AJC Hereford Limited

Collins House Dental Surgery - Hereford

Inspection Report

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Overall summary

We carried out a comprehensive inspection of Collins House Dental Surgery on 14 January 2015.

The practice provides NHS dental treatment and private dental treatment. It is part of a national dental payment plan scheme and takes part in that organisation's quality assurance arrangements.

The practice is situated in a converted former residential property in Hereford city centre. The practice has six dental treatment rooms and a decontamination room for cleaning, sterilising and packing of dental instruments. The main reception area and waiting room are on the ground floor and there are additional waiting areas near to the treatment rooms.

The practice has a full time practice manager. The principal dentist is registered with the Care Quality Commission as the registered manager. They are legally responsible for making sure the practice meets the regulations from the Health and Social Care Act 2008 relating to the quality and safety of care.

The practice has four dentists, two dental hygienists, a dental therapist and eight dental nurses. The practice manager and clinical team are supported by three receptionists.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to use to tell us about their experience of the practice. We collected seven completed cards. These provided a positive view of the service the practice provides. Patients told us that the care and treatment they received was caring, patient and thorough. They praised the skills of the clinical staff and the professionalism of the whole practice team.

The dental payment plan organisation which the practice was a member of carried out on-going surveys of patients' views about the practice. We saw the results of surveys completed by 940 patients during 2014. These showed that 94% of patients rated the dental team as ideal, 96% felt that cleanliness and hygiene were excellent and 93% considered the team to be competent and explained treatments clearly.

Our key findings were:

- Staff reported incidents and kept records of these which the practice used for shared learning.
- The practice was visibly clean and well maintained.
- Patients' needs were assessed and care was planned and delivered in line with current best practice guidance from the National Institute for Health and Care Excellence (NICE) and other published guidance.

Summary of findings

- The practice had effective safeguarding processes and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Staff had received training appropriate to their roles and were supported in their continued professional development (CPD).
- The practice took into account any comments, concerns or complaints and used these to help them improve the practice.
- Patients were pleased with the care and treatment they received and complimentary about the dentists and all other members of the practice team.

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?

The practice team took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents. The practice had suitable arrangements for infection prevention and control, clinical waste management, dealing with medical emergencies at the practice and dental radiography (X-rays). We found that the equipment used in the dental practice was well maintained.

There were sufficient numbers of suitably qualified staff working at the practice. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and adults.

Are services effective?

The dental care provided was evidence based and focussed on the needs of the patients. The practice used national guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. We saw examples of positive team work within the practice and evidence of good communication with other dental professionals.

The staff received professional training and development appropriate to their roles and learning needs. Staff who were registered with the General Dental Council (GDC) were supported in their continuing professional development (CPD) and were meeting the requirements of their professional registration.

Are services caring?

We collected seven completed CQC patient comment cards. All of the information we received from patients provided a positive view of the service the practice provided. Patients told us that the care and treatment they received was caring, patient and thorough. They praised the skills of the clinical staff and the professionalism of the whole practice team. This information was also reflected in the results of a survey of 940 patients carried out by the dental payment organisation which the practice was a member of.

Are services responsive to people's needs?

The practice provided clear information to patients about the costs of their treatment. Patients could access treatment and urgent care when required. The practice had one ground floor surgery and level access into the building for patients with mobility difficulties and families with prams and pushchairs. The team had access to telephone translation services if they needed this but had checked and established that none of their current patients needed this service.

Are services well-led?

The practice manager and principal dentist worked closely together to co-ordinate the day to day running of the practice. Staff were aware of the way forward and vision for the practice. The practice used the quality assurance processes of a national dental payment scheme to assist them to maintain the quality of the service.

Collins House Dental Surgery - Hereford

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by the CQC.

The inspection was carried out on 14 January 2015 by a CQC inspector.

Before the inspection we reviewed information that we held about the provider and information that we asked them to send us in advance of the inspection. This included their statement of purpose and a record of complaints and how they dealt with them.

During the inspection we spoke with four dentists, three dental nurses, two receptionists and the registered manager. We looked around the premises and some of the treatment rooms. We reviewed a range of policies and procedures and other documents including dental care records.

We viewed the comments made by seven patients on comment cards provided by CQC before the inspection

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

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

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

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

Are services safe?

Our findings

Learning and improvement from incidents

The practice had an adverse incident reporting policy and standard reporting forms for staff to complete when something went wrong. These were kept in the manager's office and were available for any member of staff if they needed to complete one. We saw reporting forms dating back to 2011 showing an ongoing commitment to monitoring safety at the practice. The forms provided a clear structure to help staff record relevant information.

