Ramsey Dental Surgery

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Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 2 March 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

The Ramsey Dental Surgery provides primary dental care and treatment to patients whose care is funded through the NHS and to a small number of patients who pay privately. The practice is a well- established family partnership that employs two dentists, three specialist oral hygiene dental nurses, three other dental nurses, a practice manager/receptionist and an accounts manager/ receptionist. The practice opens from 9am to 6pm Monday to Thursday and from 8am- 4pm on Fridays.

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

We received feedback from thirteen patients either in person or on CQC comments cards from patients who had visited the practice in the two weeks before our inspection. The cards were all positive and commented about the caring and helpful attitude of the staff. Patients told us they were happy with the care and treatment they had received.

Our key findings were:

Summary of findings

- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- Staff had been trained to handle emergencies and life-saving equipment was readily available in accordance with current guidelines. Emergency medicines were available in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- Infection control procedures were in place although systems followed in relation to clinical waste management and the storage of instruments required a review.
- The practice appeared clean although treatment rooms were cluttered and some were in need of refurbishment.
- Staff received training and development and were appropriately supervised.
- Patients told us they were able to get an appointment when they needed one and the staff were kind and helpful.
- Governance arrangements were in place for the smooth running of the practice. This included the completion of regular audits to help monitor the quality and safety of the service.
- The practice had recently started to develop a register of patients with a learning disability to recognise their individual needs and ensure they experienced appropriate appointments.

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

- Review the security of prescription pads in the practice and ensure there are system in place to monitor and track their use.
- Review the practice's protocols for the use of rubber dams for root canal treatment giving due regard to guidelines issued by the British Endodontic Society.
- Review and document a refurbishment plan for the treatment rooms so that the risks of spreading infection are minimised giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.
- Review the procedures for storing sterilised dental instruments are in accordance with Health Technical Memorandum 01-05: Decontamination in primary care dental practices.
- Review the practice's waste handling policy and procedure (including sharps waste) to ensure waste is segregated and disposed of in accordance with relevant regulations giving due regard to guidance issued in the Health Technical Memorandum 07-01 (HTM 07-01) and the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Review and further develop the environmental risk assessments so that all documentation is up to date and guides staff in how to minimise the risks. Review the risks of cross contamination from the use of reusable protective bibs.
- Review the referral procedure so that all of these patients are routinely offered a copy of their referral letter.
- Review the practice's recruitment policy to include specific guidance on obtaining references. The policy should also include guidelines to risk assess which staff roles require a disclosure and barring service check.
- Review the process for documenting and sharing learning points following audit so that the resulting improvements can be demonstrated.

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 appropriate systems in place to manage the service in a safe way although further action was needed to ensure they took robust measures to control the risks of health care associated infections; for example by ensuring that dental instruments were appropriately stored and clinical waste was managed appropriately. There was a robust procedure for identifying and investigating incidents and accidents. Safeguarding procedures were in place and staff were able to demonstrate knowledge of the training they had received. The practice followed national guidelines for undertaking X-rays and the management of radiation equipment. Staff also followed national guidelines for infection control although the practice needed to review some aspects of their practice to ensure that any risks to the spread of infection were robustly managed. Regular checks and maintenance of equipment ensured that all items were safe and fit for use.

Are services effective?

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

Consultations were carried out in line with best practice guidance from the National Institute for Health and Care Excellence (NICE). Patients received a comprehensive assessment of their dental needs that included an assessment of their medical history. Explanations were given to patients in a way they understood. Risks, benefits, options and costs of treatment were explained.The staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

Are services caring?

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

Staff treated patients with dignity and respect and ensured their privacy was maintained. Patient information and data was handled confidentially. We received feedback from thirteen patients who used the service. They commented on the friendly and helpful staff, told us they were good at explaining their treatment and costs and provided a service they were happy to receive.

Are services responsive to people's needs?

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

Appointment times met the needs of patients and waiting times were kept to a minimum. Patients could access treatment and urgent and emergency care when required. The practice had made reasonable adjustments to the service to ensure it was accessible and the service could be tailored to individual needs. Information about the practice and general dental health was available to patients. The practice was on two levels which included two ground floor treatment rooms for patients with mobility difficulties and families with prams and pushchairs. A complaints process was in place although none had been received in the last three years.

Are services well-led?

