Rodericks Dental Limited

# Burnham House Dental Practice

## Inspection Report

13, Abingdon Street,
Burnham on Sea,
TA8 1PH.
Tel: 01278782742
Website:

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## Overall summary

We carried out an announced comprehensive inspection on 31st May and 30th June 2016 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**

Burnham House Dental Practice is located in the centre of Burnham on Sea and provides NHS and private treatment to patients of all ages. The practice consists of three treatment rooms, toilet facilities for patients and staff, a reception/ waiting area and a staff room.

The practice treats both adults and children. The practice offers routine examinations and treatment. There are three dentists and a hygienist.

The practice's opening hours are

8.30 to 17.30 on Monday

8.30 to 21.00 on Tuesday

8.30 to 20.00 on Wednesday

8.30 to 17.30 on Thursday

8.30 to 17.30 on Friday

9.00 to 13.00 0n Saturday

We carried out an announced, comprehensive inspection on 31st May and 30th June 2016. The inspection was led by a CQC inspector who had remote access to advice from a dental specialist advisor. As the inspector was not supported by a second person on the first day they returned to complete the inspection on 30th June.

# Summary of findings

Before the inspection we looked at the NHS Choices website. In the previous year there had been two comments about the practice which were very positive about the practice and both gave them five stars.

For this inspection six patients provided feedback to us about the service. Patients were positive about the care they received from the practice. They were complimentary about the service offered which they said was satisfactory, very good and excellent. They told us that staff were caring and friendly and the practice was clean and hygienic. We received no negative comments.

**Our key findings were:**

• Safe systems and processes were in place, including a lead professional for safeguarding and infection control.

• Staff recruitment policies were appropriate however, references were not always obtained before staff started work in the practice. Staff received relevant training.

• The practice had ensured that risk assessments were in place and that they were regularly reviewed.

• The clinical equipment in the practice was appropriately maintained. The practice appeared visibly clean throughout.

•The process for decontamination of instruments followed relevant guidance.

• The practice maintained appropriate dental care records and patients' clinical details were updated.

• Patients were provided with health promotion advice to promote good oral care.

• Written consent was obtained for dental treatment.

• The dentists were aware of the process to follow when a person lacked capacity to give consent to treatment.

• All feedback received from patients was positive; they reported that it was a caring and friendly service.

• There were arrangements for governance at the practice such as systems for auditing patient records, infection control and radiographs.

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

- Review the recruitment procedures to ensure written references are obtained before new staff start work in the practice.
- Make sure evidence of recruitment checks for staff who transferred to the service is available in the practice.
- Review the process of treatment planning so that plans include options for treatment to help patients to make informed decisions about their care.
- Review the arrangements for patients who have a hearing impairment and consider providing a loop system.

# 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?**

No action 

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

There were appropriate systems for reporting incidents and for learning from incidents. Staff had received training about safeguarding adults and children. There were policies about safeguarding and whistleblowing and staff knew how to report any concerns.

There were also arrangements for dealing with foreseeable emergencies, for fire safety and for managing risks to patients and to staff. There was a business continuity plan. Hazardous substances were managed safely.

Some of the appropriate checks were not being made to make sure staff were suitable to work with vulnerable people. For example, references were not always obtained before staff started to work in the practice. Evidence of recruitment checks for some staff, who had transferred from the previous provider, was not available in the practice. Emergency medicines were in place. Equipment was regularly serviced. X-rays were dealt with safely.

The surgeries were fresh and clean and guidance about decontamination of instruments was being followed to reduce the risk of the spread of infection.

**Are services effective?**

No action 

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

The dentists took X-rays at appropriate intervals. The practice was checking the condition of the gums for every patient and they were checking for oral cancers. Patients completed medical history questionnaires and these were updated at each visit. The practice kept up to date with current guidelines and research. They promoted the maintenance of good oral health through information about effective tooth brushing. The dentists discussed health promotion with individual patients according to their needs.

The practice had sufficient staff to support the dentists. Staff received appropriate professional development and all of the expected training.

