Care Quality Commission

Whitecross Dental Care Limited

Rush Hill Dental Centre

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 4 August 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

The practice is part of the Whitecross Dental Care Ltd, IDH (Integrated Dental Holding Ltd) Dental Group which is the largest dental corporation in Europe employing over 2,500 dental professionals. IDH Rush Hill provides general dental treatments for people who live in Bath and the surrounding areas. Three dentists provide services supported by two dental nurses and there are two treatment rooms. The practice predominantly provides treatment for patients who have NHS subsidy (95%) and approximately 5% pay for treatment privately.

The practice is open on weekdays between the hours of 8.30 am and 5 pm and Saturday mornings. The practice employed three dentists. Details about the arrangements for emergency treatments out of hours was in a recorded message played on the telephone answering service when the practice was closed.

The practice is located in a purpose built general practice medical centre over two floors with patient access on the ground floor. The building was compliant with the Disability Discrimination Act (DDA) 1995. There is disabled access and disabled parking.

The practice manager was in the process of registering as the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Summary of findings

We spoke with three patients who visited the practice and we reviewed 32 patient comment cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. Patients told us the practice was clean and hygienic; staff were motivated and caring whilst treating them with dignity and respect.

Our key findings were:

- There were systems in place for staff to report incidents. There were sufficient staff on duty to deliver the service. We saw the premises were in a satisfactory state of repair and was clean and tidy.
- The patients we spoke with and the comment cards we reviewed indicated patients were treated with kindness and respect by staff. It was reported that communication with patients and their families, and access to the service and to the dentists was good.
- Staff received training appropriate to their roles.
- Information on the practice website was incorrect with regards to opening times, treatments provided and dentists working at the practice.
- Information about care and treatment options and support was available to patients, for example information of the cost of treatment.
- The practice had a complaint system in place and these were dealt with in an open and transparent way. However we found evidence some complaints had not been logged onto the complaints system.
- We found that cleaning staff did not complete a daily checklist to evidence what cleaning had taken place and no cleaning schedule had been devised.
- We saw no evidence that equipment had undergone testing or calibration to control risks arising from the use of electricity.
- We found dental care records lacked details about how consent was obtained.
- We found inconsistent use of equipment, grading and recording with regards to the use of X-rays.
- We found recruitment files did not always contain the same information and one record did not have an appropriate criminal records check.

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

- Consider having a stock of equipment required to undertake dental procedures.
- Consider the use of national guidelines. For example, for recording, grading and justification of X-rays and for equipment to support invasive treatments.
- Keep an accurate, accessible system for recording and handling of complaints.
- Consider the frequency of testing for electrical equipment and keep adequate records of safety checks of equipment.
- Maintain adequate individual recruitment and staff folders.
- Maintain accurate, complete and contemporaneous dental care records.
- Ensure a system is in place to provide and maintain a clean environment through documentation of environmental cleaning to show consistent undertaking, reporting and monitoring.

Ensure there is provision of adequate cleaning equipment which is stored safely.

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.

The practice had systems to assess and manage risks to patients, recruitment, whistleblowing, complaints, safeguarding, health and safety and the management of medical emergencies. There were clear guidelines regarding the maintenance of equipment however the practice were unable to provide evidence of maintenance in the past year. We found complaints that had not been recorded within the online complaints record.

Staff paper recruitment files did not provide evidence that full recruitment checks had been undertaken. We did not have access to the organisations on-line recruitment files. We saw that a dentist had been employed without an up to date criminal records check (DBS). DBS 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.

We found the practice to be clean however some improvements were required to strengthen these. For example, the cleaner was employed by the building owner and practice staff were unaware of the duties carried out by the cleaner.

Staff were trained to deal with medical emergencies and undertook regular practice sessions. All emergency equipment and medicines were in date and in accordance with the British National Formulary (BNF) and Resuscitation council UK guidelines.

Are services effective?

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

Patients dental care records provided information about their current dental needs and past treatment. However we saw that some records did not contain adequate information.

Staff were supported to deliver effective care through training and supervisions. The clinical staff were up to date with their continuing professional development (CPD) and they were supported to meet the requirements of their professional registration.

The practice monitored any changes to the patients oral health and made referrals for specialist treatment or investigations where indicated.

We saw that the practice did not always follow current guidelines when delivering dental care. For example the lack of equipment available to prevent contamination during root canal treatments and omissions in clinical records. We saw that dentists were aware of 'The Delivering Better Oral Health Toolkit' (DBOH) with regards to fluoride application and oral hygiene advice.

