

Compass Clinic Limited

Compass Clinic - Wells-next-the-Sea

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 14 June 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 providing safe care in accordance with the relevant regulations

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

The practice has one full time dentist, one part time dentist, two dental nurses, a receptionist and a practice manager who also works at another location. The practice provides primary dental services to NHS and private patients and opens on Monday to Friday between 9am and 5pm.

The practice manager 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 spoke with patients and reviewed 22 CQC comment cards which had been completed by patients prior to the inspection. All the comments reflected positively on the staff and the services provided. Patients commented that the practice was clean and hygienic, they found it easy to book an appointment and they found the quality of the dentistry to be excellent. They said explanations were clear and that the staff were kind, caring and reassuring.

Our key findings were:

Summary of findings

- The practice recorded and analysed significant events and complaints and cascaded learning to staff.
 - Where mistakes had been made there was a policy that patients were notified about the outcome of any investigation and given a suitable apology.
 - Staff had received safeguarding and whistleblowing training and knew the processes to follow to raise any concerns.
 - There were sufficient numbers of suitably qualified staff to meet the needs of patients.
 - Staff had been trained to handle emergencies; appropriate medicines and life-saving equipment were readily available.
 - Infection control procedures were robust and the practice followed published guidance on the majority of occasions, however, there were minor areas for improvement.
 - Patient care and treatment was planned and delivered in line with evidence based guidelines, best practice and current legislation.
 - Patients received clear explanations about their proposed treatment, costs, benefits and risks and were involved in making decisions about it.
 - Patients were treated with dignity and respect and confidentiality was maintained.
 - The appointment system met the needs of patients and waiting times were kept to a minimum.
 - There was an effective complaints system and the practice was open and transparent with patients if a mistake had been made.
 - The practice sought feedback from staff and patients about the services they provided.
 - Staff were well supported by the leadership of the practice in order to carry out their roles effectively.
- There were areas where the provider could make improvements and should:
- Ensure that patient alerts are disseminated effectively to staff and that circulation is recorded.
 - Ensure the sterilisation equipment is used in accordance with manufacturers instructions and national guidance .
 - Ensure the practice policy on completing DBS checks is followed.

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 effective systems and processes in place to ensure care and treatment was carried out safely. Significant events, complaints and accidents were recorded appropriately, investigated, analysed and then improvement measures implemented. Patients were informed if mistakes had been made and given suitable apologies. Staff had received training in safeguarding, whistleblowing and knew the signs of abuse and who to report them to. Staff were suitably trained and skilled to meet patient's needs and there were sufficient numbers of staff available at all times.

One element of infection control procedures should be brought in line with published guidance but overall arrangements were robust and staff had received training. Radiation equipment was suitably sited and regular audits had taken place in line with national guidance to ensure patients were protected. Emergency medicines in use at the practice were stored safely and checked to ensure they did not go beyond their expiry dates. Sufficient quantities of equipment were in use at the practice; they were serviced and maintained at regular intervals.

Are services effective?

We found 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 including taking a medical history. Explanations were given to patients in a way they understood. Risks, benefits, options and costs were explained. Staff were supported through training and opportunities for development. Patients were referred to other services in a timely manner. Staff understood the Mental Capacity Act 2005 and offered support when necessary. Staff were aware of Gillick competency in relation to children under the age of 16.

Are services caring?

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

Patients were treated with dignity and respect and their privacy maintained. Patient information and data was handled confidentially. Patients told us they were listened to and not rushed. Treatment was clearly explained and they were provided with treatment plans. Patients were given time to consider their treatment options and felt involved in their care and treatment.

Are services responsive to people's needs?

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

Appointment times met the needs of patients and waiting time was kept to a minimum. Information about emergency treatment was made available to patients. A practice leaflet was available in reception to explain to patients about the services provided. The practice had made reasonable adjustments to accommodate patients with a disability or lack of mobility. Patients who had difficulty understanding care and treatment options were supported. The practice had a complaints policy that outlined an intention to deal with complaints in an open and transparent way and apologised when things went wrong.