The practice had suitable arrangements for working with other health professionals and making appropriate referrals to ensure quality of care for their patients. Patients were asked for written consent to treatment. Patients told us that the dentists discussed options for treatment with them. However, the treatment plans did not include options for treatment to help patients to make decisions about their care. The dentists showed understanding about the Mental Capacity Act 2005 and what they would do if an adult lacked the capacity to make particular decisions for themselves.

# Summary of findings

**Are services caring?**

No action

We found that this practice was providing caring services in accordance with the relevant regulations. Staff in the practice were polite and respectful when speaking to patients. Patients' privacy was respected and treatment room doors were closed during consultations. The practice used an electronic record system and the computer screens in reception were shielded so that they could not be seen by patients.

Patients were positive about the care they received from the practice. They reported that staff were knowledgeable, caring and friendly. People were given treatment plans by the dentist, which they had signed to show their consent and agreement to them.

**Are services responsive to people's needs?**

No action

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

The practice had a system to schedule enough time to assess and meet patients' needs. Patients said that they could get an appointment easily. Patients with dental emergencies were usually seen on the day they contacted the practice. The practice sought feedback from patients about the care being delivered. There was a procedure about how to make a complaint and the process for investigation. We saw evidence that the practice responded to feedback made direct to the practice and made changes when necessary.

There was an equality and diversity policy and staff had received training about equality and diversity. There was information about translation services for people whose first language was not English. There was level access for wheelchair users to one of the surgeries and there was a toilet with disabled access. There was no hearing loop system for patients who had a hearing impairment.

**Are services well-led?**

No action

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

The practice had set up systems for clinical governance such as audits of the infection control, record keeping and radiographs. The area manager conducted site visits to monitor the quality of the service. There were checks of equipment. The autoclave and compressor were serviced and there were daily checks of the autoclave.

The practice had a range of policies which were made available to staff.

The practice manager was the lead for the practice supported by more senior managers in the organisation. There was a whistleblowing policy and information for staff about the duty of candour and the need to be open if an incident occurred where a patient suffered harm. So far there had been no such incidents.

The practice manager held team meetings and discussions where staff discussed developments in the practice such as new policies and patient safety alerts. Staff were responsible for their own continuing professional development and kept this up to date.

The practice was seeking feedback from patients through patient satisfaction feedback forms and a suggestion box. They planned to analyse these and make improvements in response to the feedback. The area manager sought feedback from patients during their site visits.

# Burnham House Dental Practice

**Detailed findings**

## Background to this inspection

We carried out an announced, comprehensive inspection on 31st May and 30th June 2016. The inspection took place over two days. The inspection was led by a CQC inspector who had access to advice from a dental specialist advisor.

We reviewed information received from the provider before the inspection. We also informed the local Healthwatch and NHS England. We did not receive any information from Healthwatch but we received some information from NHS England about the NHS contracts and the change of provider of the practice to Roderick's Dental Ltd.

During our inspection visit, we met with the area manager, the practice manager and the registered manager who was one of the dentists. Like registered providers, a registered manager is a 'registered person'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

We reviewed policy documents and dental care records. We spoke with four members of staff and one dentist. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We observed a dental nurse carrying out decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area.

Six people provided feedback about the service. Patients, who completed comment cards, were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

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**

There was a system for reporting and learning from incidents. There was an accident book and information about when an accident needed to be reported to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There was also an untoward incident log to record all incidents. There had not been any accidents or incidents in the practice since the new providers had taken over.

The plan was for all serious accidents or incidents to be referred to head office for investigation. When incidents were not serious in nature the log would be sent to head office monthly for overview and analysis and if necessary policies would be changed as a result. The practice manager told us that learning from accidents and incidents would be discussed in team meetings.

**Reliable safety systems and processes (including safeguarding)**

There was a procedure on the wall in each surgery about what to do if a member of staff had a sharps injury. A sharps injury is when a person is injured by a needle or other sharp object. There had been no such incidents. There were systems to reduce the risk of a sharps injury including the use of needle guards. There were sharps bins in each surgery. The general health and safety risk assessment included managing the risk of sharps injury. We saw evidence that staff were immunised against blood borne viruses (Hepatitis B) to ensure the safety of patients and staff.

