

Murgelas Practice Management Limited

Heddon's Croft

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 22 September 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 has an NHS contract and provides dental treatment for approximately 10,500 patients. General dentistry, together with restorative dentistry. It also provides private treatment.

There are four dentists (two male and two female), four dental nurses, two hygienists, one dental therapist, and two receptionists. The practice is open from 8am to 4pm on Monday to Friday. Outside of these hours emergency dentistry was provided by an out of hour's service the details of which were visible from outside the practice and on the website.

We spoke with three patients who used the service on the day of our inspection and reviewed 20 CQC comment cards that had been completed by patients prior to the inspection. The patients we spoke with were complimentary about the service. They told us they found the staff to be friendly and informative. They felt they were treated with respect. The comments on the CQC comment cards were also very complimentary about the staff and the service provided. We also spoke with nine members of staff, including the principal dentist.

The practice manager is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'.

Summary of findings

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.

Our key findings were:

- Patients' needs were assessed and care was planned and delivered in line with current professional guidelines.
- All equipment used in the practice was well maintained in accordance with the manufacturer's instructions.
- The practice was visibly clean and well maintained. Infection control procedures were robust and the practice followed published guidance.
- The practice had enough staff to deliver the service. Staff had received training appropriate to their roles and were supported in their continued professional development (CPD).
- Staff felt well supported by the practice manager and were committed to providing a quality service to their patients.
- All complaints were dealt with in an open and transparent way by the practice manager.
- The practice had a programme of regular clinical audits in place.
- Staff had been trained to handle emergencies and appropriate medicines and emergency equipment was readily available in accordance with current guidelines.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

There were systems in place to help ensure the safety of staff and patients. These included policies for safeguarding children and adults from abuse, maintaining the required standards of infection prevention control and maintenance of equipment used at the practice and the maintenance of the premises itself. The practice assessed risks to patients and managed these well. We found staff had received training and equipment was provided to respond to medical emergencies. In the event of an incident or accident occurring, the practice documented, investigated and learnt from it. The practice followed procedures for the safe recruitment of staff, this included carrying out Disclosing and Barring Service (DBS) checks, and obtaining references.

Are services effective?

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

The practice followed guidance issued by National Institute for Health and Care Excellence (NICE) for example, including prescribing antibiotics and dental recall intervals. Patients were given appropriate information to support them to make decisions. Clinical staff ensured that they received patient's consent before undertaking treatment. The practice kept detailed dental care records of treatments carried out and monitored any changes in the patient's medical and oral health.

Staff were supported by the practice in continuing their professional development (CPD) and were meeting the requirements of their professional registration. Records showed patients were given health promotion advice appropriate to their individual oral health needs such as smoking cessation and dietary advice.

Are services caring?

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

The patients we spoke with told us they were treated with dignity and respect. They told us that staff were kind, informative and attentive to their needs. We saw from the comments made on the CQC comment cards that patients felt cared for by the practice. We observed that staff treated patients with kindness and respect and were aware of the importance of confidentiality.

Are services responsive to people's needs?

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

Patients had good access to appointments at the practice and emergency appointments were available on the same day. There was sufficient well maintained equipment, to meet the dental needs of the practice patient population. There was a complaints policy clearly publicised in the reception area. We saw that the practice responded to complaints in line with the complaints policy and demonstrated shared learning when things went wrong.

Are services well-led?

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

Summary of findings

The principal dentist had a clear vision for the practice that was shared by the staff. Staff felt supported by the principal dentist and there were regular meetings where staff were given the opportunity to give their views of the service. There were good governance arrangements and an effective management structure. Appropriate policies and procedures were in place, and there was effective monitoring of various aspects of care delivery. Staff guidance was provided via policies

and procedures distributed on the company's intranet service. There was provision for induction and training for staff.

Heddon's Croft

Detailed findings

Background to this inspection

We carried out an announced inspection on Tuesday 22nd September 2015. This inspection was led by a CQC Inspector and a dental specialist advisor.

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.

We informed the NHS England area team that we were inspecting the practice; however we did not receive any information of concern from them. The practice sent us their statement of purpose and a summary of complaints they had received in the last 12 months. We also reviewed further information on the day of the inspection.

