

Kettering Central Dental Practice Partnership

Mydentist - Gold Street - Kettering

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 1 December 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Mydentist Gold Street Kettering provides primary dental care and treatment to patients whose care is funded through the NHS and to a small number of patients who pay privately. The service is part of the Partnership owned by a large provider of dental care, the IDH Group currently rebranding to Mydentist. The practice employs four dentists, four dental nurses, a trainee dental nurse, a practice manager and three receptionists. The practice opens 8.30am to 5pm Monday to Friday.

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 received feedback from 46 patients either in person or via CQC comments cards from patients who had visited the practice in the two weeks before our inspection. The cards were all very positive showing that patients valued the service they received. Patients said that staff were very welcoming and helped them to reduce their anxiety.

Summary of findings

They told us staff listened to them, involved them in decisions about their care and patients were very complimentary about the treatment and overall service they had experienced.

Our key findings were:

- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- The practice had access to emergency equipment and this included an automated external defibrillator and medical oxygen. Emergency medicines were in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- The training, learning and development needs of staff members were assessed and staff were supported to receive professional development.
- Governance arrangements were in place for the smooth running of the practice. This included audits for infection control, dental care records and radiography.
- Accidents were investigated and appropriate action was taken although the records required further improvement. Other incidents that caused, or had the potential to disrupt day to day services were actioned and reported to head office although there was no clear method to identify these as significant events and ensure appropriate monitoring.
- A complaints process was in place and this was managed effectively so that learning and improvement took place.

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

- Review guidelines for identifying, recording and monitoring any significant events to control risks, maximise learning and maintain the smooth running of the service.
- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society.
- Review procedures to ensure that all risk assessments are reviewed in a timely way. This should include the COSHH file and easy access to the action staff should take in the event of an incident with such products. The fire risk assessment also required a review.
- Review the signage of clean and dirty flows in the decontamination room so that it is clear.
- Review the safeguarding policy to include the named staff member with overall responsibility for safeguarding and any localised arrangements.
- Consider installing a hearing loop at the premises.
- Consider adding information about obtaining emergency care out of hours on the practice website.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had appropriate systems in place to manage the service in a safe way. This included investigating and taking action following any accidents and complaints. Incidents had been well managed, however there was no process for identifying these as significant events that caused a risk to the service to ensure that learning was maximised. Patients were informed if mistakes had been made and given suitable apologies. Staff had received relevant training and were suitably skilled to meet patient's needs. Safeguarding procedures were in place and staff were able to demonstrate knowledge of the training they had received. The practice followed national guidelines for infection control and radiation equipment. Regular checks and maintenance of equipment ensured that all items were safe and fit for use. This included emergency equipment and medicines.

Are services effective?

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

Consultations were carried out in line with best practice guidance from the National Institute for Health and Care Excellence (NICE). Patients received a comprehensive assessment of their dental needs 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 and staff followed appropriate guidelines for obtaining patient consent.

Are services caring?

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

Staff treated patients with dignity and respect and ensured their privacy was maintained. Patient information and data was handled confidentially. Patients told us that staff were caring, professional and always had time to listen to them. Treatment was clearly explained and they were provided with treatment plans and costs. 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 that this practice was providing responsive care in accordance with the relevant regulations.

Appointment times met the needs of patients and waiting times were kept to a minimum. 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. Patients who had difficulty understanding care and treatment options were supported. The practice had a complaints policy that outlined the process to deal with complaints in an open and transparent way and apologise when things went wrong.

Are services well-led?

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

The practice followed a clear leadership structure and staff were confident in fulfilling their roles and responsibilities. Regular staff meetings took place and these were recorded and shared. Staff told us they felt supported by the practice manager and they received support to maintain their professional development and skills. Governance procedures were in place and policies and procedures were regularly updated. A system of quality monitoring checks

Summary of findings

was well established and action was taken when improvements were identified. Patient care records we reviewed were complete and information was stored securely to protect patient's confidential information. There was candour, openness, honesty and transparency amongst all staff we spoke with. The practice sought the views of patients through an on-going satisfaction survey and the results and actions were displayed in the waiting room.

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Detailed findings

Background to this inspection

The inspection took place on 1 December 2015 and was carried out by a CQC inspector and a dental specialist advisor.

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.