The practice had policies and procedures for child protection and safeguarding adults. This included contact details for the local authority social services. The practice manager was the safeguarding lead professional for the protection of vulnerable children and adults. We saw certificates which showed that staff had received training about safeguarding adults and children. Staff would raise concerns with the safeguarding lead professional and any safeguarding issues would be discussed in team meetings to promote learning for staff. There had been no safeguarding issues reported by the practice to the local safeguarding team.

There was a whistleblowing policy which staff could follow if they had concerns about another member of staff's performance. We saw a record of a concern about practice which had been raised through the whistleblowing policy. This had been addressed appropriately to improve the service for patients and to support the member of staff concerned.

The area manager received safety alerts from the Medicines and Healthcare Regulatory Agency (MHRA) and NHS England. They passed them to the practice manager who would identify whether they were relevant to the practice. On the second day of our visit there was an alert about electrical socket covers and the area manager and practice manager took remedial action in response to this.

**Staffing and Recruitment**

The practice staffing consisted of three dentists, a hygienist, seven part time dental nurses, a receptionist and a practice manager. The recruitment records of staff who had transferred from the previous practice were not available in the practice as they had not been transferred. We looked at the recruitment records of two trainee nurses and a dentist who had been recruited to the new practice. Each member of staff had completed a curriculum vitae (CV). They each had a Disclosure and Barring Service (DBS) check and had a copy of their passport as proof of identity and information about their right to work in the UK. We saw evidence that the company had a clear policy and appropriate risk management process in place should a DBS identify a prospective employ had a recorded offence.

The references for the dentist were kept at head office and were not available to see. Two references had been requested for each of the nurses but these had not been received before they started work. There was a record of the immunisation status of the nurses and dentists. We saw that appropriate checks of registration with the General Dental Council (GDC) had been carried out for the qualified staff. There were certificates of qualifications.

A system of appraisals had been developed for staff. No appraisals had taken place since the providers took over the practice as no staff had worked sufficient time for an appraisal to take place. We were told that appraisals for dentists will be conducted by the clinical advisor in the company. New staff had an induction and a probationary period and met with the practice manager after three months and six months to monitor progress.

# Are services safe?

**Medical emergencies**

The practice had arrangements to deal with medical emergencies. Staff had received training in emergency resuscitation and basic life support and this was refreshed every year. We saw certificates which showed that staff had received training about Cardio pulmonary resuscitation. The staff we spoke with were aware of the practice procedures for responding to an emergency. The practice had emergency equipment in accordance with guidance issued by the Resuscitation Council UK. This included relevant emergency medicines and oxygen and an automated external defibrillator (AED). (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). There were defibrillator pads for both adults and children. The oxygen cylinder and resuscitation mask were in date. The oxygen cylinder was being routinely checked for effectiveness and we saw records for these daily tests. We reviewed the contents of the emergency medicines kit. We saw records of weekly and monthly audits of the medicines and equipment and all the emergency medicines were in date. There was no spacer for use with inhalers but we saw evidence that one had been ordered. The glucagon injections were being kept in the fridge and the temperature of the fridge was checked daily. On the day of our first visit milk was being kept in the fridge together with a medicine. On the second day the milk had been removed and a second fridge had been ordered for food items.

New staff had an induction and probationary staff had an induction an s

**Monitoring Health and Safety and responding to Risk**

There were arrangements to deal with foreseeable emergencies. We saw a health and safety risk assessment for the general risks in the practice. These included the action to be taken to manage risk. The practice had a fire risk assessment and there were certificates showing that the smoke detectors and emergency lighting had been serviced. The area manager said that there was a plan to upgrade the fire alarm system when alterations to the building took place. There were arrangements to meet the Control of Substances Hazardous to Health 2002 (COSHH) Regulations. We saw COSHH risk assessments for the materials used in the practice.

The practice followed national guidelines on patient safety. For example, the area manager told us that the dentists routinely used a rubber dam when providing root canal treatment to patients in line with guidance from the British Endodontic Society. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use a rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured.

The practice had a business continuity plan to ensure continuity of care in the event that the practice premises could not be used for any reason.