There was also an accident reporting book which we checked. The practice manager showed us that they filed completed accident forms separately to protect the privacy of people involved. They had a system for cross referencing these so they could easily identify and locate them if needed. None of the accidents recorded were serious enough to have been reportable to either RIDDOR or CQC.

The practice manager and principal dentist received national and local safety alerts by email. We saw evidence for a period of two years that they checked these and recorded whether any were relevant to the practice so that staff could be informed and immediate action could be taken.

The practice had a brief but clear written statement which emphasised the value of learning from significant events and other adverse incidents. This included a list of the types of things which might need to be addressed such as laboratory work not being back in time for a patient's appointment, a patient falling downstairs or a complaint about waiting times. The statement described the practice's aim to have an open culture and acknowledged that this was an important part of clinical governance.

Significant events were discussed as a team at staff meetings to provide opportunities for shared learning.

Reliable safety systems and processes (including safeguarding)

The principal dentist and practice manager were the joint safeguarding leads and staff knew who they should go to if they had a concern. The practice manager had taken on the role of joint lead following safeguarding training where it had been recommended to them that the practice have both a male and female lead. The practice had comprehensive information available regarding safeguarding policies, procedures for reporting safeguarding concerns and contact information for the local multi-agency safeguarding hub (MASH). There was written confirmation that staff had read and understood the information which was available in paper form and on the practice's computer system.

All except one member of the team (who was away from work at the time) had completed safeguarding training for adults and children in September 2014. This was provided by the national organisation the practice used for its payment plans and quality assurance.

We saw that the practice had contacted the local MASH for advice on two occasions in the previous year when they had concerns about patients' wellbeing. This showed an awareness of potential concerns although neither case had been considered to meet safeguarding criteria by staff at the MASH.

The practice also had information on how to contact a service provided by Age UK which could be used to offer support to vulnerable adults who did not meet the criteria for safeguarding but who would benefit from support.

The British Endodontic Society uses quality guidance from the European Society of Endodontology recommending the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work. The practice showed us that they had rubber dam kits available for use when carrying out endodontic (root canal) treatment and staff confirmed that they used this. We saw that the dentists had recorded the use of rubber dams in patients' dental care records

The practice had clear processes to make sure that they did not make avoidable mistakes such as extracting the wrong tooth. The dentists told us they always checked and re-checked the treatment plan and re-examined the patient. They said they took particular care with this where they were extracting a tooth on the recommendation of another dentist (such as when carrying out orthodontic extractions). They told us they had a final read of the letter from the orthodontist and also asked the dental nurse assisting them to check this. The dentists were aware that carrying out incorrect dental treatment of any kind would be reportable to CQC.

Are services safe?

Infection control

The 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05) published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for the cleaning, sterilising and storage of dental instruments and reviewed their policies and procedures. This assured us that the practice was meeting the HTM01-05 essential requirements for decontamination in dental practices. Two of the dental nurses shared lead responsibility for infection prevention and control (IPC).

We saw that dental treatment rooms, decontamination room and the general environment were clean, tidy and clutter free. Feedback confirmed that the practice maintained high standards regarding this at all times. The practice employed a cleaner for general cleaning at the practice and we saw that cleaning equipment was safely stored in line with guidance about colour coding equipment for use in different areas of the building. One of the reception team carried out an audit of general cleanliness at the practice every six months.

During the inspection we observed that the dental nurses cleaned the surfaces, dental chair and equipment in treatment rooms between each patient. We saw that the practice had a supply of personal protective equipment (PPE) for staff and patients including face and eye protection, gloves and aprons. There was also a good supply of wipes, liquid soap, paper towels and hand gel available. The decontamination room and treatment rooms all had designated hand wash basins separate from those uses for cleaning instruments.

A dental nurse showed us how the practice cleaned and sterilised dental instruments between each use. The practice had a well-defined system which separated dirty instruments from clean ones in the decontamination room, in the treatment rooms and while being transported around the practice. The practice had a separate decontamination room where the dental nurses cleaned, checked and sterilised instruments. All of the nurses at the practice had been trained so that they understood this process and their role in making sure it was correctly implemented. The dental nurses took it in turns to work in the decontamination room each day and the other dental nurses delivered and collected instruments in colour coded boxes with lids. Different boxes were used for the dirty and clean instruments.

