

Simply Smile Manor House Limited

Manor House Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 6 May 2015. The practice has three dentists; two are fulltime and one works 16 hours per week. In addition there are seven dental nurses (three of which are in training) and four dental hygienists. There is a practice manager, a financial manager and a receptionist. The practice provides primary dental services to both NHS and private patients. The full time dentists provide both NHS and private treatments and the dentist who works 16 hours per week sees predominantly private patients. The practice is open Monday to Friday between 9.00 am and 5.00 pm. 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 two patients and reviewed 24 CQC comment cards which had been completed by patients prior to the inspection. All of 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. The provider was providing care which was safe, effective, caring, responsive and well-led and the regulations were being met.

Our key findings were:

- The practice recorded and analysed significant events and complaints and cascaded learning to staff.
- Where mistakes had been made 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.

Summary of findings

- The practice was well-led, staff felt involved and worked as a team.
- Governance systems were effective and there was a range of clinical and non-clinical audits to monitor the quality of services.
- The practice sought feedback from staff and patients about the services they provided.

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

- Improve some aspects of infection control procedures in line with published guidance.
- Commission a current fire inspection for the building.

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 this practice was providing care which was safe in accordance with the relevant regulations. The practice had effective systems and processes in place to ensure all care and treatment was carried out safely. The practice responded to national patients safety and medicines alerts and took appropriate action. 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. Infection control procedures should be brought in line with published guidance but overall were robust and staff had received training. Radiation equipment was suitably sited; however, there should be increased signage to improve safety. We saw that the radiation equipment was used by trained staff only. Emergency medicine 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, it was 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 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 caring 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 handled complaints in an open and transparent way and apologised when things went wrong.

Are services well-led?

We found this practice was providing care which was well led in accordance with the relevant regulations. The practice provided clear leadership and involved staff in their vision and values. Regular staff meetings took place and minutes were taken. Care and treatment records were audited 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

Summary of findings

making improvements in procedures. There was candour, openness, honesty and transparency amongst all staff we spoke with. A range of clinical and non-clinical audits were taking place. The practice sought the views of staff and patients, and there had been a recent patient survey which was due to be repeated. Health and safety risks had been identified which were monitored and reviewed regularly.

Manor House Dental Practice

Detailed findings

Background to this inspection

The inspection took place on 6 May 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 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 and reviewed policies, procedures and other documents. We spoke with two patients and reviewed 24 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 all 11 complaints that the practice had received in the last twelve months and found that they had been recorded, analysed, investigated and learning had been identified. We found that complainants had been responded to in a timely manner and the practice displayed a duty of candour, offering an explanation, an apology and being open and transparent about the issues that had been raised. The practice had identified a theme regarding communication from some of these complaints and taken steps to address that issue. Any learning identified was cascaded to staff at team meetings or personally to individual staff members if relevant. 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 one of the dentists. Where they affected patients their electronic patient record was noted and this alerted the dentists each time the patient attended the practice. 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 as to the risk to staff and patients. 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 dentists or the practice manager. We tracked two complaints from beginning to end and found appropriate communication between the practice and complainants; they were given explanations and apologies where appropriate. We saw a list of clinical concerns and appropriate investigations carried out by a senior dentist. We examined one such recorded concern and found the investigation was appropriate and learning outcomes had been identified and acted upon. We saw minutes of the practice meetings where complaints and incidents formed part of standard agenda items and were shared with staff.

Reliable safety systems and processes (including safeguarding)

All staff at the practice were trained in safeguarding and there was an identified lead who was the practice manager. We spoke to all grades of clinical staff, the reception staff and business lead, all were aware of the different types of abuse and who to report them to if they came across 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 spoken with on the day of the inspection 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 dentists or practice manager. However they felt confident that any issue would be taken seriously and action taken by the business manager if necessary. The practice has a clinical manager who provides company oversight who would investigate any concerns of a clinical nature independent of clinicians in the practice. We were told the rubber dams during root canal treatment were not always used by every dentist in the practice. We discussed this with the clinical lead who agreed to ensure this became standard practice.