Are services well-led?

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

Summary of findings

The practice provided clear leadership and involved staff in their vision and values. Staff meetings took place regularly and minutes were taken when they occurred. We looked at care and treatment records to ensure standards had been maintained. Staff were supported to maintain their professional development and skills. There was a pro-active approach to identify safety issues and making improvements in procedures. There was candour, openness, honesty and transparency amongst all staff we spoke with. We saw clinical and non-clinical audits taking place and results analysed and the audits repeated. The practice sought the views of staff and patients, and there had been an on-going patient survey. Health and safety risks had been identified which were monitored and reviewed regularly.

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Detailed findings

Background to this inspection

The inspection took place on 14 July 2015 and was carried out 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. Prior to the inspection we asked the practice to send us some

information which we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, the details of their staff members, their qualifications and proof of registration with their professional bodies. We also reviewed the information we held about the practice and consulted with other stakeholders, such as the NHS England area team and Healthwatch; however we did not receive any information of concern from them. During the inspection we spoke with the dentist, the practice manager and a dental nurse; we reviewed policies, procedures and other documents. We spoke with patients and reviewed 22 CQC comment cards which had been completed by patients prior to the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

We looked at complaints the practice had received in the last twelve months and found they had all been answered within the expected time frame. Appropriate investigations had been carried out and apologies had been issued where appropriate. There was a policy in place and we spoke with both the dentist and the practice manager about complaints. We found they knew what constituted a complaint and we saw a folder where such complaints were filed. We tracked one complaint through the process from beginning to resolution and found that the practice had taken appropriate measures where the complaint was substantiated. The practice responded to national patient safety and medicines alerts that were relevant to the dental profession. These were sent to a dedicated email address and actioned by the practice manager. We saw a folder where the alerts were placed and staff signed to say they had read them. However, this sheet was out of date and was last signed in 2013 but staff we spoke with knew of recent guidelines. We spoke to the practice manager about this and they stated they would improve the system. Records we viewed reflected that the practice had undertaken a risk assessment in relation to the control of substances hazardous to health (COSHH). Each type of substance used at the practice that had a potential risk was recorded and graded accordingly. Measures were clearly identified to reduce such risks including the wearing of personal protective equipment and safe storage. The practice maintained clear records of significant events. Staff were aware of the reporting procedures in place and were encouraged to bring safety issues to the attention of the dentist or the practice manager.

Reliable safety systems and processes (including safeguarding)

All staff at the practice were trained in safeguarding and the practice manager was the identified lead. We spoke to all grades of clinical staff, administrative staff and the practice manager, all were aware of the different types of abuse and who to report them to if they encountered a vulnerable child or adult. A policy was in place for staff to refer to and this contained telephone numbers of who to contact outside of the practice if there was a need. There had been no safeguarding incidents since this practice had registered. Staff were aware of whistleblowing procedures

and who to contact outside of the practice if they felt that they could not raise any issue with the dentist or practice manager. However, they felt confident that any issue would be taken seriously and action taken by the manager if necessary. We were told the dentist always used rubber dams during root canal treatment. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth.

Medical emergencies

We checked that the practice had the necessary emergency medicines and equipment as listed in the British National Formulary (BNF) and the Resuscitation Council (UK) guidelines. We saw that emergency medicines and oxygen were present but there was no Automated External Defibrillator (AED) in the practice. The practice is contained within a small hospital and there was an AED present in one of the other rooms. 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. All staff had been trained in basic life support and were able to respond to a medical emergency. All emergency equipment was readily available and staff knew how to access it. We checked the emergency medicines and found that they were of the recommended type and were all in date. A system was in place to monitor stock control and expiry dates. All clinical staff we spoke with could identify the signs indicating equipment and medicine use and stated they felt confident in their ability to respond should the need arise.