The methods that were used during the inspection included talking to people using the service, interviewing staff, making observations of the environment and staff actions and a review of documents.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had a process in place for reporting and recording any incidents or accidents. There had been two reported accidents in the last two years. We saw records to show these were investigated although further improvement could be made to ensure that all of the details were accurately recorded. This included telephone calls made by a member of staff to the patient the following day to ensure they did not have an adverse effect following the accident. Accidents were also reported to the provider's head office.

We found the practice did not have a process for identifying significant events in the same way as incidents and accidents. For example there had recently been a flood in one room of the premises. This had caused minimal disruption to the service. However it was not considered as a significant event to ensure that any learning or improvement could take place. Similarly, the alarm at the practice had been triggered one night. This had not been recorded and the practice could not provide a record of any investigation that had taken place.

Staff were encouraged to be open and report any issues of concern or raise comments to the practice manager.

We spoke with staff who told us they followed steps to ensure there were no errors with wrong site surgery. For example they ensured they checked with the patient, referred to X-rays and records.

We looked at a complaints policy which clearly outlined the practice would apologise if things had gone wrong. Records we reviewed showed us that when things went wrong, patients were given an apology and informed of any actions taken as a result.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding adults. This included contact details for the local authority's safeguarding team, social services and other agencies including the Care Quality Commission. Staff had completed safeguarding training and demonstrated to us their knowledge of how to recognise the signs and symptoms of abuse and neglect. There was a safeguarding policy in place for adults and

children that contained details of the reporting process. This needed to be updated to include the named staff member with overall responsibility for safeguarding and any localised arrangements. No safeguarding issues had been reported.

A risk assessment had been undertaken for the safe use of sharps (needles and sharp instruments) in April 2015. Safe syringe systems were used to minimise risks to staff from inoculation injuries. Other risk assessments for use of sharp instruments that may put staff at risk of injury were due for review in September 2014.

We spoke with two dentists who were available during the inspection. One dentist used rubber dam during root canal treatments. A rubber dam is a thin rectangular sheet, usually made of latex rubber, used in dentistry to isolate the operative site from the rest of the mouth. Records were available to demonstrate this. The other dentists did not use rubber dam. They could not evidence to us the alternatives that were discussed or any other precautions that were taken to protect the patient's airway during the treatment.

Medical emergencies

When reporting on medical emergencies, the guidance for emergency equipment is in the Resuscitation Council UK guidelines and the guidance on emergency medicines is in the British National Formulary (BNF).

The practice had access to an automated external defibrillator. (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm).

Emergency medicines were available at the practice in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice. We checked the emergency medicines and saw that the appropriate medicines were available and within their expiry dates. We saw records to show that the drugs were checked monthly.

A suitable portable oxygen cylinder was available and equipped to use with adults and children in an emergency situation.

Staff recruitment

The staffing levels at the practice were stable. No new staff had been recruited within the last five years. There were

Are services safe?

policies and procedures in place to guide the safe recruitment of staff when it was needed. It was the provider's policy to complete Disclosure and Barring Service (DBS) checks for all staff and records we reviewed demonstrated these were all in place.

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies. We found the practice had been assessed for risk of fire in 2012 and all of the recommended actions were completed. We were not shown an updated fire risk assessment. Fire marshals had been appointed, fire safety signs were clearly displayed, fire extinguishers had been recently serviced and staff were able to describe the action they should take in the event of a fire. Staff completed a daily sign in/out log which showed at a glance who was in the premises should a fire or other emergency occur.

The practice had a health and safety risk management process in place which enabled them to assess, mitigate and monitor risks to patients, staff and visitors to the practice. There was a business continuity plan in place.

There were some arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. We looked at the COSHH file and found risks (to patients, staff and visitors) associated with substances hazardous to health had been identified. Information about the action to be taken in the event of an exposure such as ingestion or splashes to the eyes could be made much clearer so that staff have ready access to the information. It was unclear when the COSHH file had last been reviewed or updated.

Infection control

There were effective systems in place to reduce the risk and spread of infection. We asked to see the infection control policy and were provided with a policy dated August 2012. The provider has issued a revised policy since our inspection and the practice sent evidence of this. Several other infection control manuals were available for staff reference.

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 we found that staff followed appropriate disposal for all waste products. Sealed waste containers were stored securely until collection.