We spoke with three patients who used the service on the day of our inspection. We reviewed 20 Care Quality Commission comment cards that had been completed by patients prior to the inspection. We also spoke with nine members of staff, including the principal dentist and the registered manager. We reviewed the policies, toured the premises and examined the cleaning and sterilisation of dental equipment.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and reported them internally and externally where appropriate.

There was a clear understanding and reporting of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) and COSHH (Control of Substances Hazardous to Health). There had been no reportable incidents in the last 12 months. The practice manager was a nominated health and safety lead for the service and had been trained for this role.

The practice complied with relevant patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Authority (MHRA) and through the Central Alerting System (CAS). Minutes showed that a clinical governance meeting took place every month which discussed these items and provided staff with the necessary information and actions to take. All members of staff attended these meetings. We saw the minutes of these meetings. Items discussed included infection control, hand washing, and critical events elsewhere in the country.

Reliable safety systems and processes (including safeguarding)

There were reliable safety processes in place. These included systems which ensured the safe use of rubber dams. (A rubber dam – is a thin, rectangular sheet, not usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the patient's airway.) Rubber dams used by the practice were made of rubber and not latex, in order to safeguard against latex allergies. The use of rubber dams had been risk assessed, in order to ensure their safe use for patients.

The safeguarding policy had been reviewed annually and most recently in April 2015 and contained up to date contact details of the local authority and other relevant agencies. Safeguarding guidance was also displayed in each of the three treatment rooms. Staff knew how to identify, report and respond to suspected or actual instances of abuse. The practice manager was the

safeguarding lead at the practice and had received appropriate safeguarding training for this role. All staff had received safeguarding training as part of their mandatory annual training.

Staff understand the reporting system for raising concerns, such as whistleblowing, complaints and feel confident to do so and, fulfil their responsibility to report concerns.

During our visit we found that the dental care and treatment of patients was planned and delivered in a way that ensured patients' safety and welfare. Dental care records contained patient's medical history that was obtained when people first signed up at the practice and was updated every time patients visited the practice for a check-up or treatment. The dental care records we saw were well structured and contained sufficient detail enabling another dentist to know how to safely treat a patient. The dental records we saw were well structured accurate and complete. This enabled dentists to understand the nature of treatment already provided which helped in planning future treatments.

Medical emergencies

There were arrangements in place to deal with on-site medical emergencies. Staff had received annual emergency first aid training. The practice complied with the guidance for emergency equipment recommended by the Resuscitation Council UK and with the guidance on emergency medicines from the British National Formulary (BNF). The practice had two medical emergency kits which included emergency medicines and equipment, including an automated external defibrillator (AED – a device used to restart a patient's heart in the event of a cardiac arrest) and oxygen. Staff had been trained to use the emergency equipment. There was a system in place for checking the medical emergency kit. This included checking the expiry dates of medicines in the kit. We checked the medicines and we found that all the medicines were within their expiry date.

Medical alerts and national institute for health and care excellence (NICE) updates had been shared with staff. For example, in August 2015 the minutes of staff meetings had discussed NICE guidance regarding oral health best practice, management systems updates and managing dental infections.

Staff recruitment

Are services safe?

The practice had a policy for the safe recruitment of staff. We looked at two staff files. We saw that appropriate background checks had been completed prior to employment. Employment contracts and photographic proofs of identity and proofs of address were on file. Disclosure Barring Service background checks (DBS) had been completed. The DBS carries out checks to 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. It was the dental practice's policy to request a DBS check for all staff.

Staff files also included training, registration updates, employment history, absences, appraisals and correspondence.

The registered manager told us that there were sufficient numbers of suitably qualified and competent staff for the needs of their patients.

Monitoring health & safety and responding to risks

The practice had arrangements in place to deal with foreseeable emergencies. A Health and Safety Policy was in place. The practice had a risk management process which was regularly being updated and reviewed to ensure the safety of patients and staff members. For example, we saw risk assessments for fire safety, manual handling, use of visual display screens and environmental building issues. The assessments were reviewed annually and included the controls and actions to manage risks.

The practice had a comprehensive business continuity plan to deal with emergencies that could disrupt the safe and smooth running of the service. The plan covered what to do in the event of computer failure, fire or staffing issues among others. The plan included contact details of specific people and agencies to contact in event of an incident that affected the continuity of the business.