Staff recruitment

The practice had a recruitment policy that described the process to follow when employing new staff. This included obtaining proof of identity, checking skills and qualifications, registration with professional bodies where relevant, references and whether a Disclosure and Barring Service (DBS) check was necessary. We looked at three staff files and found that the process had been followed. There were sufficient numbers of suitably qualified and skilled staff working at the practice. A system was in place to ensure that where absences occurred, staff from a different practice but owned by the same provider, were contacted to attend and provide cover for their colleagues. The practice did not employ agency staff but the practice manager was aware of the checks into qualifications and competencies should this become necessary in the future.

Are services safe?

There had been high usage of locum dentists when one full time dentist had left the practice; this resulted in a high turnover of locum dentists which we saw had impacted on patient confidence. We saw evidence of this from NHS Choices and patients we spoke with on the day of our inspection. We spoke to the practice manager who told us that a permanent member of staff had now been recruited to fill the vacancy .

The practice policy was to obtain DBS checks for all clinical staff and the receptionist; we looked at the records and found that most of these staff had a current certificate of check completed. We spoke to the registered manager who showed us evidence of recent applications for those staff that required a current DBS check. DBS checks are 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.

Monitoring health & safety and responding to risks

A health and safety policy and risk assessment was in place at the practice. This covered the risk to staff and patients who attended the practice. Risks had been identified and control measures put in place to reduce them. There were other policies and procedures in place to manage risks. These included infection prevention and control, a legionella risk assessment, fire evacuation procedures and risks associated with Hepatitis B. Processes were in place to monitor and reduce these risks so that staff and patients were safe. We saw the practice had commissioned a private contractor to carry out a fire assessment of the building; this had been done in September 2014.

Infection control

The practice was visibly clean, tidy and uncluttered. We saw cleaning contracts in place and spoke to the dental nurse about how they cleaned the consultation rooms. An infection control policy was in place and a lead had been identified. The policy clearly described how cleaning was to be undertaken at the premises including the surgeries and the general areas of the practice. The types of cleaning and frequency were detailed in the policy and checklists were available for staff to follow. We looked at the records kept and found that they had been completed correctly. Records held reflected that the quality of the cleaning was being monitored and feedback given to the cleaning staff accordingly. We saw evidence of a recent infection control

audit the practice had undertaken which was repeated every six months. We found there were adequate supplies of liquid soaps and hand towels throughout the premises and hand washing techniques were displayed in the toilet facilities. Sharps bins were properly located, signed, dated and not overfilled. A clinical waste contract was in place and waste was stored securely until collection. We looked at the procedures in place for the decontamination of used dental instruments. 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. We found that instruments were being cleaned and sterilised in line with published guidance (HTM 01:05) with some minor exceptions. On the day of our inspection, a dental nurse demonstrated the decontamination process to us and showed us that following hand washing the instruments were placed into bags and then into the autoclave. This was contrary to manufacturer's instructions for this particular machine. An autoclave is a device for sterilising dental and medical instruments. We spoke with the practice manager who agreed to amend this practice and to seek further clarification from the machine manufacturer. This is important to ensure the equipment is cleaned effectively and to comply with published guidance (HTM 01:05) At the end of the sterilising procedure the instruments were correctly sealed, stored and dated with an expiry date. We looked at the sealed instruments in the surgeries and found that they all contained an expiry date that met the recommendations from the Department of Health. All instruments were bagged and appropriately stored. The decontamination room had clearly defined dirty and clean zones in operation to reduce the risk of cross contamination. Staff wore appropriate personal protective equipment during the process which included disposable gloves, face masks and aprons. The equipment used for cleaning and sterilising was maintained and serviced as set out by the manufacturers. Daily, weekly and monthly records were kept of sterilisation cycles and tests and when we checked those records it was evident that the equipment was in good working order and being effectively maintained. There were daily checks being carried out on the autoclave machine which are needed to ensure the machine is working correctly each day. Staff told us that they wore personal protective equipment when treating people who used the service. Staff files examined showed that all clinical staff were up to date with Hepatitis B

Are services safe?

immunity. The practice had a legionella risk assessment in place and conducted regular tests on the water supply. There was a contract in place with the hospital where the practice was based. This detailed procedures for checking water supplies and we saw evidence that this was taking place. An independent organisation had surveyed the hospital water supply and checked for legionella, this was last completed in December 2013 and was due to be repeated later this year. Legionella is a term for particular bacteria which can contaminate water systems in buildings.