Are services caring?

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

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection. We looked at 32 CQC comment cards patients had completed prior to the inspection and spoke with three patients. Patients were positive about the care they received from the practice. They commented they were treated with compassion, kindness, respect and dignity while they received treatment.

Summary of findings

Staff described to us how they ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood. Patients commented they felt involved in their treatment, it was fully explained to them and they were listened to and not rushed.

Are services responsive to people's needs?

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

The practice had an efficient appointment system in place to respond to patients' needs. There were vacant appointment slots for urgent or emergency appointments each day. Patients commented they could access treatment for urgent and emergency care when required. There were clear instructions for patients requiring urgent care when the practice was closed.

There was a procedure in place for acknowledging, recording, investigating and responding to complaints and concerns made by patients. This system was used to improve the quality of care. The practice was open and transparent in how they managed complaints, for example patients were given an apology if an error was made.

The practice was accessible for patients with a disability or mobility limitations.

Are services well-led?

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

There was a clearly defined management structure in place and staff all felt supported and appreciated in their own particular roles.

The practice did not carry out the NHS Family and Friends Test (FFT) to get feedback about the quality of the service which they provided. The practice did ask patients how likely they were to recommend the practice to family and friends although this data was not available.

We saw that the practice could make improvements to meet the requirements with regard to good governance. For example, we found a lack of consistency in the practice amongst the recording in patient dental care records; the complaint log did not contain all the complaints received by the practice; there was no practice specific work schedule for environmental cleaning.

Rush Hill Dental Centre

Detailed findings

Background to this inspection

We carried out a comprehensive inspection at Rush Hill Dental Centre on 4 August 2015 as part of our inspection programme. The inspection was carried out by a Care Quality Commission inspector and a dental specialist advisor. The inspection included the review of records, policies and procedures. In addition we spoke with six staff (including dentists; dental nurses; practice managers and receptionists) and three patients. 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 observed how patients were dealt with and how the nurses undertook decontamination of dental instruments.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had clear guidance for staff about how to report incidents and accidents. We saw evidence that they were documented, investigated and reflected upon by the dental practice. Patients were given an apology and informed of any action taken as a result.

Staff understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). No RIDDOR reports had been made in the last 12 months.

The practice received regular clinical updates and guidance from the organisation which impacted on dental care and provision. We spoke with staff about patient safety and were told there were no concerns at the practice.

Reliable safety systems and processes (including safeguarding)

Staff undertook training in relation to child protection and safeguarding vulnerable adults and were able to describe their responsibilities in reporting concerns. We looked at the safeguarding policies in place for child protection and protecting vulnerable adults. These included information for staff about what was abuse and what they needed to do if they were concerned. We were told by the practice manager that all staff had completed online training about safeguarding.

At the time of employment the organisation had accepted a criminal records check from a previous employment checking however in 2013 the public body for these checks changed

The practice had safety systems in place to help ensure the safety of staff and patients. These included clear guidelines about responding to a sharps injury (needles and sharp instruments). During our inspection we saw that rubber dams (this is a rectangular sheet of latex used by dentists for effective isolation of the root canal and operating field and airway) were not always available to be used in root canal treatment. This was in contradiction to guidance from the British Endodontic Society.

Medical emergencies

Staff within the practice had received training annually in dealing with medical emergencies. They also told us about the different scenarios they discussed during practice meetings such as what they would do if a patient with diabetes had a hypoglycaemic attack. A receptionist told us how they had recently responded to a patient who fainted and that the event had been discussed at a practice meeting.

The practice had access to emergency resuscitation equipment including an Automated External Defibrillator (AED), oxygen and emergency medicines. The equipment and medicines for use in an emergency were contained within two sealed emergency bags. The seal was checked daily and a record of the visual check was maintained. When equipment such as a mask for the use of oxygen or medicines were used the practice notified the organisation and they replaced the item and resealed the bag. When the bag was sealed it had a complete range of medicines and equipment as recommended by the Resuscitation Council UK and the British National Formulary (BNF). (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 regular checks were carried out to ensure the equipment and emergency medicines were safe to use.

Staff recruitment

The practice had a policy for the safe recruitment of staff, this included, Disclosure and Barring Service (DBS checks), occupational health checks, professional registration, references, employment contracts and the immunisation status for staff. The practice had a system in place for monitoring professional registration and medical indemnity.