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, an Automated External Defibrillator AED and oxygen were readily available if required. 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 including the use of the defibrillator 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 the equipment and drug 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 when employing new staff. This included obtaining

Are services safe?

proof of identity, checking skills and qualifications, registration with professional bodies where relevant, references and whether a Disclosure and Barring Service check was necessary. We looked at four 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, part-time staff were contacted to attend the practice and cover for their colleagues. The practice did not employ agency staff but was aware of the checks into qualifications and competencies should this become necessary in the future. The practice policy was to perform DBS checks on all clinical staff and the receptionist; we looked at the records and found that all these staff had a current certificate of check completed. 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 patients and staff who attended the practice. The 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 that this had been done in 2011. Since this time the building had remained unchanged in terms of layout and occupation; however the risks associated with a very old building mean that an up to date assessment was needed. This was to ensure those risks were managed appropriately. The practice undertook to carry out a further fire assessment in the near future.

Infection control

The practice was visibly clean, tidy and uncluttered. We saw cleaning contracts in place and spoke to the dental nurses 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 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 accordingly. The practice is sited in a grade 1 listed building and faces onto a main road; this produced some challenges for the practice in terms of maintaining hygiene. This was in terms of the dust generated by an old building and from road traffic. We found the practice did not regularly examine surgeries for the impact arising from increased risk due to the building and location. We spoke to the practice manager and they agreed to put an inspection process in place to ensure that environmental conditions do not adversely affect the standards expected. An infection control audit had been carried out on an annual basis for the last two years with the last audit being in March 15, this reflected that infection control procedures were robust. Where areas for improvement had been identified, these had been recorded then actioned. We found that 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 this 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). On the day of our inspection, a dental nurse demonstrated the decontamination process to us and used the correct procedures. At the end of the sterilising procedure the instruments were correctly packaged, 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 and these included disposable gloves, aprons and protective eye wear . The equipment used for cleaning

Are services safe?

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. Staff told us that they wore personal protective equipment when cleaning instruments and treating people who used the service. Staff files examined showed that all clinical staff were up to date with Hepatitis B immunity. We saw an updated internal policy concerning the removal of matrix bands (a matrix band is a metal band used dentists to secure around the crown of a tooth to confine the restorative material filling a cavity). This updated policy ensured the bands are removed in the surgery and were not transported to the decontamination room. The practice had a legionella risk assessment in place and conducted regular tests on the water supply. This included maintaining records and checking on the hot and cold water temperatures achieved. An external contractor attended annually to ensure that procedures were in place to reduce the risk to staff or patients. The last visit took place in July 2014 and the practice was graded as meeting the necessary requirements.

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 in sufficient quantities. We spoke to clinical staff all of which understood the indications for the use of emergency medicines and 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. We did note that one x-ray machine on the ground floor was operated directly behind a wooden door. There was a sign on the door to indicate the presence of the machine but there was no signage that the machine was in operation or a physical barrier to ensure the door was not opened. We discussed this with the clinical manager who agreed to update this area to ensure measures were put in place to protect patients and staff. 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 people 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 July 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.

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 was completing an audit regarding outcomes in radiography with the intention of improving outcomes, this had not been finalised on the date of our inspection. The dental assessments were carried out in line with recognised guidance from the National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC) guidelines. 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

A dental therapist/hygienist and two hygienists worked at the practice on a full time basis. The dentist and dental therapist provided advice to improve and maintain good oral health. Details of discussions between the clinician and their patient were recorded which included diet advice, the use of fluoride paste, rinses and smoking cessation advice. The dental therapist 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 Department of Health 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. We spoke with the clinical manager who had conducted an audit on the notes completed and follow up of treatment concerning periodontal care; we were told this review would ensure that all future treatments and notes were consistent with current guidelines.