Risks to safety from service developments and disruption were assessed, planned for, and managed in advance. There were systems in place to report physical hazards or defects to the provider's service centre. For example, a fault in the main alarm system had been reported in September 2015 and had been remedied within 24 hours.

A fire evacuation drill had taken place every six months. We saw that regular fire audits had taken place. The audits included the checking on of all fire equipment such as

extinguishers, emergency lighting and alarms. A recent audit had identified the fire extinguishers were due for their annual service. This had been carried out. Fire alarms were tested every Monday.

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. All clinical staff were aware of the work flow in the decontamination room from the 'dirty' to the 'clean' areas. There was a separate hand washing sink for staff, in addition to two separate sinks for decontamination work. The procedure for cleaning, disinfecting and sterilising the instruments was clearly displayed on the wall to guide staff. Staff told us that they wore appropriate personal protective equipment when working in the decontamination room and when treating patients and this included disposable gloves, aprons and protective eye wear. There was a lead for infection control.

We found that instruments were being cleaned and sterilised in line with published guidance (HTM01-05). The dental nurse spoke knowledgeably about the decontamination process and demonstrated that they followed the correct procedures. For example, instruments were examined under illuminated magnification and sterilised in an autoclave. Sterilised instruments were correctly packaged, sealed, stored and dated with an expiry date. We saw there had been a daily audit of expiry dates; this was undertaken by each dental nurse. For safety instruments were transported between the surgeries and the decontamination room in lidded boxes.

The clinical waste bins had been placed in the dirty area of the decontamination room in order to protect the cleanliness of the other areas of the room.

Risk assessments had been undertaken for issues affecting the health and safety of staff and patients using the service. This included for example use of PPE (personal protective equipment), radiography equipment, sharps storage and security of the premises.

Staff carried out daily checks on the dental equipment such as the autoclave and washer disinfectant to ensure they were working effectively. Any problems were reported to the provider's engineering contractor. We saw that responses from them were prompt and effective.

Are services safe?

The practice undertook regular infection control audits in accordance with the guidance by the Department of Health in HTM01-05. The practice used an Infection control audit template recommended by the infection prevention society (IPS). The last such audit had been completed in September 2015 which had achieved an overall score of 97%. The previous audit had been undertaken in April 2015 which had scored 81% and had identified improvements which were required, such as the prevention of blood borne infections. Steps had been taken to implement these, resulting in the improved score in September.

The practice used an external cleaning contractor to clean the practice. The practice provided the contractor cleaning schedules to follow. The contractor cleaned the non-clinical areas. We saw that the signed off cleaning schedules showed that this cleaning took place on a daily basis when the practice was closed. Dental nurses told us that they cleaned clinical work surfaces and the decontamination room. Written cleaning schedules were also in place for this and showed they were being followed. We observed the practice was clean and tidy.

Cleaning equipment and materials were stored appropriately in line with Control of Substances Hazardous to Health (COSHH). COSHH is the law that requires employers to control substances that are hazardous to health.

The dental water lines were maintained in accordance with current guidelines to prevent the growth and spread of Legionella bacteria. Flushing of the water lines was carried out in accordance with current guidelines and supported by an appropriate practice protocol. A Legionella risk assessment had been carried out by an appropriate contractor in June 2015 and documentary evidence was provided to support this. Legionella is a bacteria found in the environment which can contaminate water systems in buildings.

There were hand washing facilities in each treatment room and staff had access to good supplies of personal protective equipment (PPE), such as gloves and masks for patients and staff members. Staff and patients we spoke with confirmed that staff wore protective aprons, gloves and masks during assessment and treatment in accordance with infection control procedures.

The practice met the requirement of relevant legislation to ensure that the premises and equipment had been properly purchased, used and maintained such as Sharps regulations 2013, HTM 07-01 (healthcare waste). We saw that the practice had a contract with an authorised clinical waste disposal contractor to dispose of their clinical waste.

Equipment and medicines

We found that all of the equipment used in the practice was maintained in accordance with the manufacturer's instructions. This included the equipment used to clean and sterilise the instruments and X-ray equipment. Portable appliance testing (PAT) was completed in accordance with good practice guidance, most recently in August 2015.