Equipment and medicines

Records we viewed reflected that equipment in use at the practice was regularly maintained and serviced in line with manufacturers guidelines. Portable appliance testing (PAT) took place on all electrical equipment. Fire extinguishers were checked and serviced regularly by an external company and staff had been trained in the use of equipment and evacuation procedures. Medicines in use at the practice were stored and when out of date disposed of in line with published guidance. Medicines in use were checked and found to be in date. There were sufficient stocks available for use and these were rotated regularly. The ordering system was effective. Emergency medical equipment was monitored regularly to ensure it was in working order and present in sufficient quantities. We spoke to clinical staff, all of whom understood the indications for the use of emergency medicines. Staff stated they felt confident to intervene in the event of emergency.

Radiography (X-rays)

X-rays were carried out safely and in line with local rules that were relevant to the practice and equipment. These were clearly displayed. X-ray machines were the subject of regular visible checks and records had been kept. A specialist company attended at regular intervals to calibrate all X-ray equipment to ensure they were operating safely. Where faults or repairs were required these were actioned in a timely fashion. A radiation protection advisor and a radiation protection supervisor had been appointed to ensure that the equipment was operated safely and by qualified staff only. Those authorised to carry out X-ray procedures were clearly named in all documentation. This protected patients who required X-rays to be taken as part of their treatment. The practice's radiation protection file contained the necessary documentation demonstrating the maintenance of the X-ray equipment at the recommended intervals. Records we viewed demonstrated that the X-ray equipment was regularly tested serviced and repairs undertaken when necessary. We saw records that indicated the practice was certified until September 2015 before the next inspection of its radiation equipment was due. We looked at the training records and saw the appropriate clinicians had received up to date training in the procedures for x-rays.

There had been an audit of radiography undertaken by the practice. Current regulations for the use of ionising radiation for medical and dental purposes (IRR99 and IR(ME)R2000) place a legal responsibility to establish and maintain quality assurance programs in respect of dental radiology. As part of this, it is necessary to ensure the consistent quality of radiographs through audit. We looked at this audit and found that the dentist was complying with all necessary guidance.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Patients attending the practice for a consultation received an assessment of their dental health after supplying a medical history covering health conditions, current medicines being taken and whether they had any allergies. There was also consideration made whether the patient required an X-ray and whether this might put them at risk, such as if a patient may be pregnant. One of the clinicians at the practice had completed an audit regarding outcomes in radiography with the intention of improving outcomes, we looked at this audit and found it contained all the necessary information and had been shared with clinicians in the practice. The dental assessments were carried out in line with recognised guidance from the National Institute for Health and Clinical Excellence (NICE) guidelines and General Dental Council (GDC) standards. This assessment 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 and whether it had changed since the last appointment. Following clinical assessment, the dentists followed the guidance from the Faculty of General Dental Practice before taking X-rays to ensure they were required and necessary. A diagnosis was then discussed with the patient and treatment options explained. Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included smoking cessation advice, alcohol consumption guidance and general dental hygiene procedures such as prescribing dental fluoride treatments. 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 NICE recommendations. 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 they were very satisfied with the assessments, explanations, the quality of the dentistry and outcomes.