**Infection control**

There were systems to reduce the risk and spread of infection. The practice manager was the infection control lead professional for the practice. There was a comprehensive infection control policy. Clinical staff were required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. There were good supplies of protective equipment for patients and staff members including gloves, masks, eye protection and aprons. There were hand washing facilities in the treatment rooms and the toilet. The dentists, nurses and hygienist wore uniforms in the clinical areas and they were responsible for laundering these.

An external company had carried out a Legionella risk assessment for the practice and there were no outstanding actions. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). We saw a log book of monthly checks of the temperatures at the cold and hot water outlets. The nurse showed us how they flushed the dental unit water lines in accordance with current guidance in order to prevent the growth of Legionella.

We examined the facilities for cleaning and decontaminating dental instruments in the decontamination room. The practice had followed the guidance about decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)' when setting up

# Are services safe?

their decontamination room. In accordance with HTM 01-05 guidance dirty instruments were carried from the surgery to the decontamination room in a designated sealed box to ensure the risk of the spread of infection was minimised.

There was a clear flow from 'dirty' to 'clean.' There were two sinks, one for washing and one for rinsing. The nurse showed us the process for decontamination of instruments. They put on personal protective equipment (PPE) including domestic style rubber gloves. They scrubbed the instruments with a long handled brush before rinsing them in the rinsing sink. They inspected them for debris under an illuminated magnifying glass, placed them on trays and put them into the autoclave to sterilise. After the sterilisation cycle was complete they took the instruments out of the steriliser to the clean area of the room, put them into date stamped bags and put them into a clean container to take back to the surgery. The nurses also showed us how they cleaned down the surgeries between patients to prevent the spread of infection.

The autoclave was checked daily for its performance, for example, in terms of temperature and pressure. A log was kept of the results demonstrating that the equipment was working well. The autoclave was new and they planned to service it annually.

The practice was following relevant guidance about cleaning and infection control. Cleaning schedules were completed and the practice looked clean throughout. The nurses cleaned the surgeries. Two patients we spoke with and four patients who completed comment cards said that the environment was always clean and hygienic. Ten people who completed comment cards said that he environment was safe and hygienic

Procedures to control the risk of infection were monitored as part of the daily checks and the practice had carried out infection control audit as required and there were no outstanding actions. The practice had an on-going contract with a clinical waste contractor. Waste was being appropriately stored and segregated. This included clinical waste and safe disposal of sharps.

**Equipment and medicines**

We found that the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents which showed that the air compressor, fire equipment and X-ray equipment had all been inspected and serviced. We saw evidence that portable appliance testing (PAT) for electrical items took place every three years and was booked again for the following month.

Medicines were stored securely in a cupboard and a designated fridge. Prescription pads were locked in the safe. The defibrillator was kept in reception. There was an oxygen cylinder with an up to date certificate. Staff said that there were sufficient dental instruments.

**Radiography (X-rays)**

There was an X–ray unit in each of the three surgeries. There were suitable arrangements in place to ensure the safety of the equipment. There were two new x-ray machines and we saw certificates to show that these had been installed correctly and were safe to use. We saw a log to show that the third x-ray machine was maintained. The name of an external radiation protection adviser (RPA) was made available and each dentist was their own radiation protection supervisor (RPS). X-rays were graded as they were taken. The service had recently adopted a system of digital x-rays and had audit sheets available to start auditing when sufficient had been taken.

# Are services effective?

(for example, treatment is effective)

## Our findings

**Monitoring and improving outcomes for patients**

We reviewed a sample of patient dental care records. These showed that the dentists took X-rays at appropriate intervals, as informed by guidance issued by the Faculty of General Dental Practice (FGDP). They also recorded the justification, findings and quality assurance of X-ray images taken. The records showed that an assessment of periodontal tissues was undertaken using the basic periodontal examination (BPE) screening tool. (The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to a patient's gums.) Patients' BPE scores were recorded in the dental care records we read.

We found evidence that record keeping was audited every four months. We saw that information about the patient's past medical history was entered in their records and the records showed that this was reviewed and updated at every visit. This information was kept up to date so that the dentists were informed of any changes in patient's physical health which might affect the type of care they received.