Radiography (X-rays)

The practice maintained suitable records in their radiation protection file demonstrating the maintenance of the x-ray equipment. The practice had a radiation protection supervisor (RPS). They were named on x-ray guidance information in each of the three surgery rooms. X-ray audits were undertaken at least on an annual basis.

The audits looked at issues such as the maintenance of X-ray equipment, quality of images and the radiography training staff had undertaken. This was done to ensure X-rays that were taken were of the required standard. We saw that local rules relating to the X-ray machine were displayed. We saw there were continuous professional development (CPD) records related to radiography for all staff that undertook radiography tasks.

The practice met the requirement of relevant legislation to ensure that premises and equipment were properly purchased, used and maintained such as, Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

Routine checks on radiography equipment were carried out. For example, weekly routine tests had been performed to ensure images were being read correctly by the X-ray scanner. Equipment had been serviced and maintained.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We reviewed the information recorded in patients' dental care records about the oral health assessments, treatment and advice given to patients. We found these were comprehensive and included details of the condition of the teeth, soft tissues lining the mouth and gums. These were repeated at each examination in order to monitor any changes in the patient's oral health. Patients were asked to complete a questionnaire updating the practice on their medical history each time they attended an appointment.

Records showed assessment of the periodontal tissues; to monitor gum disease was undertaken and recorded using the basic periodontal examination (BPE) screening tool. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). BPE scores were noted in the records and the dentist planned treatment around the score that was achieved.

The practice kept up to date with current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, the dentists used current National Institute for Health and Care Excellence (NICE) guidelines to assess each patient's risks, needs and to determine how frequently to recall them. The practice also demonstrated compliance with the Delivering Better Oral Health Tool-kit. 'Delivering better oral health' is an evidence based toolkit to support dental teams in teams in improving their patient's oral and general health.

Staff told us that they offered treatment on the basis of clinical need and that they did not discriminate on the grounds of age, disability, gender reassignment, pregnancy and maternity status, race, religion or belief when making care and treatment decisions.

Health promotion & prevention

Patients medical histories were updated regularly which included questions about smoking and alcohol intake. Appropriate advice was provided by staff to patients based on their response to the medical history and life style questionnaires patient completed before each consultation or treatment. We saw the practice provided preventive care advice on tooth brushing and oral

health instructions as well as smoking cessation, fluoride application, alcohol use, and dietary advice.

The practice carried outreach programmes to improve oral health in the local area. This included dental kids clubs. These kids' clubs involved a visit to the dentist for an examination and oral health advice was offered which was designed for children and their carers to understand. Resources included pictures of the tooth fairy for colouring, reward stickers for good behaviour, models and diagrams to explain effective tooth brushing. Any patient under the age of 18 years was invited. These kids' clubs took place on a weekly basis during school holidays. A dentist ran the club, carried out examinations, and provided the oral health advice and free oral health products to the attendees. During the August 2015 holiday attendees at the dental kids club numbered approximately 40 children each Friday. A total of 160 children had attended during the August school holiday.

The practice also carried out leaflet campaigns which targeted at families that used food banks. The leaflets were provided to the organisers of the food bank for distribution. The leaflets included details of the practice's services and oral health advice.

Staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. The provider ran its own in house clinical conferences to keep up to date with the latest developments in dentistry. Dentists from the practice had attended the most recent one in September 2015. This covered some of the latest treatments in dentistry and medical emergencies.

Staff are supported to deliver effective care through opportunities to undertake training, learning and development and through meaningful and timely supervision. Staff had received annual appraisals from the practice manager in August 2015 in line with the provider's best practice.

The learning needs of staff had been identified through annual appraisals and regular meetings between staff and management. Dental nurses told us they had been provided with the time and resources to attend a presentation on forensic dentistry at the local college.

Are services effective?

(for example, treatment is effective)

A dentist told us that they had requested training in endodontics (root canal treatment). This had been arranged for October 2015. Additional training in mentoring was also being provided.

The practice maintained a programme of professional development to ensure that staff were up to date with the latest practices. This was to ensure that patients received high quality care as a result. The practice used a variety of ways to ensure development and learning was undertaken including both face to face and e-learning. Examples of staff training included core issues such as health and safety, safeguarding, radiography, medical emergencies and infection control. We reviewed the system in place for recording training that had been attended by staff working within the practice. We also reviewed information about continuing professional development (CPD) and found that staff had undertaken the required number of CPD hours.

