Oasis Dental Care (Central) Limited

Oasis Dental Care Central - Hereford

Inspection Report

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Overall summary

We carried out a comprehensive inspection of Oasis Dental Practice on 9 January 2015. The practice is known locally as Pool Farm.

Pool Farm is a mixed dental practice providing NHS and private treatment. The practice caters for children and adults and is situated in a part of Hereford that has areas of social deprivation. Hereford has a significant Eastern European population and the practice team includes dentists who speak several European languages.

The practice is situated in a converted listed building which had been upgraded since our last inspection. The practice provides services on two floors and has a reception area on the ground floor. This is separate from the ground floor waiting room to provide greater privacy for patients when speaking with reception staff. The practice has seven dental treatment rooms and three decontamination rooms for cleaning, sterilising and packing dental instruments.

The practice has a full time practice manager who 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 seven dentists and twelve multi-skilled dental nurses one of whom is the practice's lead nurse. The dental nurse team also carry out reception duties and there are two further receptionists and a practice co-ordinator. There are two part time dental hygienists who provide preventative advice and gum treatments on prescription from the dentists working in the practice. A number of the dental nurses carry out extended duties including preventative fluoride applications and the provision of oral health education. Oasis had recently appointed a lead dentist to provide clinical leadership to the other dentists at the practice.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice. We collected 19 completed cards. These provided a positive view of the service the practice provides. Patients commented that the team were courteous, efficient and

Summary of findings

kind. Several wrote that they were seen on time and were pleased with their dental treatment. A number commented that the practice was clean and that they appreciated the recent improvements to the building.

Our key findings were:

- Staff reported incidents and kept records of these which the practice used for shared learning. The practice had enough staff to deliver the service.
- 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.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- The practice placed an emphasis on the promotion of good oral health and provided regular oral health instruction to patients.
- Staff had received training appropriate to their roles and were supported in their continued professional development (CPD).
- Information from 19 completed CQC comment cards gave us a positive picture of a friendly, professional service.
- The practice took into account any comments, concerns or complaints and used these to help them improve the practice.
- The practice manager and lead nurse were proud of the practice and their team. Staff felt well supported and were committed to providing a quality service to their patients.

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 had robust arrangements for essential topics such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found that all the equipment used in the dental practice was well maintained. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents. 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 vulnerable 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), had frequent continuing professional development (CPD) and were meeting the requirements of their professional registration.

Are services caring?

We collected 19 completed CQC patient comment cards. These provided a positive view of the service the practice provided. Patients commented that the team were courteous, efficient and kind. Several wrote that they are seen on time and were pleased with their dental treatment. The staff we met spoke about patients in a respectful way and wanted to provide a caring and friendly service.

Are services responsive to people's needs?

The service was aware of the needs of the local population and took those these into account in how the practice was run. Patients could access treatment and urgent and emergency care when required. The practice provided patients with written information in other languages or formats if they needed this and had access to telephone interpreter services. Several dentists at the practice spoke one or more of the European languages spoken by some patients. The practice had ground floor surgeries and level access into the building for patients with mobility difficulties and families with prams and pushchairs.

Are services well-led?

The practice manager, lead dental nurse and other staff had an open approach to their work and shared a commitment to continually improving the service they provided. The practice had robust clinical governance and risk management structures in place. Staff were aware of the way forward and vision for the practice. Improvements to the interior of the practice during 2014 had motivated staff who told us that they felt well supported and could raise any concerns with the practice manager. All the staff we met said that the practice was a good place to work.

Oasis Dental Care Central - 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 9 January 2015 by a CQC inspector and a dentist specialist advisor.

Before the inspection we reviewed information that we held about the provider and information that we asked the provider 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 three dentists, three dental nurses, the registered manager and the lead dental nurse. 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 19 patients on comment cards that we provided 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 incidents reporting policy and standard reporting forms for staff to complete when something went wrong. The policy contained clear information to support staff to understand the wide range of topics that could be considered to be an adverse incident. The topics listed ranged from cancelling a patient's appointment at short notice to more serious events.

We saw details of the most recent significant event and of a small number of recorded sharps injuries, ('sharps' are needles and sharp instruments). The information showed that the practice took appropriate action in each case. One example related to a sharps injury which was carefully documented and had been used in a staff meeting to provide an opportunity for shared learning. The practice also had an appropriate accident record book which was used correctly to protect the privacy of individuals filling in the forms.

The practice received national and local alerts relating to patient safety and safety of medicines. They had a system for logging these and for making sure that all members of the dental team received copies of relevant information. The practice manager explained that they discussed any urgent actions with the team immediately.