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

Summary of findings

The practice manager and other staff had an open approach to their work and worked as a team to continually improve the service. Governance procedures were in place and policies and procedures were regularly updated. A system of quality monitoring checks had been established and action was taken when improvements were identified. Patient feedback was sought, considered and acted upon. Staff told us that they felt well supported and could raise any concerns with the practice manager or principal dentist.

Ramsey Dental Surgery

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.

This inspection took place on 2 March 2016 and was led by a CQC Inspector who was supported by a specialist advisor. Before the inspection, we asked the practice to send us some information for review although this was not received.

We informed NHS England area team that we were inspecting the practice; however, we did not receive any information of concern from them.

During the inspection, we spoke with the practice manager, dentists, the dental nurses, reception staff and reviewed policies, procedures and other documents. We also obtained the views of four patients on the day of the inspection and received nine comment cards that we had provided for patients to complete two weeks before the inspection took place.

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 an incident reporting system in place along with forms for staff to complete when something went wrong, this system also included the reporting of minor injuries/accidents to patients and staff. There had been three reported incidents at the practice within the last year and they had all been dealt with by the practice manager in a timely way. We saw that where relevant, incidents were shared and discussed with staff at the practice meeting to raise awareness and help prevent further occurrences. The practice also had a no blame policy to encourage staff to report issues that required a review and improvement. The practice manager had a good understanding of RIDDOR (The reporting of injuries diseases and dangerous occurrences regulations). They were also familiar with the duty of candour to ensure that patients were informed if they were affected by something that went wrong, given an apology and informed of any actions taken as a result.

Reliable safety systems and processes (including safeguarding)

The principal dentist acted as the safeguarding lead and was a point of referral should members of staff encounter a child or adult safeguarding issue. A policy was in place for staff to refer to in relation to children and adults who might be the victim of abuse or neglect. Training records showed that all staff had received appropriate safeguarding training for both vulnerable adults and children. Staff had recently completed training in the Mental Capacity Act. Information was displayed in the practice that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. There had been no safeguarding incidents that required further investigation by appropriate authorities.

We asked the practice about their use of rubber dam during patient's root canal treatments. (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). We spoke with two dentists and found that a rubber dams was not routinely used in all root canal treatments in line with guidance issued by the British Endodontic Society. One dentist told us they considered and assessed the risk but it was not clear whether this was always documented in dental records.

Medical emergencies

The practice had arrangements in place to deal with most medical emergencies at the practice. The practice had an automated external defibrillator (AED), which is a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Staff had received training in how to use this equipment and completed daily checks of the AED to ensure that it was in working order.

The practice had in place most emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The expiry dates of medicines were checked by staff on a regular basis. The practice had access to oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines and oxygen we saw were all in date and stored in a central location known to all staff.

Staff recruitment

The practice had not recruited any new staff in the last two years. There was a recruitment policy in place and additional guidance was in place on when to check references. This did not provide detail on the checks required if potential employees had previously worked in a health or social care setting.

It was the practice's policy to request a Disclosure and Barring Services (DBS) check for most of their staff with the exception of the receptionist. There was no documented risk assessment in place to support this decision. DBS checks are used to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they might have contact with children or adults who may be vulnerable.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable risks. We found the practice had completed a fire risk assessment, appointed designated fire marshals and staff had received fire safety

training. Records demonstrated that fire safety equipment was regularly serviced and staff were able to describe the action they should take in the event of a fire. Fire drills took place every six months.

The practice had a health and safety risk assessment in place that covered risks such as sharps injuries, risk of eye injury and electric shocks. While these helped to address and mitigate the risks identified, further assessment of the environmental risks had not been addressed. For example, we found that a mobile generator was placed in front of two fire extinguishers which could restrict access to them in an emergency. There was no documented risk assessment detailing how clinical waste would be safely stored.

There were some arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. We looked at the COSHH file and found risks (to patients, staff and visitors) associated with substances hazardous to health had been identified which was reviewed in April 2015.

Infection control

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 The decontamination lead for the practice was the principal dentist. We found that HTM 01 05 (national guidance for infection prevention control in dental practices') Essential Quality Requirements for infection control was followed although improvements were required in some areas. We observed that audits of infection control processes were completed regularly and issues identified were acted upon.