Working with other services

Effective arrangements were in place for working with other health professionals to ensure quality of care for the patient. The service liaised with orthodontics services at the local hospital for patients who required braces. Referrals for conscious sedation were sent to their sister practice in Barnstaple. Conscious sedation is a technique in which the use of a drug or drugs are used to sedate patients to enable treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation. The drug or drugs used have a margin of safety wide enough to render loss of consciousness unlikely. There was an up to date data protection policy to ensure that computer records were shared appropriately.

There were clear guidelines for referring patients to specialist colleagues based on current guidelines. The practice had referred patients to special care general

anaesthetic services. This included patients protected under the mental capacity act 2005 (MCA) The MCA is a legal framework which protects patients who need support to make important decisions. The practice was aware of the appropriate usage of Independent Mental Capacity Advocates (IMCA) when appropriate. IMCA is a type of advocacy introduced by the MCA. The MCA gives some people who lack capacity a right to receive support from an IMCA in relation to important decisions about their care.

Consent to care and treatment

Patients' who used the service were given appropriate information and support regarding their dental care and treatment. We spoke with three patients who used the service and reviewed 20 CQC comments cards. Patients told us they had been given clear treatment options which were discussed in an easy to understand language by practice staff. Patients told us they understood and consented to treatment. This was confirmed when we reviewed patient records and found signed consent forms for treatments.

A monthly audit on consent records was conducted. This had identified where there were any gaps in the written recording of consent and rectified this. Appropriate learning points had been shared. A full audit cycle was in place.

Practice dentists had received training on the MCA and had talked with staff about implications it had for staff and patients. Staff were aware of how they would support a patient who lacked the capacity to consent to dental treatment. They explained how they would involve the patient and carers to ensure that the best interests of the patient were met. This meant where patients did not have the capacity to consent, the dentist acted in accordance with legal requirements and that vulnerable patients were treated with dignity and respect.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patients were treated with kindness, dignity, respect and compassion while they received care and treatment.

We spoke with one family during our inspection who told us the dentists were experienced in dealing with children and were very patient and considerate. The dentists told us they used various strategies such as providing children with stickers and allocating more time for patients according to individual need.

Nervous patients had a warning marker on their computerised records to alert staff. So that suitable arrangements could be made to support those patients including offering longer appointment times if necessary.

The practice worked with a local out of hour's service to treat homeless patients to provide services to this hard to reach group.

The practice had access to a language line telephone translation service to assist communication with patients whose first language was not English.

The reception desk was next to the waiting room. Background music was played to reduce the likelihood of private conversations being overheard. Staff told us that if patient's wished to speak in private there were rooms available. Staff were aware of the need to maintain patient confidentiality. Patients we spoke with confirmed this. We saw that treatment room doors were always closed when a patient were receiving treatment.

We observed that staff took time to interact with patients and those close to them in a respectful, appropriate and considerate manner.

Staff recognised and respected people's diversity, values and human rights. The provider had a clear equality and diversity policy which staff had access to.

Patients told us that staff were sympathetic and caring towards them to ensure that patients who used services, and those close to them, received the support they need to cope emotionally with their care and treatment. During our inspection we noticed that patients knew staff well and there was much friendly interaction between patients and staff. Patients reported that staff responded to pain, distress and discomfort in a timely and appropriate way.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area that gave details of NHS dental charges. We also saw that the practice had a website that included information about dental care and treatments, costs and opening times. The website also contained information regarding how patients could access emergency dental care if required; this information was also available in the patient information leaflet located in the reception area.

Staff told us that treatments, risks and benefits were discussed with each patient to ensure the patients understood what treatment was available so they were able to make an informed choice. The dentist explained what they were going to do and used aids such as models of teeth to show patients the treatment they proposed to undertake. They were also shown this on a radiograph (x ray) where applicable. The practice had installed digital screens in surgery rooms to enable dentists to show patients images of their teeth and fully explain treatment options. Patients were then able to make an informed choice about which treatment option they wanted. Written treatment plans had been provided.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patient's needs

Services were planned and delivered to meet the needs of patients. The facilities and premises were appropriate for the services that are planned and delivered.

There was signage on display in the waiting room which showed that guidance had been provided to patients following changes in the law about smoking in a private vehicle when children are present.