The dental nurse showed us the practice's decontamination processes. This included how staff rinsed the instruments, checked them for debris and used the washer/disinfector and autoclaves (equipment used to sterilise dental instruments) to clean and then sterilise them. Clean instruments were packaged and date stamped according to current HTM01-05 guidelines. They confirmed that the nurses in each treatment room checked to make sure that they did not use packs which had gone past the date stamped on them. Any packs not used by the date shown were processed through the decontamination cycle again.

The dental nurse showed us how the practice checked that the decontamination system was working effectively. They showed us the paperwork they used to record and monitor these checks. These were fully completed and up to date. We saw maintenance information showing that the practice maintained the decontamination equipment to the standards set out in current guidelines.

The practice used single use dental instruments whenever possible and the special files used for root canal treatments were never used for more than one treatment.

A specialist contractor had carried out a Legionella risk assessment for the practice and we saw documentary evidence of this. Legionella is a bacterium which can contaminate water systems. We saw that staff carried out regular checks of water temperatures in the building as a precaution against the development of Legionella. The practice used a continuous dosing method to prevent a build-up of legionella biofilm in the dental waterlines. Regular flushing of the water lines was carried out in accordance with the manufacturer's instructions and current guidelines.

The practice carried out audits of infection control every six months using the format provided by the Infection Prevention Society. The practice also completed an annual IPC report in line with guidance from the Department of Health code of practice for infection prevention and control.

The practice had a record of staff immunisation status in respect of Hepatitis B a serious illness that is transmitted by

Are services safe?

bodily fluids including blood. There were clear instructions for staff about what they should do if they injured themselves with a needle or other sharp dental instrument including the contact details for the local occupational health department. The practice made us aware of this information and asked about our hepatitis vaccination and immunity status before allowing us to go into the decontamination room.

The practice had adopted a policy that all staff should attend occupational health to be checked following a sharps injury even where the risk of infection was assessed as low. The practice manager routinely contacted the patient for whom the instrument had been used to ask them to consider taking a blood test. The member of staff attending occupational health obtained a patient leaflet and the practice manager posted this to the patient concerned. The practice manager told us that all sharps injuries were recorded as accidents and as significant events and we saw evidence that this was done.

The practice stored their clinical and dental waste in line with current guidelines from the Department of Health. Their management of sharps waste was in accordance with the EU Directive on the use of safer sharps and we saw that sharps containers were well maintained and correctly labelled. The practice had an appropriate policy and used a safe system for handling syringes and needles to reduce the risk of sharps injuries.

The practice used an appropriate contractor to remove dental waste from the practice and we saw the necessary waste consignment notices.

Equipment and medicines

We looked at the practice's maintenance information. This showed that they ensured that each item of equipment was maintained in accordance with the manufacturer's instructions. This included the equipment used to sterilise instruments, X-ray equipment and equipment for dealing with medical emergencies. All electrical equipment had been PAT tested by an appropriate person. PAT is the abbreviation for 'portable appliance testing'. The practice manager had a list of dates when all of the equipment was next due to be checked as a quick reference tool.

Prescription pads and antibiotics held by the practice were securely stored. We saw that the practice had a written log of new stock and medicines removed from stock. They also had written records of prescription pads to ensure that the use of these was monitored and controlled.

The practice told us that they were currently conducting an audit of antibiotic prescribing using national guidance. The dentists and practice manager planned to meet discuss the audit results and confirmed that they would repeat the audit in six months.

The batch numbers and expiry dates for local anaesthetics were always recorded in the clinical notes.

Temperature sensitive medicines were stored in a fridge and the staff kept a record of the fridge temperatures.

Monitoring health & safety and responding to risks

The practice had a comprehensive business continuity plan which described situations which might interfere with the day to day running of the practice and treatment of patients. This included extreme situations such as loss of the premises due to fire. The document contained essential information including contact details for utility companies and practice staff. The practice manager and principal dentist had copies of the plan at home so that essential information was always available.

The practice had a practice wide risk assessment which addressed specific risks associated with dentistry as well as general day to day health and safety topics. This had been updated in January 2014. The practice manager told us that they were due to review it shortly and planned to make it more detailed.

We saw that there was a fire risk assessment and the practice manager told us they were due to review this during January 2015. The fire safety records showed that the practice had carried out fire checks and tests every month and that they tested the fire alarm every week. We also saw evidence of regular fire drills over the previous ten years showing a long term commitment to fire safety. All of the staff had taken part in fire safety training in June 2014 which was provided by a specialist fire safety company.