Health promotion & prevention

There was no dental therapist working at the practice but one was available at another practice nearby and operated by the same provider. The dentist provided advice to improve and maintain good oral health; there was a process to refer to a therapist if needed. Details of discussions between the clinician and their patient were recorded, this included advice regarding diet, the use of fluoride paste, rinses and smoking cessation. In addition to treatment the dentist focused on treating gum disease, giving advice on the prevention of decay and gum disease including advice on tooth brushing techniques and oral hygiene products. There was some information available for patients about oral health on the practice website and information leaflets were given out by staff. The dentist we spoke with confirmed that adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. The dentist was aware of the NHS England publication for delivering better oral health which is an evidence based toolkit to support dental practices in improving their patient's oral and general health. CQC comment cards that we viewed reflected that patients were happy with the service and parents were satisfied with the services provided for their children; they had made positive comments about the advice they received.

Staffing

The practice employed one full time dentist and one dentist that practiced once in every two weeks. In addition there were two dental nurses. There was a practice manager that was shared with another location. A receptionist was employed at the practice.. Dental staff were appropriately trained and those that were qualified were registered with their professional body. Staff were encouraged to maintain their continuing professional development (CPD) to maintain their skill levels. Staff training was being monitored and we found evidence of this in their personal files. The practice had identified some training that was mandatory and this included basic life support and safeguarding. Staff had received an annual appraisal. We spoke with staff who told us they felt valued, supported and involved in the appraisal process which was fair. They were given the opportunity to discuss their training and career development needs and were graded on their performance. They told us that managers were supportive and always available for advice and guidance.

Are services effective?

(for example, treatment is effective)

We spoke with the registered manager who had a programme in place to appraise the dentists which had been performed by a senior dentist. We saw appraisals for other staff that contained objectives and training requirements. The practice no longer used locum dentists or nurses but had a policy that staff from a different location also controlled by the same provider would be used if required. Staff had access to the practice computer system and a comprehensive list of written policies which contained information that further supported them in the workplace. This included current dental guidance and good practice. Staff meetings were used to seek feedback from staff about possible improvement areas.

Working with other services

The practice had a policy in place to refer patients to other practices or specialists if the treatment required was not provided at their location. This included conscious sedation for nervous patients. We saw evidence of records containing valid consent and patient leaflets were available with up to date British Dental Association (BDA) advice sheets. The care and treatment required was explained to the patient and they were given a choice of other dentists who were experienced in undertaking the type of treatment required. A referral letter was then prepared with full details of the consultation and the type of treatment required. This was then sent to the practice that was to provide the treatment so they were aware of the details of the treatment required. When the patient had received their treatment they would be discharged back to the practice for further follow-up and monitoring. Where patients had complex dental issues, such as oral cancer, the practice

referred them to other healthcare professionals using their referral process. This involved supporting the patient to access the 'choose and book' system and select a specialist of their choice.

Consent to care and treatment

The practice had a consent policy to support staff in understanding the different types of consent a patient could give and whether it could be taken verbally or in writing. Staff we spoke with told us they had read the policy and they had ready access to it. Staff we spoke to had a clear understanding of consent issues, they understood that consent could be withdrawn by a patient at any time. Clinical and reception staff were aware about consent in relation to children under the age of 16 who attended for treatment without a parent or guardian. This is known as Gillick competence. They told us that children of this age could be seen without their parent/guardian and the dentist told us that they would ask them questions to ensure they understood the care and treatment proposed before providing it. This is known as the Gillick competency test. The dentist we spoke with also explained how they would take consent from a patient if their mental capacity was reduced. This followed the guidelines of the Mental Capacity Act 2005 and included involving any carer to ensure that procedures were explained in a way the patient could understand. We spoke with two patients and asked them about their care, they both said they felt fully involved in their care and options for treatment. They were able to show the places where costs were advertised and we found these on notice boards in both waiting areas and in the reception.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patients we spoke to felt that practice staff were kind, caring and they were treated with dignity, respect and staff were helpful. One patient told us they were nervous about seeing the dentist but had been reassured on each occasion making their experience less stressful. This patient had transferred from another practice and stated they had not worried about their treatment since arriving. CQC comment cards we viewed reflected that patients were very satisfied with the way staff treated them at the practice. Comment cards and patients we spoke with stated they did not feel rushed and the dentist always gave them time. A data protection and confidentiality policy was in place of which staff were aware, we looked at this policy and found it up to date and regularly reviewed. This covered disclosure of patient information and the secure handling of patient information. We observed the interaction between staff and patients, finding that confidentiality was being maintained. Records were held securely. We observed that staff at the practice treated patients with dignity, respect and maintained their privacy. The reception area was open plan but we were told by reception staff/dental nurse that when a confidential