We saw evidence that the practice kept up to date with the current guidelines and research in order continually to develop and improve their system of clinical risk management. For example, the practice referred to the National Institute for Health and Care Excellence (NICE) guidelines in relation to referring patients for removal of wisdom teeth and prescribing antibiotics. They conducted risk assessments for patients to help them to decide appropriate intervals for recalling patients. The dentists were aware of the Delivering Better Oral Health Toolkit when considering care and advice for patients.

**Health promotion & prevention**

The dentists discussed health promotion with individual patients as part of the routine examination process. This included discussions around smoking and sensible alcohol use. We saw records of examinations of soft tissue to check for the early signs of oral cancer.

The practice promoted the maintenance of good oral health through information about effective tooth brushing. We observed that there was information about tooth brushing and health promotion displayed in the waiting area. This could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition.

**Staff skills and experience**

There was a practice manager, three dentists, three qualified nurses, four trainee nurses, a dental hygienist, and a receptionist. The practice manager told us that all staff received professional development and training. Courses for all staff included safeguarding, cardio pulmonary resuscitation, medical emergencies, infection control, health and safety, equality and diversity and the Mental Capacity Act 2005 (MCA.) The dentists, hygienist and the nurses were responsible for their own continuing professional development (CPD.) They logged all their training hours online with the General Dental Council (GDC.) We saw evidence that the nurses and dentists were keeping their CPD up to date. The four trainee nurses had each received an induction and the training required at the practice and were registered for dental nurse training courses.

Annual appraisals and personal development plans were planned for all staff. However, none had taken place at the time of the visit as the practice had been taken over recently by the new provider.

**Working with other services**

The practice had suitable arrangements for working with other health professionals to ensure quality of care for their patients. The dentists used a system of onward referral to other providers, for example, for oral surgery and orthodontics. Where there was a concern about oral cancer a referral was made to the local hospital by the dentist and the patient was seen within two or three days. Referral information was sent to the specialist service about each patient, including their medical history and x-rays.

**Consent to care and treatment**

The practice ensured that valid consent was obtained for all care and treatment. The dentists discussed treatment options, including risks and benefits, as well as costs, with each patient. We saw records of verbal and written consent in the patient notes and patients signed the FP17 NHS form. These forms were used as treatment plans for NHS patients and patients who had both NHS and private treatment. However, the recorded treatment plans did not

# Are services effective?

## (for example, treatment is effective)

contain options for treatment only information about the treatment that had already been decided upon. They were not easy to read and did not contain sufficient detail to help patients to decide about possible treatments. One of the dentists said that when children had a dental examination they explained about the options for treatment with a simple explanation about procedures and pictorial information on the computer so that they could be involved in decision making.

We found that staff had received training about the Mental Capacity Act 2005 (MCA). We spoke with two dentists who demonstrated knowledge about the MCA and capacity to consent. They said that they would always assume a patient had capacity to consent to treatment and would explain to the patient in simple terms. If the patient had a relative with Power of Attorney they would involve them in decision making about treatment. They would always consider what was in the patient's best interests.

# Are services caring?

## Our findings

**Respect, dignity, compassion & empathy**

Patient confidentiality was respected. The practice had recently converted their records from a paper record system to an electronic system. We noted that records were locked away so that they could not be seen by patients. Electronic records were password protected. The computer screens in reception could not be seen by patients. Patients were afforded appropriate privacy as the treatment room doors were closed during consultations. The waiting room was away from the consulting rooms so that conversations could not be heard from the other side of the door. If a patient wished to discuss something with the receptionist in private they were requested to come into the office behind reception. We observed that staff in the practice were polite and respectful when speaking to patients. Patients told us that they were treated with respect.

Patients, who completed comment cards, were positive about the care they received from the practice. Patients reported that staff were knowledgeable, caring and friendly. They said that they provided a very good service. Two patients we spoke with said that the dentist and nurse were very friendly and nice.