We saw a folder containing detailed information about the control of substances hazardous to health (COSHH). The practice manager told us that they and the principle dentist had decided to improve how this information was set out

to make it more accessible to staff. They showed us that this included clearer information to make it easier for staff to take prompt action in the event of an incident involving substances containing chemicals.

The dental care record system included alerts about information that the team needed to be aware of such as whether patients had allergies or were taking medicines used to thin the blood.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice and the principal dentist was the lead for this. There was an automated external defibrillator (AED - a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). Staff received annual training in how to use this. Four members of the team were designated first aiders and had completed full first aid at work training. The practice had the emergency medicines as advised in the British National Formulary guidance. Oxygen and other related items such as face masks were available in line with the Resuscitation Council UK guidelines.

The emergency medicines were all in date and stored securely with emergency oxygen in a central location known to all staff. The practice monitored the expiry dates of medicines and equipment so they could replace out of date items promptly.

Staff recruitment

The practice showed us evidence that they had obtained all of the required information for members of the team before they had contact with patients.

The practice's written procedures did not contain clear information about all of the required checks for new staff. Two days after the inspection the practice sent us an improved written procedure. This included a flow chart for prospective employees explaining to them what documents they would be expected to provide and what checks the practice would carry out. These included educational certificates, a valid UK Passport or National Identity Card, General Dental Council (GDC) and professional indemnity certificates (if applicable) and Hepatitis B vaccination evidence if available.

The Disclosure and Barring Service 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. The practice had obtained DBS checks for all staff employed there.

The new flow chart that practice developed informed applicants that the practice would carry out a DBS check and informed them what documentation they would need to provide for this. The information informed applicants that they would be asked to provide a written explanation of any gaps in employment. The flow chart also explained that as well as requesting references from applicants' most recent employers the practice would also contact previous employers where the work included contact with children or vulnerable adults.

The practice told us that they had decided to continue to develop this work to create a comprehensive recruitment pack to use for future job applicants.

Radiography (X-rays)

The practice was working in accordance with the Ionising Radiation Regulations 1999 (IRR99) and the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). They had a named Radiation Protection Adviser and Supervisor and a well maintained radiation protection file. This contained the required information including the local rules and inventory of equipment, critical examination packs for each X-ray machine and the expected three yearly maintenance logs.

We saw evidence that the recorded evidence of the reasons why they had taken X-rays and that X-rays were always checked to ensure the quality and accuracy of the images. The principle dentist quality assured this process. One dentist explained they were using a particular type of cone on the X-ray machine which was the same shape and size as an X-ray. This reduced the area that was exposed to radiation. They showed us their on-going clinical audit records for the quality of the X-rays they took; this showed they were using this process to monitor their own performance in this aspect of dentistry.

The dentists and dental nurses involved in taking X-rays had completed the required training. One dental nurse we spoke with explained that she was not yet allowed to actively participate when a dentist took X-rays because they had not completed the necessary training.

Are services effective?

(for example, treatment is effective)

Our findings

Consent to care and treatment

The practice had a consent policy which was up to date and based on guidance from the General Dental Council (GDC). The dentists described the methods they used to make sure patients had the information they needed to be able to make an informed decision about treatment. They told us that they often used pictures and photographs as well as X-rays to illustrate information for patients.

The Mental Capacity Act 2005 provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Staff at the practice had completed training about the MCA and consent during 2014. Members of the team told us that at present they had few patients where they would need to consider the MCA when providing treatment but were aware of the relevance of the legislation in dentistry.

Monitoring and improving outcomes for people

We found that the practice planned and delivered patients' treatment with attention to their individual dental needs and views about the outcomes they wanted to achieve. The dental care records we saw were clear and contained detailed information about patients' dental treatment.

The dentists were using a structured oral health assessment screening tool. This was to help them monitor patients' oral health and communicate areas of concern to patients in a more effective way. The tool used a traffic light style red, amber, green system which the dentists said they and their patients found helpful in understanding their risks of developing dental problems.

The records contained details of the condition of the gums using the basic periodontal examination (BPE) scores. The BPE is a simple and rapid screening tool that is used to indicate the level of treatment needed and offer tailored advice to help patients improve their dental health. We saw that the dentists also checked and recorded the soft tissues lining the mouth and external checks of patients face and necks which can help to detect early signs of cancer.