We looked at four staff paper files to see how the recruitment policy was implemented for two dentists, a dental nurse and reception staff. We saw that staff files were incomplete and varied in information. For example, we saw that files had missing information which included curriculum vitae (CV); references; photographic identification and a pre-employment medical questionnaire.

The organisation had not taken steps to ensure relevant background checks were carried out for all staff. We saw that one dentist had a criminal records check with the Criminal Record Bureau (CRB), now the Disclosure and Barring Service (DBS). The criminal records check had been undertaken in previous employment so was not up to date

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as the public body providing these checks had been replaced. At the time of employment a DBS check should have been undertaken. We could not evidence that this had been undertaken or that checks had been carried out by the organisation to ensure the information in the CRB certificate was correct and up to date. (DBS 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).

We saw that there was up to date information regarding the dentists membership with the General Dental Council and dental indemnity insurance. The files contained evidence of appropriate immunisation against infectious disease and an induction checklist.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. We saw the building maintenance for example, emergency lighting; fire alarm testing and fire equipment was managed by the GP practice which owned the building. The fire safety procedure was displayed and there was equipment to deal with fire emergencies. We saw the equipment was checked weekly and an identified fire marshal led a fire drill monthly. The last of these was in July 2015.

Health and safety information was displayed and health and safety and risk management policies were in place For example, we saw risk assessments for disability access. We saw that the practice held quarterly learning updates. Staff had received update training in health and safety that focussed on learning across all of IDH's practices.

The practice had two designated first aiders who had undergone additional training.

We saw the practice had completed risk assessments having obtained safety data sheets from the manufacturers for products used in line with the Control of Substances Hazardous to Health Regulations (COSHH 2002). The risk assessments recorded the actions to be taken by staff to minimise any risks associated with using a product. We saw that the products used for cleaning the premises were not included in the risk assessments undertaken.

Infection control

We saw the practice completed infection control audits every six months in line with the guidance provided by the Infection Protection Society (IPS). The last of these was conducted in July 2015, prior to our inspection.

We looked at the arrangements for decontamination of dental instruments. The practice had a dirty and clean decontamination room. Staff used personal protective clothing and equipment during treatments and in the decontamination process including eye shield, gloves, mask and apron. The practice placed used instruments into an ultrasonic bath to remove debris and there were two 'rapid' sterilisation machines that could be used after the instruments had been inspected under a lit magnifying glass. Dental instruments were placed in pouches at the end of the sterilisation process and date stamped to be used within one year. Both nurses demonstrated how they processed instruments and showed a good understanding of the correct processes.

Equipment used in the decontamination processes were checked daily and weekly and the ultrasonic bath test strips were kept. We saw daily, weekly, quarterly and annual checks to ensure the decontamination process continued to be effective.

We saw that the practice 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)'. However we saw a daily log to evidence the management of the dental unit water lines which were checked daily had commenced one month prior to our inspection. Both nurses were able to demonstrate the daily and quarterly checks they undertook to manage the water lines.

The practice had a mercury spillage kit to ensure safe disposal of spilt amalgam. Clinical waste was kept in a designated, locked, bin outside for safe and secure storage between the weekly collections. Hand hygiene guidance was displayed above hand washing sinks in treatment rooms.

The practice used the bins recommended for the storage of used sharp instruments and these were handled through a contract with a waste management company in line with the Department of Health guidance Health Technical Memorandum HTM: 0701 'Safe management of healthcare

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waste'. We saw the sharps boxes in treatment rooms were positioned safely and dated. The practice policy in relation to needlestick injury clearly outlined what staff should do if they sustained an injury.

General cleaning of the practice was carried out by a cleaner employed by the GP practice within the building. Limited cleaning products were stored in a cupboard in the patient toilet which also contained the electric circuit board. At the time of the inspection the door to the cupboard was unlocked and therefore accessible to patients. We saw that the equipment including chemicals were limited and poorly stored. For example, the cleaning equipment (mops and buckets) did not meet the NPSA standards required.

At the time of our inspection the practice was unable to evidence that the cleaner completed the organisations 'dental practice cleaning checklist for cleaners' or that a specific cleaning schedule had been devised, as stated in the organisations policy. We saw little evidence that the IDH cleaning policy was implemented with regards to environmental cleaning. For example, work schedules were not prominently displayed in a public part of the appropriate work area. The cleaning plan was reviewed annually to ensure standards were maintained. Staff were unaware as to the duties the cleaner performed. We spoke to the GP practice who informed us that there was not a dental cleaning schedule for the cleaner to follow.