**Involvement in decisions about care and treatment**

The practice provided treatment plans for patients including costs. Written consent was obtained for the dentist's treatment plans. Two patients we spoke with said that they had signed their treatment plans and the dentist explained treatment to them very clearly so that they could make decisions. However, the treatment plans did not give options for treatment to help patients to make decisions about their care.

**Support to patients**

The practice had a system of alerts on the computer to help the dentists identify when they had a nervous patient. The receptionists scheduled longer appointment when a patient was nervous. The dentist said that they put patients at their ease by chatting and explaining their treatment in simple terms. If necessary they referred patients to another practice for sedation or to the dental hospital for extractions. Patients who required urgent treatment were usually seen on the day they requested an appointment. Two patients we spoke with said that the dentists always listened to what they had to say.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting patients' needs**

The practice had a system to schedule enough time to assess and meet patients' needs. The practice fitted emergencies into the appointment schedule. Patients commented that the staff provided a good service. Two patients said that they had been seen promptly when they had an emergency. The practice actively sought feedback from patients about the care being delivered through satisfaction surveys.

**Tackling inequity and promoting equality**

There was an equality and diversity policy and there was training about equality and diversity. There were some reasonable adjustments in place. There was information in reception about translation services and staff translated letters using a computer translation system. The area manager told us that the population they served was not very diverse. However they were seeing more Polish patients and they had a Polish dentist. There was no loop system for patients who had a hearing impairment. One of the surgeries was downstairs with level access for people who used wheelchairs and there was a toilet with disabled access on the ground floor.

**Access to the service**

The opening hours were displayed in reception and the website. Patients told us that they had no difficulty getting appointments. Emergencies were usually fitted in on the day the patient contacted the practice. For out of hours care patients phoned 111.

**Concerns & complaints**

There was a patient leaflet about the procedure for making a complaint, including timescales for responding to complaints and the process for investigation. Information about how to make a complaint was displayed in the reception area. Two patients we spoke with knew how to make a complaint. Information about concerns and complaints would be recorded. However, there had been no formal complaints. One of the dentists told us that within one month they had received two thank you cards.

# Are services well-led?

## Our findings

**Governance arrangements**

The practice had set up systems for clinical governance. There were audits of handwashing, patient satisfaction, infection control, and records. A system for auditing radiographs was being introduced. There were also peer reviews of practice, tracking of untoward events, monitoring of complaints and discussions in staff meetings. The area manager conducted regular site visits to monitor the quality of the service.

There were checks of equipment. We saw evidence that the autoclave and compressor had been serviced. The nurse told us that they conducted daily checks of the autoclave and we saw records of these tests. We saw that there was a range of policies which were made available to staff. Appropriate records were kept.

**Leadership, openness and transparency**

The practice manager was the lead professional for the practice and they were also the lead professional for safeguarding, infection control and medical emergencies. We saw information for staff about the duty of candour and the need to be open if an incident occurred where a patient suffered harm. However, when we spoke with one of the nurses they were not aware of the policy. The practice manager said that it was a new policy and they planned to discuss it with staff at the next team meeting. So far there had been no incidents where patients had suffered harm. We saw a whistleblowing policy which was made available to staff.

**Management lead through learning and improvement**

The practice manager told us that there were team meetings once a month. There were also shorter weekly meetings called team talks where staff discussed developments in the practice such as new policies and learning from incidents and complaints. Any new information from head office was placed on the notice-board for staff to read and sign when they had read it, for example the latest patient safety alert. This would be followed up with a staff discussion in team talk. The nurses told us that they were responsible for their own continuing professional development and kept this up to date. They said that they also had training within the practice and we saw records, which showed that relevant training was taking place, for example for safeguarding and health and safety. A system for personal development plans and appraisals for staff had been set up.

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

There were patient satisfaction feedback forms but these had not been analysed yet as the provider had only recently taken over the practice. The practice manager planned to discuss views and suggestions from the surveys with staff in team talk. There was also a suggestions box in reception. The area manager sought feedback from patients during their site visits. Two patients we spoke with said that they were aware of the suggestions box. They said that they had no suggestions for improvements. We saw evidence that the practice responded to feedback that they received. For example, patients said that they would like the practice to have a hygienist and a hygienist had been recruited.