The practice was aware of the value of clinical audit to help them monitor and improve the care and treatment they provided. One dentist showed us their on-going clinical audit records of their success with endodontic (root canal) treatments. They were reviewing whether patients who had had root canal treatment still had the tooth treated after five years. They had begun their audit with treatments they had carried out in 2006/07 and were currently reviewing patients treated in 2008/09. The audit looked at whether the tooth had survived, was symptom free and, if not, whether the loss of the tooth was related to the treatment or some other cause. Their results to date showed high success rates.

The dentists we spoke with were aware of various best practice guidelines including National Institute for Health and Care Excellence (NICE) guidelines and the Faculty of General Dental Practice Guidelines.

Working with other services

We saw evidence that the practice used liaised with other dental professionals and made appropriate referrals to other services when this was needed. For example, they referred children who needed orthodontic treatment to specialists in this aspect of dentistry. The practice took part in a scheme with other local dentists to provide reciprocal arrangements for emergency dental treatment outside surgery hours. This service was available to patients using the payment plan or paying for treatment direct to the practice.

Health promotion & prevention

The practice was aware of the Public Health England 'Delivering Better Oral Health' guidelines and was proactive in providing preventative dental care as well as carrying out restorative treatments.

The practice was increasingly developing the role of the dental hygienists and dental nurses to help patients improve their oral health. We learned that some of the dental nurses had completed extended training to enable them to carry out assessments of patients' risk of developing dental decay. This was viewed a part of their role in promoting good oral health and included saliva testing as well as looking at patients' diets and offering help and advice where required.

One of the dentists had a particular interest in preventative dentistry and a minimal intervention approach to dental treatment. They told us that they were completing a master's degree focussed on this and showed us examples of their record keeping regarding patients care and treatment. We saw that they used photography as an integral part of patients' treatment plans and for oral health education with adults and children.

Are services effective?

(for example, treatment is effective)

The water supply in Hereford does not contain fluoride and the practice offered fluoride varnish applications as a preventive measure for adults and for children.

Staffing

The practice manager had been at the practice for about a year. They were developing their knowledge and experience in their role and were fully supported by the principal dentist and other members of the practice team.

We saw evidence that members of the clinical team had completed appropriate training to maintain the continued professional development required for their registration with the General Dental Council. This included medical emergencies in dental practices, infection control, child and adult safeguarding, dental radiography (X-rays), oral cancer and other specific dental topics. The staff files contained details of confirmation of current General Dental Council (GDC) registration, current professional indemnity cover and immunisation status. The practice manager had a system for monitoring this information.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The patients who completed comment cards were complimentary about the care and treatment they received at the practice. Some highlighted that they had been patients for many years or had remained patients even after moving away from Hereford. Patients commented on the kindness and gentleness of their dentist as well as the positive attitudes approach of the whole team. All the staff we met spoke about patients in a respectful and caring way and were aware of the importance of protecting patients' privacy and dignity.

This view was reflected in information patients had written in compliments made directly to the service.

Involvement in decisions about care and treatment

When we looked at dental care records we saw that the dentists recorded information about the explanations they had provided to patients about the care and treatment they needed. This included details of alternative options which had been described. One dentist explained and showed us how they described root canal treatments to patients using leaflets about the subject and models of teeth. A dentist showed us a detailed letter they had written to a patient which included photographs and guidance about the risks and benefits of the available treatment options. We saw another example where a patient had been to the practice for an emergency appointment. The dental care records showed that the dentist gave them information about the risks and benefits of the possible treatment options. They provided temporary treatment so that a full treatment plan could be discussed in a longer appointment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice provided NHS dental treatment and private dental treatment which patients could choose to pay for though a national dental payment plan scheme. The practice statement of purpose and website provided information about the types of treatments that the practice offered.

Herefordshire does not have fluoride in its drinking water and the practice offered fluoride varnish application for children and adults. One of the dental nurses was receiving extended training to enable them to provide this and another was completing an oral health education course.

Tackling inequity and promoting equality

The practice had an equality and diversity policy and aimed to provide the same quality of care to all its patients even though treatment options might vary for NHS and private patients. Hereford has a significant eastern European community and the practice had conducted an audit and checked with patients to find out whether any of their patients would benefit from having an interpreter for their appointments. This work had established that no patients needed this at present.

There was level access into the building through the rear door from the car park. The practice had one treatment room on the ground floor for patients unable to go upstairs. There was also an accessible toilet. The practice had a portable hearing loop to benefit patients who used hearing aids. The principal dentist told us that because there were limited accessible toilet facilities in Hereford they had informed patients that they could use those at the practice.

