are

Are services well-led?

appropriately qualified and competent to work in the United Kingdom. The practice manager kept a record to evidence that staff were up to date with their professional registration.