We examined the facilities for cleaning and decontaminating 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. The lead dental nurse showed us how reusable instruments were decontaminated. There were separate zones for clean and dirty instruments to prevent cross contamination of instruments although the signs to guide staff could be made clearer. Staff wore appropriate personal protective equipment (including heavy duty gloves and a mask) while instruments were decontaminated and rinsed prior to being placed in an autoclave (sterilising machine). Once sterilised, instruments were placed in pouches and dated to indicate when they should be reprocessed if left unused.

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

We observed how waste items were disposed of and stored. The practice had an on-going contract with a clinical waste contractor. We saw the differing types of waste were appropriately segregated and stored at the practice. This included clinical waste and safe disposal of sharps. Staff confirmed to us their knowledge and understanding of single use items and how they should be used and disposed of which was in line with guidance.

We looked at the treatment rooms where patients were examined and treated. The rooms and equipment appeared visibly clean. Hand washing posters were displayed next to each dedicated hand wash sink to ensure effective decontamination. Patients were given a protective bib and safety glasses to wear each time they attended for treatment. There were good supplies of protective equipment for patients and staff members.

Records showed a risk assessment process for Legionella had been completed. This process ensures the risks of Legionella bacteria developing in water systems within the premises had been identified and preventive measures taken to minimise the risk of patients and staff developing

Are services safe?

Legionnaires' disease. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). Staff also conducted regular tests on the water supply. This included maintaining records and checking on the hot and cold water temperatures achieved.

The last infection control audit had been carried out in November 2015 and we found the audits were completed regularly. Where areas for improvement had been identified, these had been recorded then actioned.

There was a good supply of environmental cleaning equipment which was stored appropriately. The practice had a cleaning schedule in place that covered all areas of the premises and detailed what and where equipment should be used. This took into account national guidance on colour coding equipment to prevent the risk of spreading infection.

Equipment and medicines

There were systems in place to check equipment had been serviced regularly, including the dental air compressor, autoclaves, fire extinguishers, oxygen cylinder and the X-ray equipment. We were shown the annual servicing certificates.

An effective system was in place for the prescribing, dispensing, use and stock control of the medicines used in clinical practice such as antibiotics and local anaesthetics. These medicines were stored safely for the protection of patients.

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 in the treatment rooms.

X-ray machines were the subject of regular visible checks and records were maintained to support this. 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 and this included the four dentists and one dental nurse. This meant that patients were protected against the risks associated with taking X-rays as the staff were all competent in the safe use of the equipment.

We saw records that indicated the X-ray equipment had been inspected the day prior to the inspection visit.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice asked patients to supply them with an assessment of their medical history, current health, medication being taken and any allergies. The information was reviewed at appropriate intervals to ensure that any potential health issues were considered as part of their dental assessment and treatment plan.

Patients 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 dietary advice 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 patients were very satisfied with the assessments, information they received and the quality of the dental care they received.

Health promotion & prevention

The practice promoted the maintenance of good oral health as part of their overall philosophy and had considered the Department of Health publication 'Delivering Better Oral Health; a toolkit for prevention' when providing preventive oral health care and advice to patients.

The dentists also focused on treating and giving advice on the prevention of decay and gum disease. This included advice on tooth brushing techniques and oral hygiene products such as high fluoride toothpaste for adults at high risk of decay. There was some information available for patients about oral health on the practice website and information leaflets were provided to patients as required. Health promotion information was displayed in the waiting rooms and leaflets to guide patients on good dental health were available. This included information for parents and guardians of children to support good dental care.

CQC comment cards that we viewed and patients we spoke with confirmed that they had received helpful health promotion advice.

Staffing

The practice employed four dentists some of whom worked on a part-time basis. In addition there was a practice manager, a lead receptionist and two other receptionists, four dental nurses and one trainee dental nurse. The lead dental nurse had extended duties in radiography and the application of fluoride treatments.

Planned staff leave could be covered with support from another local practice run by the provider. If this was not possible agency staff were used from time to time. We saw the practice used a clear induction process for agency staff.

There was a system in place to monitor staff training and we found evidence of this in their personal files. There was a head office based training academy and we saw records that showed staff completed core training through eLearning as well as in person. This included areas such as responding to medical emergencies and infection control and prevention.

There was an appraisal system in place which was used to identify training and development needs. Staff told us they had found this to be a useful and worthwhile process; they felt well supported by the practice manager and they were given opportunities to learn and develop. A clinical manager for the area completed the dentists' appraisals.

Are services effective?