Reliable safety systems and processes (including safeguarding)

The practice manager was the safeguarding lead and they had established a working partnership with a named nurse from the Herefordshire multi-agency safeguarding hub (MASH). This nurse was the practice's main point of contact for child and adult safeguarding concerns and had visited the practice to speak with the team about safeguarding roles and responsibilities. The practice manager told us that they maintained regular contact with other professionals involved in child safeguarding including school nurses. The practice had worked with the MASH team to make sure their internal processes for information sharing were effective.

The practice had comprehensive information available at the practice regarding safeguarding policies, procedures and contact information. The practice recorded appropriate information about children with child protection plans. We spoke with all the dentists that were on duty on the day of our visit. They understood the importance of safeguarding issues and were aware of the role of the dental team in helping to monitor welfare and safety. The practice manager told us they had changed the way dentists were allocated work to provide improved consistency of dental care for children where there were known concerns.

All of the staff team had completed safeguarding training for adults and children and knew that they had to keep this up to date. The practice manager planned to include safeguarding scenarios as a topic at staff meetings so that staff had regular opportunities to discuss the topic.

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. A trainee dental nurse told us they had assisted with a root canal treatment that day and had noted that the dentist used this equipment. The dentists we spoke with confirmed that they used a rubber dam as far as practically possible.

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.

We saw that dental treatment areas, decontamination rooms and the general environment was visibly clean, tidy and clutter free. Decontamination of dental instruments was carried out in two separate decontamination rooms, one on each floor. The lead dental nurse demonstrated the decontamination process to us. We saw that this followed a well-defined system which separated dirty instruments

Are services safe?

from clean ones. We also saw clear separation of dirty and clean areas in the treatment rooms. The practice used a system of manual scrubbing using the two sinks system as part of the initial cleaning process.

When instruments had been sterilised they were packed in and stored appropriately until required. We saw that the packs were dated with an expiry date in accordance with current HTM01-05 guidelines. The nurse showed us how the practice checked that the three autoclaves (equipment used to sterilise dental instruments), were working effectively. They showed us the paperwork which staff used to record the essential daily and weekly validation checks of the sterilisation cycles. These were fully completed and up to date. We observed maintenance information showing that the autoclaves were maintained to the standards set out in current guidelines.

We inspected the drawers in a treatment room that was to be used on the day of our visit. These were visibly clean and tidy. All of the instruments were in dated packs and it was clear which items were single use. The practice had personal protective equipment (PPE) such as disposable gloves, aprons and eye protection available for staff and patient use. The decontamination rooms and treatment rooms all had designated hand wash basins separate from those uses for cleaning instruments.

Legionella is a bacterium that can grow in contaminated water and can be potentially fatal. A Legionella risk assessment had been carried out by an appropriate contractor and the practice showed us documentary evidence of this. 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 current guidelines and was supported by an appropriate practice procedure.

The practice carried out regular audits of infection control using the format provided by the Infection Prevention Society. A separate audit of hand washing effectiveness of each member of staff was also in place.

The practice had a record of staff immunisation status in respect of Hepatitis B - a serious illness that is transmitted by 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 had an information leaflet to give to patients if staff were injured with an item used in their treatment to ask them to consider taking a blood test and explaining why.

The segregation and storage of dental waste was in line with current guidelines from the Department of Health. The treatment of sharps waste was in accordance with the EU Directive on the use of safer sharps. The practice had an appropriate policy and used single use dental syringes to reduce the risk of sharps injuries. We observed that sharps containers were well maintained and correctly labelled with a copy of the sharps injury procedure next to each container. Staff we spoke with were aware of and understood this.

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 maintenance schedules and routine daily and weekly testing regimes for the equipment used in the practice. This showed that 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 using an appropriate qualified person. PAT is an abbreviation for 'portable appliance testing'.

The practice had a comprehensive recording system for the prescribing and recording of medicines. The records we saw were complete and provided an account of medicines patients had been prescribed. We saw from a sample of clinical records that the dentists always recorded the name of the medicines they prescribed together with the dose, timing, prescription numbers and patient instructions. The batch numbers and expiry dates for local anaesthetics were always recorded in the clinical notes. Medicines and prescription pads were stored securely and to prevent incidents of prescription fraud, NHS prescriptions were stamped with the appropriate official practice stamp only at the reception desk.

Monitoring health & safety and responding to risks

We saw a comprehensive business continuity plan which described situations which might interfere with the day to

Are services safe?

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 contact details for utility companies, practice staff and Oasis head office support staff. Information about the local NHS dental access centre for dental emergencies was included together with details of the nearest Oasis practice 16 miles away. The practice manager confirmed that they and two other team members had copies of the plan at home so that the information was always available.