Dentists had had training in dental implants, minimizing invasive dentistry and the role of written evidence in dentistry. One dentist was receiving training to become a mentor for other dentists.

Appointment times were scheduled to ensure people's needs and preferences (where appropriate) are met. The service was open 8am to 4pm Monday to Friday. Outside of those hours the service was provided by Devon Dentist's or NHS 111.

The practice made reasonable adjustments for patients such as adjusting the temperature of the room. Patient could choose which dentist treated them and were offered a choice of treatment options. Where patients had requested a male or a female dentist then these wishes had been complied with.

The practice took into account the needs of different people on the grounds of age, disability, sex, gender reassignment, race, religion or belief, sexual orientation, pregnancy and maternity. The practice had an equal opportunities policy which had been reviewed within the last 12 months.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services that included access to telephone translation services. The building was accessible to wheelchair users, with a portable ramp to allow access to the ground floor facilities and a surgery.

Staff were able to describe to us how they had supported patients with additional needs such as a learning disability or those who were wheelchair users. For example, staff told us that a front door bell had been installed for use by

patients to summon staff for assistance when required. There were pictures, easy to understand diagrams and models available which dentists used to help explain treatment options to patients.

Access to the service

Patients could access care and treatment in a timely way. Waiting times, cancellations and delays were minimal.

The practice had level access and was based on the ground floor and first floor. There was a treatment room on the ground floor which was available to patients who were wheelchair users.

Waiting room chairs were robust, comfortable, and some had arms for support. There was a patient's toilet adjacent to the waiting room.

There was currently no hearing aid induction loop in place at reception. This was planned to be installed in October 2015. Reception staff informed us that they would use written means to communicate if required, in larger font sizes. A language translation line service was available.

Patients had timely access to urgent treatment. Staff told us they always saw urgent cases within 24 hours. There was time set aside daily to deal with urgent appointments. During the inspection, one patient told us that they had contacted the practice and with an urgent problem and had been seen by a dentist within the hour.

Patients reported that they are aware of how they can access emergency treatment, including out of normal hours. This was displayed on the front door.

Concerns & complaints

The complaints procedure was displayed in the waiting room with details of how to escalate a complaint should a patient wish to do so. There were policies in place which ensured patients were told when they were affected by something that goes wrong, given an apology and informed of any actions taken as a result.

Patient's concerns and complaints were listened and responded to, and used to improve the quality of care. There was a complaints system in place, which was publicised, accessible, understood by staff and patients who use the service.

Are services responsive to people's needs?

(for example, to feedback?)

There was openness and transparency in how complaints were dealt with. There had been four complaints in the past 12 months. The complaints were recorded on a central system monitored by the provider's head office. Complaints had been dealt with appropriately and in a timely manner.

The practice received a large number of written compliments. Complaints and compliments were shared with staff at team meetings and learning points discussed.

Are services well-led?

Our findings

Governance arrangements

The service was part of a large corporate provider, IDH Group Ltd which was being rebranded as MyDentist, a national provider. The provider had in place effective governance arrangements supported by a central head office, a regional office and four nearby sister practices in the area.

The practice manager undertook quality audits at the practice. This included audits on health and safety, x-ray audits, infection control, staffing and dental care records. We saw that action plans had been drafted following audits and actions taken as necessary.

The practice had a clear vision and objectives which were displayed in the patient waiting area and in staff areas. The values included the provision of high quality patient centred care and offering clear advice and choices about oral health care.

There was a practice manager who was the registered manager and oversaw the management of the practice. Staff meetings were held once a month. All staff attended these meetings. The practice manager also attended area meetings with four other sister practices to ensure best practice in governance is shared.

We looked at records of staff meetings in the last six months. The records showed these meetings were minuted appropriately and action taken to ensure the practice remained safe, caring, effective, responsive and well led. We saw that meetings had discussed practice performance, health and safety incidents, other incidents, infection control, campaign updates on oral health, changes to COSHH and complaints and compliments. Dental care record audit results had been discussed with shared learning points.

Staff were supported and managed and were clear about their lines of accountability. The registered manager understood their responsibilities and was supported by the company.

There was an effective approach for identifying where quality and/or safety was being compromised and steps

were taken in response to issues. These include quarterly audits of radiological images, clinical notes, weekly legionella audits, quarterly infection prevention control audits and autoclave checks.