(for example, treatment is effective)

Working with other services

When required, patients were referred to other dental specialists for assessment and treatment. The practice had a system in place for referring and recording patients for dental treatment and specialist procedures such as orthodontics, oral surgery and sedation. This ensured that patient's needs were followed up appropriately after their treatment and dental records were updated.

The dentists we spoke with referred patients to specialists within the corporate group, or to local services if the treatment required was not provided by the practice. This was always completed following discussion with the patient so that informed choices could be made where possible. Staff told us the care and treatment required was fully explained to the patient and referrals were completed promptly.

Consent to care and treatment

The practice ensured valid consent from patients was obtained for all care and treatment. Staff confirmed

individual treatment options, risks and benefits were discussed with each patient who then received a detailed treatment plan and estimate of costs. Patients were given time to consider and make informed decisions about which option they wanted and this was recorded in their dental care records.

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Two dentists we spoke with demonstrated an understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment. This included assessing a patient's capacity to consent and when making decisions in a patient's best interests. They were also familiar with the Gillick principles to ensure that children and young people were enabled to make their own decisions about their treatment if this was age appropriate.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Staff explained how they ensured information about patients using the service was kept confidential particularly at the reception desk. When a patient required a confidential discussion about their care or treatment staff ensured these took place in a treatment room where information could not be overheard. Patients' electronic dental care records were password protected and paper records were stored securely in locked cabinets.

On the day of our inspection, we observed staff being polite, friendly and welcoming to patients.

We received a total of 43 CQC comments cards completed by patients during two weeks leading up to the inspection. The cards were all very positive showing that patients valued the service they received. Patients said that staff were very caring and helped to reduce their anxiety, provide them with support and listened to their needs.

Involvement in decisions about care and treatment

We received comments on the CQC cards from patients who told us they received a good level of information about their treatment or general dental needs that enabled them to make choices about their treatment. They also felt able to ask their dentists questions about their treatment and told us they were happy with the outcomes of their treatment. Patients we spoke with confirmed they received information about their dental costs prior to any treatments taking place. We also found that information about treatment costs for NHS and any private dental care was displayed in the waiting room.

We spoke with staff who gave us examples of individualised care that enabled patients to make their own decisions. For example allowing a patient with a learning disability to make choices and informed decisions about their own care before seeking support from their carer. Records we checked showed that patients consent had been obtained before treatment plans were progressed.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice leaflet and website explained the range of services offered to patients. This included regular check-ups, fillings, extractions, root canal, dentures, bridges and crowns. The practice undertook mainly NHS and some private treatments. Costs were displayed in the waiting room and were also explained to patients during their consultation.

Staff reported (and we saw from the appointment records) the practice had a system in place to schedule enough time to assess and undertake patients' care and treatment. Staff told us they did not feel under pressure to complete procedures and always had enough time available to prepare for each patient.

Emergency appointment slots for the dentists were held each day to ensure that some urgent requests from patients could be accommodated on the same day. If the practice could not provide a convenient appointment to meet the patient's needs, the practice advised them to try another local dentist or the local dental access centre.

Tackling inequity and promoting equality

We asked staff to explain how they communicated with people who had different communication needs such as those who spoke another language. Staff told us they treated everybody equally and welcomed patients from different backgrounds, cultures and religions. Some members of staff spoke Polish and Latvian. Staff also encouraged patients with limited English language skills to attend with a relative or friend who could translate for them. Alternatively, they could access a translation service. There was no hearing loop available at the practice.

The practice made a note on patient dental records to indicate whether a patient had particular needs, for example if they required help to access the stairs to the practice as it was situated on the first and second floor of the building. Patients with a disability were seen if they were able to access the first set of stairs to the practice. If this was not possible, they were advised to attend the other local practice run by the provider. There was a doorbell at

the bottom of the staircase to the practice for patients to call for assistance if they required it. Reception staff told us this included families with young children who may require further support.

Access to the service

The practice offered a range of general dental services and opened weekdays from 8.30am until 5.00pm. It provided treatment to NHS patients on the first and second floors of the premises. The practice operated a system to remind patients of their appointment details by email or text messaging if the patient had given permission for this.

The interval in between routine check-ups was determined by each dentist in line with national guidelines. Patients we spoke with were satisfied with access to routine and emergency appointments.

Information about obtaining emergency care out of hours was displayed in the reception. If patients called when the practice was closed, an answerphone message explained what to do. This information was not on the practice website.