The practice had a fire safety risk assessment which was carried out by a specialist company and was due to be repeated in March 2015. We saw that the practice also had a detailed general risk assessment looking at a variety of environment risk factors in the practice and specific risk assessments related to the provision of dental services.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had 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. The practice had the emergency medicines set out 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 expiry dates of medicines and equipment were monitored using a daily and monthly check sheet which enabled the staff to replace out of date drugs and equipment promptly. The practice held training sessions for the whole team to maintain their competence in dealing with medical emergencies. On the day of our visit a patient fainted after their treatment. The practice team dealt with this safely and effectively.

Staff recruitment

The practice recruitment policy did not include specific information about the checks that Oasis carry out on applicants they are considering for employment. The company's documentation requirements were listed on an employment checklist but this did not specify when these checks would be obtained or at what stage staff would be allowed to have contact with patients. We noted that the company relied on the use of written information from applicants. This did not provide them with an opportunity to ask applicants for all the information required by Regulation 21, Schedule 3 of Health & Social Care Act 2008 (Regulated Activities) Regulations 2010. The practice manager said that they would look at the regulations again and speak with the central human resources team at Oasis about this.

We looked at the recruitment information for a member of the team who had started at the practice in the last year. All of the required information was available for them and had been in place before they had contact with patients.

The Disclosure and Barring Service (DBS) 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.

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 looked at a sample of clinical records where X-rays had been taken. These showed that the dentists recorded the reasons they had taken X-rays and the results.

We also saw a copy of the most recent radiological audits for each dentist working in the practice. Each dentist had a sample of their X-rays audited and peer reviewed by another dentist in the practice to provide an assessment of the quality of the images taken by each dentist.

Are services effective?

(for example, treatment is effective)

Our findings

Consent to care and treatment

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. The practice manager had delivered to the practice team about the relevance of the Act to dental professionals. This training was based on the Act and training materials published by the Department of Health. The practice manager had previously worked in community dentistry providing dental care to patients where their capacity was a significant factor in their care. They were therefore able to demonstrate a clear understanding of requirements of the Act.

Two of the dentists gave specific examples of how they had taken mental capacity issues into account when providing dental treatment. They were aware of the Mental Capacity Act and explained how they would manage a patient who lacked the capacity to consent to dental treatment. They explained how they would involve the patient's family along with social workers and other professionals involved in the care of the patient to ensure that the best interests of the patient were met.

The dentists we spoke to explained how they obtained valid informed consent. They explained how they explained their findings to patients and kept detailed clinical records showing that they had discussed the available options with them. They also explained that they used the appropriate NHS dental forms to assist in the process.

Monitoring and improving outcomes for people using best practice

We saw a range of clinical and other audits that the practice carried out to help them monitor the effectiveness of the service. These included the quality of clinical record keeping, quality of dental radiographs, patient waiting times, practice safety reviews and infection prevention control procedures.

During our visit we found that the care and treatment of patients was planned and delivered in a way that ensured patients' safety and welfare. We saw that patient records contained a written medical history which the practice always obtained before starting to treat a patient. These were then updated regularly. The clinical records we saw were well-structured and contained sufficient detail about each patient's dental treatment.

The records contained details of the condition of patients' gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE is a simple and rapid screening tool that is used to indicate the level of treatment needed). These were carried out at each dental health assessment. We saw that the dentists had also carried out more detailed assessments for patients with more severe forms of gum disease.

All of the dentists we spoke with on the day of our visit were aware of various best practice guidelines. For example they explained the way wisdom teeth problems should be managed in accordance with National Institute for Health and Care Excellence (NICE) guidelines. All of the dentists explained to us that they used a risk based assessment when setting patients' dental recall intervals using NICE recall guidance. They explained that they assessed patients' risks in relation to dental decay, gum disease and motivation and set the recall interval accordingly. We looked at a sample of clinical records that showed this had taken place in discussion with patients.

The dentists were aware of various Faculty of General Dental Practice Guidelines. This included guidelines in relation to selection criteria for dental X-rays and clinical examination and record keeping.

Working with other services

We established from speaking with dentists and looking at a sample of clinical records that the practice referred patients to other services when necessary and made evidence based decisions about this. For example, they used NICE criteria for deciding when to refer patients for wisdom teeth removal. A dentist we spoke with was aware of the Index of Orthodontic Treatment Needs criteria for the referral of orthodontic cases into specialist NHS care.

The dentists used specialist specific templates for the referral of patients into secondary or specialist care services. These templates were contained within the practices' dental computer software system which provided a tracking system to monitor the progress of referrals. Oasis also used this system to monitor any trends of inappropriate referrals which indicated a training need for a dentist.