Staffing

The practice has three dentists two of which are fulltime and one works 16 hours per week, in addition there are seven dental nurses three of which were trainees and four part time dental hygienists. There is a practice manager, a financial manager and a receptionist. 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. Most staff had received annual appraisal, staff spoken with felt supported and involved in the appraisal process. They were given the opportunity to discuss their training and career development needs and were graded on their performance. Staff we spoke to felt the process was fair and they felt valued. They told us that

Are services effective?

(for example, treatment is effective)

managers were supportive and always available for advice and guidance. We spoke with the clinical manager who had a programme in place to appraise the dentists and saw evidence of dates where these appraisals were planned. The practice did not use locum dentists or nurses but we did see a staff file for a nurse that only worked occasionally to cover short term absences. This staff file was up to date and contained relevant information to ensure competence. Staff had access to the practice computer system and policies, these 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. There was in addition, a comprehensive list of written policies in the practice managers office.

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 a robust clinical relationship with a hospital that provides secondary care. 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 that 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, it was not possible to hear conversations outside these rooms. We saw that patients who had an uncomfortable experience were reviewed by the clinical team in order to provide relief from pain and discomfort. For example we reviewed a case where a poorly fitting set of dentures could not be correctly adjusted by one dentist, this case was reviewed by senior dentist and the patient reported the situation resolved.

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 5.30pm. Patients with emergencies were seen within 24 hours of contacting the practice, sooner if possible. There were consultation rooms available on the ground floor and first floor affording access for patients with limited mobility; we saw arrangements for wheelchair access including a separate entrance. The practice had completed a patient survey in 2014 with another due as part of the internal appraisal process scheduled for May 2015. We looked at this survey and the practice reflected on its contents. We saw evidence that the practice took account of the content of the survey; for example they commissioned an internal survey on medical histories as a result.

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 from patients using wheel chairs. The practice was located within a house in a residential road, there was a surgery on the ground and first floor. The stairs leading to the first floor were suitable for elderly patients or those with a disability, they had a handrail and the grading/depth of the each step was appropriate. There was a waiting area, patient toilet, hygienist consultation room and a dentist surgery on the ground floor which meant patients could be accommodated according to their needs. Appointments were available at various times of the day and all emergency patients or those with specific needs could be met.

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 was always enough dentists available to see urgent cases and if

necessary the dentists 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. Staff we spoke with told us that patients could access appointments when they wanted them and patients we spoke with and comment cards we viewed confirmed this.

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. The procedure explained to patients 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. There was material readily available to read that explained the complaints procedure for both private and NHS patients. There was a notice board in both waiting rooms that also outlined the procedures and practice policy. We looked at the patient survey for 2013-2014 and found that for patients responding 100% of them replied they had not had to make a complaint in that period; this was mirrored by the patients we spoke to. 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 both the clinical lead and practice manager. 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 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 new clinical governance lead in place who was shared with other practices, this lead is extremely experienced and we found the contribution to the practice very worthwhile. The practice is of moderate size and shares some business functions with a group. We saw a business plan in place and areas for development identified, for example the internal practice policies were being updated and we saw evidence of the new policies in place. There was a full range of policies and procedures in use at the practice. These included health and safety, infection prevention control, patient confidentiality and recruitment. Staff we spoke with were aware of the policies and they were readily available for them to access. Staff spoken with 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. The staff we spoke with 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. We looked at five staff files and found they were complete and contained the relevant information such as pre-employment checks, identity checking, DBS checks, professional registration, learning certificates and appraisals. The practice had a system in place to monitor medicines in use at the practice. We found that there was a sufficient stock of medicines and they were all in date. Records had been kept of the process to check both serial numbers and dates of expiry.

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 including learning, 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

The practice had a new clinical governance lead and a practice manager who had been in place since 2014. The relatively new team were proactive in their approach to improvement and had made many changes to the policies and procedures; for example sharps handling, periodontal note taking and staff appraisals. 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.

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

The practice had conducted a recent patient survey by asking patients to complete a questionnaire about the services they provided, this had been completed in September/October 2014 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 reviewed the feedback from patients who had cause to complain. A system was in place to assess and

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analyse complaints and then learn from them if relevant, acting on feedback when appropriate. 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.