We saw that the practice looked clean. Dental nurses were able to evidence the weekly and monthly duties they undertook to decontaminate and maintain all dental equipment.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). The practice manager had received training in the control of legionella. We saw records for daily and annual safety checks. We were told a risk assessment had been completed a week prior to our inspection which was not available to view.

Equipment and medicines

There was a refrigerator designated for medicines requiring cold storage.

Equipment used in the decontamination processes was serviced under contract with a specialist contractor and we saw records that this had taken place. We were told that other equipment was serviced annually and that the service was arranged by the GP practice who owned the building. The practice were unable to evidence a maintenance plan or provide evidence of inspection and testing of electrical equipment not used for dental treatments. For example, computer cables; portable lighting; suction pumps; the fridge and the kitchen.

The practice manager addressed our concerns regarding safety testing and calibration of equipment and provided evidence after our inspection that these had been completed the day after the inspection.

Radiography (X-rays)

There were written protocols for the referral and justification of the taking of X-rays. We saw the dentists did not always follow the protocol. The radiation protection file identified the radiation protection supervisor and external advisor. There was a certificate from the Health and Safety executive showing the radiography equipment was safe and there was evidence the equipment had been maintained and there were no recommendations. The local rules for the operation of radiography equipment were displayed in each of the treatment rooms.

The nurses demonstrated the process they undertook daily to ensure that processing of x-rays met quality standards. We looked at the quality of the X-rays and saw no concerns. We saw that current guidelines were not always followed. For example the X-ray equipment was left switched on when not in use; film holders and beam aiming devices were not always used and we found some of the patients records contained no rationale or justification for taking the X-rays.

We saw that a recent audit of twenty X-rays that had taken place. At the time of the inspection the audit had not been fed back to the dentists although an action plan was in the process of being written.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We looked at the dental care and treatment records for six patients. They identified the dentist who carried out examinations or treatment and the dental nurse who assisted. There were records of periodontal scores recorded (in relation to the condition of gums), along with updates of the patients medical history signed by the patient.

Where patients had treatment there was documentary evidence that the treatment was discussed along with any warnings given about possible side effects from the treatment. If a patient had doubts about treatment they were reassured and any questions they had were answered.

Three of the records we looked at had omissions which included details of how consent to treatment was obtained; a lack of justification and reporting of X-rays; an undated set of X-rays; a prescription without the dose or frequency recorded; a referral letter missing and notes written in the paper records rather than on the computer. We were told that one dentists appointments had been reduced to enable them to have more time completing computerised records. This dentist had also been attending the practice during days off to spend time getting familiar with the computer records system.

We observed the dentists accurately recording treatment and writing comprehensive computerised notes during our inspection.

Patient recalls for examination were based on guidelines produced by the National Institute for Health and Care Excellence. Most patients attended for six monthly checks.

We were told that patients were contacted the day after major tooth extractions or following an emergency, for example, fainting in order to check that they were well.

Health promotion & prevention

We saw there were a range of dental health information leaflets in the waiting room to assist patients understanding of their care and treatment. These included leaflets relating to oral hygiene such as effective tooth brushing and interdental cleaning. In addition, there was information in relation to tooth extraction and root canal treatment. We saw there were a range of oral health

products available for patients to purchase.

Oral health such as, prevention of dental caries or periodontal deterioration risk advice, was given and we saw care and treatment records reflected this. One dentist told us that they were reluctant to provide health promotion advice in relation to oral hygiene, smoking cessation and reducing alcohol consumption unless it was clear the patient was willing to make life style changes.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. Staff told us they had good access to training which supported their skill level and they were encouraged to maintain the continuous professional development required for registration with the General Dental Council (GDC). Records showed professional registration with the GDC was up to date for all staff and we saw evidence of on-going continuing professional development.

Mandatory training included basic life support and infection prevention and control. Records showed staff had completed this in the last 12 months. In addition staff had completed child protection and safeguarding vulnerable adults training and radiation protection training. There were specific courses available for staff to attend. For example one of the dentists had completed a course about oral cancer and another regarding antibiotic usage.

IDH provided an on-line academy. The academy provides learning opportunities to develop clinicians and staff and the on-line resource gave opportunities for verifiable continuing professional development.