We saw that the general areas of the practice such as the waiting area, reception and toilet were clean, tidy and clutter free. There were four treatment rooms. One had recently been refurbished and had surfaces that could be easily cleaned. However this was not the case in all of the treatment rooms. For example two rooms were partially carpeted and were at risk of spills or splashes during dental treatments. Cupboards and work surfaces were worn and made of material that could not easily be cleaned. All treatment rooms were cluttered with items on work surfaces and one contained an oversized plant close to the dental treatment area that could easily be splashed or contaminated with aerosols. This made it difficult for staff to maintain a clean environment. The identified zones for clean and dirty areas to prevent cross contamination from used dental instruments and materials were not clearly marked in any of the treatment rooms. Hand washing facilities were available including liquid soap and paper towel dispensers in each of the treatment rooms and toilet.

Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors. Although protective bibs were available for patient use, these were a reusable items rather than the disposable type for single use. This meant staff were required to clean the bibs thoroughly between each use. If the bibs become damaged through general wear and tear, this increased the risk of cross contamination.

We found daily, weekly and monthly tests were performed to check that the decontamination equipment was working efficiently and correctly maintained. Records were kept of the results to support this.

The dental water lines were flushed regularly to prevent the growth and spread of Legionella bacteria. (Legionella is a term for particular bacteria which can contaminate water systems in buildings). Staff described the method they used which was in line with current HTM 01 05 guidelines. A Legionella risk assessment had been carried out at the practice by a competent person. The recommended procedures contained in the report were carried out and logged appropriately.

The decontamination room was located on the first floor of the practice. A dental nurse demonstrated the process from taking the dirty instruments through the cleaning process and ready for use again. The practice used a system of manually cleaning the instruments before placing them in an autoclave (a device for sterilising dental and medical instruments). When instruments had been sterilised, items that were not often used were pouched, dated with an expiry date and stored until required. Items in frequent use were not pouched, but placed in plastic trays and stored uncovered in a drawer in each treatment room. Although all of these items were re-sterilised every 24 hours in line with guidelines, they were not stored in sterile trays or covered to prevent contamination from spray or dust. Furthermore, when we completed a visual inspection of the surgeries, the trays used for storing the instruments were not visibly clean.

Are services safe?

We were shown the systems in place to ensure that the autoclaves used in the decontamination process were working effectively. It was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were always complete and up to date.

The management of clinical waste required a review. We observed that sharps containers were not always labelled and it was not clear which waste bins in the treatment rooms were for clinical waste and which were for municipal waste because bin liners were not used and there were no labels. There were no disposal bins for sanitary waste. The practice used an appropriate contractor to remove clinical waste from the practice every four weeks. However, clinical waste was stored in a small multipurpose room that was not locked. Waste consignment notices were available for inspection.

Staff were responsible for the cleaning schedules for cleaning the premises and cleaning records were maintained suitably. However the cleaning equipment was stored with other items in a cramped cupboard that also served as the darkroom for developing X-rays.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclaves and X-ray machines had been serviced and calibrated. Portable appliance testing had been carried out within the last year. The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored securely for the protection of patients. We found that the practice did not store prescription pads in a secure cabinet to prevent loss due to theft.

Radiography (X-rays)

We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for each X-ray set along with the three yearly maintenance logs and a copy of the local rules. The maintenance logs were within the current recommended interval of three years.

Radiological audits were completed regularly for each dentist and action was taken in response to any findings. Dental care records we saw reported the justification for the X-rays that were taken and the findings and actions taken as a result. This was in accordance with national radiological guidelines and showed that patients and staff were protected from unnecessary exposure to radiation. Training records showed all staff where appropriate, had received radiological training updates in line with IRMER 2000.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We spoke with two dentists about the care and treatments they offered to patients. Dental assessments and treatments were carried out in line with recognised general professional guidelines. Patients completed a questionnaire about their medical history, current health, medication and any known allergies before the dentists commenced their own assessment. The information was reviewed at subsequent visits to ensure that any potential health issues were considered as part of their dental assessment and treatment plan. Dentists then completed an assessment that included an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health, whether it had changed since the last appointment and any recommended treatments options were discussed.

The dentists followed the guidance from the Faculty of General Dental Practice before taking X-rays to ensure they were required and necessary to help a diagnosis and treatment plan. The patient notes were updated with the proposed treatment after discussing options with the patient. Patients were monitored through follow-up appointments and these were scheduled in line with National Institute for Health and Care Excellence (NICE) recommendations. Staff were able to demonstrate their knowledge of NICE guidelines for dentistry practice.

Patients requiring specialised treatment such as conscious sedation were referred to other dental specialists. Their treatment was then monitored after being referred back to the practice once it had taken place to ensure they received a satisfactory outcome and all necessary post procedure care.

Patients spoken with and comments received on CQC comment cards reflected that patients were satisfied with the assessments, information they received and the quality of their dental care.