Access to the service

The practice was open from 8.30am to 5pm from Monday to Friday apart from Tuesdays when it was open until 7pm.The practice aimed to provide same day emergency treatment during opening hours and took part in a local scheme amongst a group of local dental practices to provide emergency dental treatment outside surgery hours. Information about this was provided on the practice website and on the out of hours answer phone message. The practice provided NHS patients with details of how to access NHS emergency out of hours dental care.

Concerns & complaints

The practice had a complaints process which was available on the practice website as well as in print at the practice. We looked at information available about comments, compliments and complaints dating back four years. The information showed that there was a longstanding commitment to listening to concerns raised and discussing these with the practice team so the learning about these could be shared. We noted that there were far more compliments recorded than concerns and that the practice recorded informal concerns as well as more significant ones. These related to the environmental impact of the practice due to the number of light bulbs and other electrical features, a request for incentives for existing patients in line with those for new ones, waiting times and a request for coat hooks to be provided.

We also looked at the practice's summary of more formal complaints and the records of some of these. These showed that the practice had listened to patients views and concerns, looked into these and offered explanations and where necessary an apology. We noted that in some cases the responses made to patients had been verbal rather than in writing. Each complaint summary identified the learning for the practice such as improving communication with patients. Because several concerns had been raised about this topic the practice had arranged communication training for the whole staff team.

Are services well-led?

Our findings

Leadership, openness and transparency

The practice had a relatively new but enthusiastic and empowered practice manager who was being given effective support by the partners. They had started work at the practice in 2014 and this was their first post as a practice manager although they had previously had a more junior management role in a dental practice. They were enrolled on a level four practice management course which the practice had funded.

We saw that relationships between members of the practice team were professional, respectful and supportive. Staff in all roles described the practice as a happy place to work where they were supported by the partners and other team members.

Governance arrangements

The practice partners held meetings to discuss a range of business, clinical and administrative topics. We saw that they kept minutes of these and that they discussed actions from previous meetings. The practice told us that they were planning to extend the opportunities that the team had for shared learning by introducing additional regular scheduled meetings for clinical discussions involving the dentists and dental hygienists.

The practice had a range of policies and procedures to support the management of the service. We saw that relevant risk assessments were available. These covered general environmental risk factors and specific risks related to the provision of dental services.

The practice had a brief but clear written statement which emphasised the value of learning from significant events and other adverse incidents. This included a list of the types of things which might need to be addressed such as laboratory work not being back in time for a patient's appointment, a patient falling downstairs or a complaint about waiting times. The statement described the practice's aim to have an open culture and acknowledged that this was an important part of clinical governance.

The practice was part of a national dental payment organisation which provided different levels of quality assurance scrutiny for member practices. Collins House had chosen to take part in the highest level of quality monitoring. We saw the results of their most recent quality monitoring visit by this organisation in December 2014. The practice had achieved 100% scores in all of the areas looked at including the dental care records and X-ray processes. The only recommendation made related to obtaining more detailed results of staff Hepatitis B status. The principle dentist told us that staff did not always receive this level of detail when they had their test results.

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

The dental payment plan organisation which the practice was a member of carried out on-going surveys of patients' views about the practice. We saw the results of surveys completed by 940 patients during 2014. These showed that 94% of patients rated the dental team as ideal, 96% felt that cleanliness and hygiene were excellent and 93% considered the team to be competent and explained treatments clearly.

As a result of comments from patients in those surveys the practice had introduced free access to Wi-Fi, provided a range of sugar free snacks for patients to buy at reception and made a commitment to work hard to reduce the time patients were kept waiting for their appointments. In response to a comment made direct to the practice the practice manager was looking into providing a coat rack.

Staff told us that the practice manager and dentists were approachable and that they could discuss anything they needed to.

The practice was planning to adopt the NHS Friends and Family test as an additional measure of the quality of the service they provided.

Management lead through learning and improvement

The practice took learning and development seriously and encouraged staff to take part in activities to develop their knowledge and skills. We found that the clinical dental team all undertook the necessary learning to maintain their continued professional development which is a requirement of their registration with the General Dental Council (GDC). .

The practice had regular team meetings which were used to share information and to discuss significant events and complaints. These provided opportunities for shared learning within the team. Some of the meetings were for the whole team while others were for the dentists and hygienists and for the dental nurses to focus on clinical topics.