Leadership, openness and transparency

The leadership and culture reflected the vision and values, encouraged openness and transparency and promoted delivery of high quality care. Staff were aware of the duty of candour, which encourages a policy of openness and honesty when mistakes are made. We saw that the practice provided apologies when things had gone wrong and written responses when concerns had been raised if appropriate. Staff told us that the culture of the practice encouraged this positive environment. A whistle blowing policy was in place and staff we spoke with were aware of it and how to access the policy.

Policies and procedures about all aspects of the work of the practice were available to all staff on a computer system. This included online quick guides for systems, for jargon busting and for assistance on all aspects of work at the practice.

The practice manager attended monthly management meetings with other IDH Group Ltd managers in the area. These meetings included discussions on patient treatment, staffing and operational matters, any training or safety updates. The governance arrangements ensured that responsibilities were clear, quality and performance were regularly considered, and risks were identified, understood and managed. Staffing levels at the practice were closely monitored on an ongoing basis. There was at least one dental nurse to support every dentist. In the event of unplanned absence, the practice was able to call upon staffing support from four other sister practices locally that were all in IDH Group Ltd (MyDentist). The provider had a list of approved locums who could also be deployed if necessary.

The dentists carried out peer reviews of each other's work with dentists at the four other sister practices nearby. Items discussed included dental care records, and quality of referrals.

The provider produced two staff newsletters on a monthly basis called The Buzz and the Operations Bulletin. We looked at a recent edition of The Buzz and saw that it included relevant information on the updated whistle

Are services well-led?

blowing policy, mouth cancer and the rebranding of the provider as MyDentist. The operations bulletin from August 2015 included details of the new medical emergency policy, practice security and clinical waste management.

The provider had systems in place to support communication about the quality and safety of services and what actions have been taken as a result of concerns, complaints and compliments.

All levels of staff told us that candour, openness, honesty and transparency and challenges to poor practice were the norm.

Management lead through learning and improvement

Quality assurance was used to encourage continuous improvement. The practice monitored its activity via a weekly activity report which was shared with all staff. We looked at recent activity reports. We saw that the practice recorded all of its activity including such areas as system reviews which monitored lapsed patients. A lapsed patient is a patient who has fallen outside of their six or twelve month review. The practice sent reminders to these patients.

We saw that the audit processes functioned well and had a positive impact in relation to quality governance, with clear evidence of action to resolve concerns. Audits included radiology, infection control, legionella and patient dental care record audits. Findings had been compared with previous audits.

Dental care record keeping and treatment plan audits had been completed on a quarterly basis, to ensure patient details were up to date.

Each patient had a signed treatment plan with a consent form, audited every quarter.

A hand washing audit was completed quarterly, most recently in August 2015 and shared learning had taken place with staff.

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

The practice had gathered feedback from patients through a comments box in reception. The practice carried out the NHS Friends and Family survey on a monthly basis. There were also blank feedback forms for complaints or compliments in the waiting room. In August 2015 we found that 93% of 64 patients who completed the NHS Friends and Family survey stated they would recommend the service to their friends and family.

We were shown examples of where patients had made comments on NHS choices. One patient reported how the practice had provided excellent support for their dental phobia. Another patient reported they had been required to wait for an hour for treatment. Written responses had been provided by the practice and were displayed on NHS Choices.

Patients who used the service, the public and staff were engaged with the service. For example, there was a feedback box in the waiting room with blank forms and pens. We looked at 20 comments cards during our visit and saw that patients had made entirely positive comments about the practice and the staff.

A patient listening group was planned for November 2015 at the practice where six patients had been invited in to provide feedback on the service.

The provider had a form which staff could use to provide written feedback or suggestions; this was called Your Voice. All staff we spoke with were extremely positive about the new practice manager.

Staff reported that the provider valued their involvement and that they feel engaged and said their views were reflected in the planning and delivery of the service. Staff feedback had been received positively by the management. For example, the practice had acted upon this feedback to allow staff the time and resource to attend forensic dentistry training at the local college.

In June 2015 the practice manager had carried out a needs analysis engaging with all staff, examining what staff needed. The practice manager had acted upon feedback for example by providing more equipment, revising the cleaning schedules and adjusting the staff rota.