Health promotion & prevention

The practice promoted the maintenance of good oral health as part of their overall philosophy and had considered the Department of Health publication 'Delivering Better Oral Health; a toolkit for prevention' when providing preventive oral health care and advice to patients. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. Where relevant, preventative dental information such as smoking cessation advice, alcohol consumption guidance, dietary advice and general dental hygiene procedures were provided.

Adults and children were provided with advice on the steps to take to maintain healthy teeth and correct tooth brushing techniques. Patients could be referred to the dental nurses who had completed additional training in dental health. Dental care records we observed demonstrated that dentists had given oral health advice to patients. The waiting room and reception area contained leaflets that explained the services offered at the practice. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area.

Staffing

The practice was led by two principal dentists (one of whom worked on a part time basis). Two associate dentists were employed along with six dental nurses. Three of the nurses had completed additional training in oral health education and were able to provide appointments for patients who required this advice. The dental team were supported by a practice manager/receptionist and an accounts manager/receptionist.

Planned and unplanned staff leave was covered within the team as several staff worked part time hours and were able to work flexibly if required. Agency staff were not used. Staff had clear job descriptions and although there had been no new staff employed within the last two years, we saw there was an induction process to support and prepare new staff for their role.

There was an appraisal system in place and the staff received annual appraisals and a personal development plan that identified training and development needs. Staff told us their appraisal was helpful and they felt well supported by the practice to maintain their professional development. The practice manager monitored staff progress with required training to ensure they were able to maintain their registration with the General Dental Council. Any additional training needs were discussed at the quarterly practice meetings so that appropriate arrangements could be put in place.

Are services effective?

(for example, treatment is effective)

Working with other services

When required, patients were referred to other dental specialists for assessment and treatment. This included for example, specialist procedures such as orthodontics, oral surgery and sedation. Patients were not routinely offered a copy of their referral letters for information. Non- urgent referrals were made within five days and urgent referrals within twenty four hours. The practice had completed checks to ensure these response times were adhered to. Patients' needs were followed up appropriately after their treatment and dental records were updated. The dentists we spoke with told us they completed a referral following discussion with the patient so that informed choices could be made where possible.

Consent to care and treatment

The practice ensured valid consent from patients was obtained for all care and treatment. We spoke with two dentists who told us that individual treatment options, risks and benefits were discussed with each patient who then received a detailed treatment plan and estimate of costs. Patients were given time to consider and make informed decisions about which option they wanted and this was recorded in their dental care records. Appropriate levels of consent were gained for each treatment and records we saw confirmed this.

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The dentists we spoke with demonstrated an understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment. This included assessing a patient's capacity to consent and when making decisions in a patient's best interests. Staff had all received training in the MCA.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting areas and we saw that doors were closed at all times when patients were with dentists. Conversations between patients and dentists could not be heard from outside the treatment rooms which protected patients' privacy. Patients' clinical records were stored in paper form only. Large open cabinets were situated behind the reception area and we noted these were not lockable. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality. They told us the reception desk was covered by a member of staff so that dental records could not be easily accessed by patients and visitors.

Before the inspection, we sent Care Quality Commission (CQC) comment cards to the practice for patients to use to tell us about their experience of the practice. We collected nine completed CQC patient comment cards and obtained the views of four patients on the day of our visit. These provided a positive view of the service the practice provided. All of the patients commented that the quality of care was very good. They also told us that their treatment was explained clearly, the staff were caring and also put their children at ease during their appointments. They also said that the reception staff were helpful and efficient. During the inspection, we observed staff in the reception area who were friendly, polite and helpful towards patients and the general atmosphere was welcoming.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. Patients we spoke with confirmed they received a good level of information about their care and treatment. We also saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them.

A poster detailing NHS and private treatment costs was displayed in the waiting area.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we looked at examples of information available to people. We saw that the practice waiting area displayed a variety of information including the practice information leaflet, the complaints process, the patient's charter and the results of the last patient survey. In addition there was some information about the promotion of good dental health and cosmetic treatments. There was also information about local health groups and social activities.