Out-of-hours cover is provided by the NHS 111 service.

Concerns & complaints

The practice had an appropriate complaints policy in place and the practice manager was responsible for dealing with any complaints received and sharing this information with the team. It was also reported to the support team at head office. Information on how to raise a complaint and how it would be dealt with was available in written format in the waiting room. The website also included a link to the complaints policy and advised patients to contact the practice manager.

The practice maintained a log of any complaints they received about the service. We found that three complaints had been recorded during the last year. A review of the records and a discussion with the practice manager demonstrated that the complaints were acknowledged, investigated and that patients received an apology. Opportunities to improve the service had been taken as a result of any learning from complaints. For example patients who had not paid for their treatment, received a telephone call reminding them of this before formal letters to request a payment were sent to them.

Are services well-led?

Our findings

Governance arrangements

It was the responsibility of the practice manager to lead on governance and quality monitoring issues. The practice also shared business support services and policies issued by the provider which aimed to support a common approach.

There was a full range of policies and procedures in use at the practice. These included health and safety, infection prevention and control, patient confidentiality and recruitment. Staff we spoke with were aware of the policies, had easy access to them and could demonstrate knowledge of the policies used to support their practice. We looked at a range of policies and found they were up to date.

A staff bulletin was published weekly by the provider and this included clinical and administrative updates for staff. The practice manager had established regular practice meetings to discuss internal quality issues and share guidance from the provider. A recent meetings template had been introduced by the provider to ensure that key issues were always discussed on the agenda such as health and safety, infection control and prevention and patient feedback.

Systems were in place to ensure the safety of the environment and of equipment such as machinery used in the decontamination process and fire safety equipment. Risk assessments were in place although some centrally held risk assessments had not been updated.

Records we reviewed demonstrated that regular audits took place for infection control, radiography and dental care records. The practice manager gave feedback to individual staff in relation to performance and also shared the generalised findings at team meetings if it was appropriate to do so.

Leadership, openness and transparency

There was a clear leadership structure in place and staff understood their roles and responsibilities within the practice. For example there was a lead dental nurse, fire marshals and a safeguarding lead. The practice manager set standards and ensured they were maintained.

Staff were involved in regular team meetings and minutes of these were available for staff reference. The staff we spoke with told us that they worked well as a team and they were supported to raise any issues about the safety and quality of the service and share their learning. We were told that there was a no blame culture at the practice and that the delivery of high quality care was a high priority.

All staff knew how to raise any issues or concerns and were confident that action would be taken by the practice manager without fear of discrimination.

Learning and improvement

There were systems in place to promote learning and service improvements. Staff recognised and acted on complaints. Accidents had been reported and acted upon although further development was needed to ensure that staff recognised other incidents or significant events that were a risk to, or caused disruption to the day to day running of the service. These issues were not currently logged as such by the practice manager for quality monitoring purposes or to ensure the identity and management of further risks.

Staff we spoke with said they had opportunities to receive mandatory training that had been defined by the provider and additional clinical training was accessible through the NHS. The training was available through online courses as well as face to face training. One nurse told us they had been able to access training in radiography and infection control.

We saw evidence of training, continuing professional development and staff support that was monitored by the practice manager. In addition the practice manager held some peer review meetings with clinical staff at the other practice she was responsible for. This was used as an opportunity to share practice and promote improvement.

Dentists and dental nurses at the practice were registered with the GDC. The GDC registers all dental care professionals to make sure they are appropriately qualified and competent to work in the United Kingdom. The practice manager kept a record to evidence that staff were up to date with their professional registration.

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

The practice used the friends and family test to monitor patient satisfaction and address any comments or

Are services well-led?

concerns. The monthly results were displayed in reception. They had not received any constructive comments that could lead to service improvement. The provider also used their own form of patient feedback slips but they had received very little from patients through this route. The practice manager also checked the NHS Choices website on a regular basis and responded to comments appropriately.

The practice reviewed the feedback from patients who raised concerns or complaints. The complaints policy focused on resolving issues at the first point of contact

when possible or referring to the practice manager. We found that the complaints raised had been managed in an appropriate way and there was evidence of learning and improvement.

Staff we spoke with told us their views were sought at team meetings and informally. They told us their views were listened to and they felt part of a team who worked well together. The practice manager had an open door culture and encouraged staff to share their views and opinions. Staff we spoke with shared this view.