Dental nurses were supervised by the dentists and supported on a day to day basis by the practice manager. Staff told us the practice manager was readily available to speak with

at all times for support and advice. Staff told us they had received appraisals and reviews of their professional development. We saw evidence that appraisals for staff had been completed.

Are services effective?

(for example, treatment is effective)

When new staff were appointed they completed an induction related to the systems, policies and procedures for the running of the practice. We saw evidence that some staff had a formal induction plan however one recently appointed member of staff told us that they had not received a formal induction although staff were always approachable when they needed advice or support. The practice manager monitored staffing levels and planned for staff absences to ensure the service was uninterrupted.

Working with other services

When patients required treatments that were not available within the practice they were referred to specialist providers. This was for orthodontics (tooth alignment) or dental implants. The practice website stated that often patients can be referred to another practice within the IDH group where these services were provided. We saw a list of other preferred providers for referral

displayed in each of the treatment rooms.

Patient records contained referral letters including referrals to an in-house hygienist who worked at the practice at the time. We saw that one record had a reply following treatment by another practice. We did not see the initial referral letter. Another record showed that a patient who did not speak English had been referred appropriately to a specialised dentist.

Consent to care and treatment

We saw that some patient records did not contain consent to care and treatment. We observed the dentists explain treatment options to patients choosing words they could understand and using visual aids and demonstrations so they could make an informed choice. We saw that verbal consent was obtained. The nurses told us that dentists always asked for consent.

Staff we spoke with had an understanding of the principles of the Mental Capacity Act (MCA) 2005 and how it was relevant to ensuring patients had the capacity to consent to dental treatment. Some staff did not know about the principles of the Mental Capacity Act however reception staff were able to give examples of how they helped two vulnerable patients who required support to make decisions.

Reception staff told us that they always made sure that young people were aware that they needed to be accompanied by an adult if they were aged 16 or under.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We looked at 32 patient comment cards patients had completed prior to the inspection and spoke with three patients on the day of inspection. We also observed patients undergoing treatment. Patients told us they were treated with kindness, dignity, respect and

compassion whilst they received care and treatment and were always made to feel comfortable. They said staff supported them and were quick to respond to any distress or discomfort during treatment.

We observed reception staff talking with patients in person and on the phone. We saw that they were always polite and accommodating and interacted with patients in a respectful, appropriate and kind manner. Whilst speaking to patients on the telephone we saw the receptionist maintained the patients confidentiality. One patient required an urgent appointment and we observed the receptionist offer an appointment for early the next day so the patient would not be left in discomfort.

We saw that the reception area did not have information on maintaining confidentiality. Receptionists told us if a patient requested a more private area for discussion they would take them into an empty treatment room. When dentists were ready to examine or treat patients they collected them from the waiting area.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients felt involved in their treatment and told us 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. The practice displayed information in the waiting area that gave details of NHS dental charges.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Patients we spoke with told us that the practice was providing a service that met their needs. The practice offered patients a choice of dentist and treatment options to enable patients to receive care and treatment to suit them. Patients we spoke with confirmed they had sufficient time during their appointment and didn't feel rushed. We observed that appointments ran smoothly on the day of the inspection and patients were not kept waiting.

We found the practice had an appointment system in place to respond to patients' needs. There were vacant appointment slots to accommodate urgent or emergency appointments. Dentists told us the system gave them sufficient time to meet patients' needs.

The practice had a 'tell us about your experience form' and patients were encouraged to complete these. The IDH academy (an online eLearning programme for staff) had learning and development modules about the patient journey and of valuing patients.

Tackling inequity and promoting equality

The practice was set in the lower ground floor with disabled access.

We saw that a patient who did not speak English was referred to another practice where staff would be able to provide care without a language barrier.

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

Access to the service

The practice was open from 8.30am until 5.00pm and whilst the practice website showed the practice was closed on a Friday we were told this was not the case. We saw that the practice displayed its opening hours in their premises. We saw that the practice intended to provide patients with Saturday morning clinics later that month to meet the needs of working age people.

In case of emergencies the Out of Hours telephone number was included in the practice answerphone message.

An online booking service was available. We found the information on the practice website, with regard to opening hours and dentists who worked at the practice did not contain the correct information.

Concerns & complaints

The organisations website provided patients with an online complaint and compliment form which advised patients the organisation aimed to be in touch within three working days. The website asked that all complaints be directed to the practice manager in the first instance so they could address the patient's needs promptly and provide details of who they could contact if not satisfied with the response.