The dentists decided how long a patient's appointment needed to be and took into account any special circumstances such as whether a patient was very nervous, had a disability and the level of complexity of treatment. Routine appointments were usually booked for 15 minutes. Each dentist was allocated two urgent appointment slots per session to respond to patient requests for urgent appointments. The appointments diary was not overbooked and staff told us they had enough capacity to meet the demand for appointments. Patients we spoke with told us they had good access to suitable appointments.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to prevent inequity for disadvantaged groups or vulnerable patients who used the service. The practice did not use an electronic dental records system which made it difficult to highlight patients with particular needs. However, due to the low staff turnover they were able to build their knowledge of the patients registered with them. The practice had recently started to develop a register of patients with a learning disability to recognise their individual needs and ensure they experienced appropriate appointments. They were also aware of some patients with a latex allergy and ensured they were seen at the beginning of a session. Staff also explained they would help patients on an individual basis if they were partially sighted or hard of hearing to complete NHS and other forms. There was a small ramp and hand rails to enable patients with limited mobility to access the building and two treatment rooms were available on the ground floor.

Access to the service

The practice was open from 9am to 6pmMonday to Thursday and from 8am to 4pm on Fridays**.** The practice used the NHS 111 service to give advice in case of a dental emergency when the practice was closed. This information was made available to patients in the practice information leaflet and on the telephone answering machine when the practice was closed.

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. Information for patients about how to make a complaint was seen in the patient leaflet that was available in the waiting area.

The practice had not received any complaints in the last three years. The practice manager explained that in the event of a complaint they adopted a very proactive response to any patient concern or complaint. The concerns would be discussed with the patient either by telephone or by a face-to-face meeting in an attempt to resolve the complaint or concern as soon as was practically possible. Patients would receive an immediate apology when things had not gone well.

Are services well-led?

Our findings

Governance arrangements

It was the joint responsibility of the practice manager and principal dentist to lead on governance and quality monitoring issues. A range of policies and procedures were in use at the practice. These included health and safety, infection prevention and control, patient confidentiality and recruitment. Staff we spoke with were aware of the policies, had easy access to them and could demonstrate knowledge of the policies used to support their practice. Quarterly practice meetings had been established and these included issues such as patient feedback, health and safety and incidents. Minutes of these meetings were available to any staff who were unavailable for the meetings. We noted the meetings did not always contain action points for example following discussions with staff about feedback from patients.

Systems were in place to ensure the safety of the environment and of equipment such as machinery used in the decontamination process and fire safety equipment. Risk assessments were in place although these required further development. Records we reviewed demonstrated that regular audits took place for infection control, radiography and dental care records. The practice manager gave feedback to individual staff in relation to performance and the general findings were shared at team meetings.

Leadership, openness and transparency

There was a clear leadership structure in place and staff understood their roles and responsibilities within the practice. For example there were fire marshals, first aiders and a safeguarding lead. The practice manager and principal dentist worked together to set standards and ensure they were maintained. Dental nurses told us that the lead nurse role was shared by dental nurses with the most experience and additional skills however this did not seem to be a clearly defined role.

Staff we spoke with told us that they worked well as a team and they were supported to raise any issues about the safety and quality of the service and share their learning. We were told that there was a no blame culture at the practice and that the delivery of high quality care was a high priority. Through our discussions with the dentists and nurses we found that staff adopted a patient centred approach to care that aimed to raise awareness of the prevention of poor dental health. We found staff were committed to the work they did. All staff knew how to raise any issues or concerns and were confident that action would be taken by the practice manager or principal dentist without fear of discrimination.

Learning and improvement

Systems were in place to identify staff learning needs through an appraisal system and staff were supported to develop their knowledge and skills by accessing a range of training. Annual core training programmes were available to staff online with some additional practice based training. The practice manager monitored staff's progress with continuing professional development to ensure that they maintained their requirement to register with the General Dental Council.

We found there were a number of clinical and non-clinical audits taking place at the practice. These included clinical record keeping, infection control, prescribing audits and X-ray quality audits. There was evidence of repeat audits at appropriate intervals and these reflected that standards and improvements were being addressed. For example infection control and clinical records audits were undertaken every six months.

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

The practice gathered feedback from patients through an annual patient survey. The results from the survey in April 2015 were displayed in the waiting room. The survey had recently been repeated although the results were not yet ready for display. The practice manager told us that the findings indicated actions taken last year had proved beneficial in improving waiting times, and providing better information to patients about their dental health risks. Comments boxes were available in the waiting room although there were no pens available for ease of use. The practice also monitored the results of their NHS friends and family test. A display showed that patients were extremely likely to recommend the practice.

Staff told us they felt included in the running of the practice and that the principal dentist and practice manager listened to their opinions and respected their input at meetings. Staff told us they felt they were a valued member of the practice team.