matter arose, a private room just outside the waiting area was available for use. We saw that when any consultation took place this was always in a consultation room with the door shut. We did see that there was a prefabricated wall between the two consulting rooms and a gap at one end of this wall. This gap allowed conversations to be heard from the consultation room. We spoke with staff regarding this; all were aware of this issue and stated they made every attempt not to have private conversations which both rooms were occupied. We saw an appointment system that clearly noted that the two rooms were only used at the same time once in every fourteen days.

Involvement in decisions about care and treatment

Patients we spoke with told us that the dentist listened to them and they felt involved with the decisions about their care and treatment. They told us that consultations and treatment were explained to them in a way they understood, they felt that they had options regarding their treatment. We looked at care plans and examined comment cards all of which showed evidence that the patients were valued and their wishes considered. For example one comment card stated that the patient had always been listened to and treated with dignity and respect. We found clear evidence that pricing plans and overall costs were explained to patients.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice information leaflet and practice booklet described the range of services offered to patients, the complaints procedure, information about patient confidentiality and record keeping. The practice offered both NHS and private treatment and the costs of each were clearly displayed in the booklet and on boards in each of the waiting rooms. Appointment times and availability met the needs of patients. The practice was open from 9.00am to 5.00pm. Patients with emergencies were seen as soon as possible and always within 24 hours. We saw evidence that appointments were available for emergency patients on the day of our inspection and for the following week. The practice had an on-going patient survey and we looked at a comments book in which patients had written. All the comments were complimentary about the service particularly about the sensitive treatment provided by the main dentist.

Tackling inequity and promoting equality

The practice was accessible for those patients with mobility issues, using wheelchairs or mobility scooters. There was a separate door leading to one of the consulting rooms that enabled direct access for patients using wheel chairs. The practice was located within a hospital in a rural setting. The consultation rooms were all on the ground floor affording access for patients with limited mobility; we saw arrangements for wheelchair access including a separate entrance. There was a waiting area, patient toilet, and x-ray facilities all located on the ground floor. The main hospital operated a reception desk and the staff were available to assist any patient that needed help. There was a large car park available. We spoke with the practice manager who told us that there was a possibility that an alternative entrance was going to be used for patients after 3pm. We looked at this entrance and found that it was not suitable for patients with limited mobility. It was poorly lit, the doorway was small and the walking surface uneven. There was a very short steep ramp which would be very difficult to access in a wheelchair. The practice manager intended to oppose the use of this entrance with the hospital management and we were told it was not used at present.

Access to the service

Patients could access care and treatment in a timely way and the appointment system met the needs of patients. Where treatment was urgent patients would be seen the same day if necessary. Reception staff told us there were always enough dentists appointments available to see urgent cases and if necessary the dentist stayed late to finish the daily list. Patients we spoke with told us that the availability of appointments met their needs and they were rarely kept waiting. They said they had no problems obtaining an appointment of their choice. The practice had started telephoning their patients to remind them they were due for a scheduled check-up. We saw patients waiting less than 10 minutes to be seen. The arrangements for obtaining emergency dental treatment were clearly displayed in the waiting room area and in the practice booklet.