There was information included advising patients about contacting the NHS England area team. There were also the contact details for the Independent Complaints Advocacy Service (ICAS), the Dental Complaints Service (private patients only) and the Parliamentary and Health Service

Ombudsman. IDH also pointed out the Care Quality Commission (CQC) was keen to hear about patients experiences (good or bad) and outlined our function. It drew attention to the CQC website.

The practice manager told us they checked the NHS choices website monthly. We saw four out of five reviews were positive. We noticed the practice did not reply online to the reviews.

We looked at the record of complaints for the last year. The complaint log indicated there had been three complaints made directly to the practice. Two of the complaints were regarding treatment provided and one was concerning the quality of an X-ray. We found additional complaints had not been included in the complaint log however we saw they had been dealt with appropriately. We spoke to one dentist about a complaint and they told us as a result of one complaint they had undertaken update training about medicines.

Individual complaint records showed evidence of how the complaint had been investigated and the feedback to the patient including, where appropriate, an apology. Staff were able to tell us about the guidelines for handling complaints which were in line with the organisations complaint policy. We saw that complaints were a regular agenda item at practice meetings.

Are services well-led?

Our findings

Governance arrangements

The practice manager had been in post for four months. Prior to this the practice had been without a practice manager or registered manager for a lengthy period. Staff were aware of the management structure in place and told us that they felt supported by the new practice manager and were clear about their roles and responsibilities.

We saw that the organisation had clinical governance protocols and processes in place to ensure the practice was compliant with all current legislation affecting dental practices. These included health and safety, infection prevention and control, patient confidentiality and recruitment.

The practice manager's role included managing and coordinating audits with the organisations audit teams. We saw audits related to infection prevention, decontamination arrangements and waste management. There were recent audits related to X-rays and clinical records where actions were required in order for the practice to work within current guidelines. The results of the clinical records audit had been fed back to the dentists on the day of the inspection and a plan was in place for staff to meet and work towards an action plan where improvements had been identified.

We saw the practice was not meeting the requirements with regards to good governance. For example, staff personnel and recruitment records were kept as paper and electronic records. We saw the records were varied in information and did not always contain information relevant to their recruitment. Dental care and treatment records were kept electronically and on paper and we found some to be incomplete and inaccurate. We also found the complaints log did not contain all the complaints received by the practice. Although we saw evidence complaints were dealt with in line with the organisations policy.

Staff told us that there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. There were regular staff meetings to discuss issues or incidents which had occurred.

Leadership, openness and transparency

The practice manager had been in post since April 2015 and had not previously had experience within dentistry. We saw that the practice manager was enthusiastic and staff described them as approachable. Since commencement of employment the practice manager had instigated regular staff meetings and ensured all documents were completed to show the necessary daily recording of checks were in place. For example they had introduced a daily log for the maintenance of the dental unit water lines.

Staff told us they enjoyed working in the practice, that there was good leadership and support and spoke about the good team work. One member of staff referred to the dentists and said they received a lot of good feedback about them from patients. Staff said they felt comfortable about raising concerns with any of the dentists or the practice manager. They felt they were listened to and the practice management team responded when they raised issues of concern or suggestions for improvement.

Learning and improvement

Staff were positive about the IDH training academy. We looked at the academy and found modules which outlined what staff would achieve by undertaking the courses. A new member of staff told us that they had been well supported to undertake there role and although they had not had a formal induction they felt able to ask any member of staff for assistance. We were shown certificates in the staff files which demonstrated staff had attended appropriate training for their role.

Staff received an annual appraisal where their performance was discussed and learning needs were identified.

Communication between the staff members was effective and a variety of systems were used to ensure safe processes were in place and learning cascaded. These included a handover each day for morning and afternoon staff. Practice meetings were held monthly and staff we spoke with told us about the content of the meetings. They told us they discussed any complaints received along with compliments.

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

Are services well-led?

The practice manager gathered feedback from staff through staff meetings and discussions. Staff told us they felt comfortable raising any concerns or issues. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice did not make use of the Family and Friends Test, which is a national programme to allow patients to provide feedback on the services provided. Instead the organisation had a 'tell us about your experience' feedback card for patients to complete. The feedback card asked patients how likely they were to recommend the practice and why they gave the response.

Patients we spoke with on the day told us they were very satisfied with the standards of care provided. They told us they felt involved in making decisions about their care and treatment.