Concerns & complaints

The practice had a complaint procedure and policy which we saw was regularly reviewed. Staff we spoke with were aware of the procedure to follow if they received a complaint and forms were available for the purpose. There was information available for NHS and private patients which explained the process to follow, the timescales involved for investigation, the person responsible for handling the matter and details of other external organisations that a complainant could contact. We looked at complaints that had been received in the last 12 months. We found that they had been recorded, investigated and the complainant written to in a timely manner. Steps had been taken to resolve the issues to the patient's satisfaction, a suitable apology and an explanation had been provided where appropriate. It was evident from this record that the practice had been open and transparent. We saw a potential trend in the complaints and we discussed this with the practice manager. We were told that one dentist had suddenly left the practice and the majority of complaints originated from the quick turnover of locum staff. This was consistent with our view of the complaints. We were told that the use of locum dentists had now stopped and a full time dentist was employed. We looked at the complaints recorded and found there had been a dramatic reduction since the employment of the full time dentist. We were told of a process that involved staff appraisals and learning from the events. Support was in place for staff to address some of the areas for personal

Are services responsive to people's needs?

(for example, to feedback?)

improvement. Patients we spoke with on the day of our inspection had not had any cause to complain but felt that staff at the practice would treat any matter seriously and investigate it professionally.

Are services well-led?

Our findings

Governance arrangements The practice had a clinical governance lead in place that was shared with the other practice owned by the same provider. The practice is of small size and shares some business functions with the other practice. We saw a business plan in place and areas for development identified, for example the internal practice policies were extensive. These included health and safety, infection prevention control, patient confidentiality and recruitment. Staff were aware of the policies and they were readily available for them to access. They were able to discuss many of the policies and this indicated to us that they had read and understood them. We looked at a range of policies and found them to all be up to date; there was a system in place to ensure they were updated regularly. Staff felt supported and remarked on the culture within the practice that encouraged them to contribute. We saw evidence of training and continuing professional development that was supported by management and a proactive style of course allocation; this for example identified potential gaps in learning and provided opportunity for action to address these gaps. We examined care records and found they were complete and contained all the necessary details, the practice operated a secure electronic system of notes and we saw evidence of the security in place to protect patient records.

Leadership, openness and transparency

The clinical lead at the practice set standards and ensured they were maintained. Staff were involved and regular team meetings took place. We looked at the records of the team meetings and found that all staff were included and minutes were recorded in detail. The staff we spoke with were aware of all relevant safety and quality issues. We found the culture open and all staff said they felt supported if they had to raise an issue. We found the procedures in place to record and respond to complaints, compliments and comments were robust and contained all the necessary details. Staff spoken with told us that the dentist encouraged them to report safety issues and they felt confident to raise any concerns they had. These were discussed openly at staff meetings where relevant and it was evident that the practice worked as a team and dealt with any issue in a professional manner. All staff were

aware of whom to raise any issue with and were confident that it would be acted on appropriately. We were told that there was a no blame culture at the practice and that the delivery of high quality care was part of the practice ethos.

Management lead through learning and improvement

Regular staff meetings took place and all relevant information cascaded to them. Prior to meetings staff were encouraged to consider items for the agenda and meetings were used positively to identify learning and improvement measures. The meetings were used to share experience; there was a standing agenda that included opportunities to learn. Staff appraisals were used to identify training and development needs. These would provide staff with additional skills and to improve the experience of patients at the practice. The practice had been carrying out audits of quality of radiography, infection control and the information contained in patient records.

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

The practice had conducted an on-going patient survey by asking patients to complete a questionnaire about the services they provided, this had been completed in April 2013 and we saw an analysis of this survey. There was a general theme of satisfaction and this was supported by the patient feedback cards we saw together with reports from the patients we spoke with. This survey contained items such as how many visits the patient had completed in the last year, waiting times for appointment and their views regarding their treatment. The practice manager stated that the practice had started the NHS friends and family tests but there were no published results at the time of our inspection. The practice reviewed the feedback from patients who had cause to complain. A system was in place to assess and analyse complaints and then learn from them if relevant, acting on feedback when appropriate. We saw results of internal investigation that had arisen after complaints had been made and we saw improvements that the practice had made as a result. Staff we spoke with told us their views were sought at appraisals, team meetings and informally. They told us their views were listened to and they felt part of a team, the practice manager was identified as the first point of contact if they had a point to raise and we spoke with that manager about how they action such views.