Are services effective?

(for example, treatment is effective)

Health promotion & prevention

Health promotion and prevention was championed by the Lead Nurse. The water supply in Hereford does not contain fluoride. The practice had supported the training of extended duty dental nurses (EDDN) for the provision of fluoride varnish applications as a preventive measure for children. The dental nurses were trained to provide oral health education to young children and adults who are at a higher risk of dental decay and gum disease. The practice allocated two full days and one evening session to health promotion and prevention clinics which were staffed by the EDDNs. The practice had recently put in a tender to NHS England to provide smoking session advice clinics to patients.

Staffing

The practice manager was an experienced registered dental nurse and manager. They were developing their management skills by completing an NVQ level three in management.

The practice manager told us that the practice ethos was that all staff should receive appropriate training and development. The practice used a variety of ways to ensure staff development including internal training and staff meetings as well as attendance at external courses and conferences. The practice provided a rolling programme of professional development. This included training in cardio pulmonary resuscitation (CPR), infection control, child protection and adult safeguarding, dental radiography (X-rays) and other specific dental topics.

We confirmed that the dental nurses received an annual appraisal and had personal development plans. These appraisals were carried out by the practice manager and lead nurse. The dentists received one to one performance reviews with the practice manager.

The development of EDDNs showed effective use of skill mix in the practice. This enabled the dentists to concentrate on providing care to patients whose needs were more complex whilst the dental nurses and dental hygienists provided routine care and advice. A sample of clinical records demonstrated a high standard of record keeping by the practice lead nurse and the dental hygienists.

The practice manager showed us their system for recording training that staff had completed. We looked at files for staff in various roles. These contained details of continuing professional development (CPD), confirmation of current General Dental Council (GDC) registration, and current professional indemnity cover where applicable. It was noted that staff receive an induction programme before they join the company.

Three of the five reception team were registered dental nurses. The practice was developing the skills of the reception team with a view to all staff working on reception being registered dental nurses. They believed this would provide increased flexibility for annual leave and sickness and provide an enhanced service for patients.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The practice's computer system recorded and displayed important information about patients that the team needed to be aware of. For example, the system informed staff if a patient had hearing or sight difficulties or other specific needs. This helped staff make adjustments for patients without compromising their dignity.

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 19 completed cards. These provided a positive view of the service the practice provided. Patients commented that the team were courteous, efficient and kind. Several wrote that they were seen on time and were pleased with their dental treatment. During the inspection we observed staff in the busy reception area. We observed that they were polite and helpful towards patients and that the general atmosphere was welcoming and friendly.

All the staff we spoke with individually spoke about patients in a respectful and caring way and were aware of the importance of protecting patients' privacy and dignity.

Involvement in decisions about care and treatment

All of the dentists we spoke with paid particular attention to patient involvement when drawing up individual care plans. Attached to each dental chair was a computer monitor. The dentists explained that they used this to display X-rays and information from the internet to help explain treatment needs and options to patients. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was aware of the needs of the local population and recognised the importance of oral health education and the provision of NHS treatment in the area. Herefordshire does not have fluoride in its drinking water and the lead nurse was trained to provide fluoride varnish applications. The lead nurse was also trained to provide oral health education.

The practice used posters displayed in the waiting areas to give details of NHS dental charges. We saw that the practice had a comprehensive website. This gave details of out of hours care, the types of care offered and details of professional charges. This ensured that patients had access to appropriate information in relation to their care.

We observed that the appointment diaries were not overbooked and that this provided capacity each day for patients with pain to be fitted in. The dentists decided how long a patient's appointments needed to be and took into account any special circumstances such as whether a patient was very nervous or had a disability. This was highlighted in patients' records so that the dentists, nurse sand reception staff were all aware of the level of support each patient might need.

Tackling inequity and promoting equality

The practice had an equality and diversity policy and provided training for the staff team about this. Information was readily available about the Equality Act 2010 and supporting national guidance. The topic was included in the practice's induction training.

The practice used a translation service which they arranged if it was clear that a patient had difficulty in understanding information about their treatment. The practice had a multi-national team and between them spoke several languages which met the needs of most patients.

There was a hearing loop to assist patients who used hearing aids if the found this beneficial. Oasis head office had the facilities to convert information into Braille for patients who used it.

There was level access into the building and two ground floor treatment rooms for patients unable to go upstairs. There was a disabled toilet with suitable grab rails and an emergency call bell. As part of the improvements to the premises a low level section of the reception counter was provided to cater for patients who used wheelchairs.

Access to the service

The practice provided extended hours to meet the needs of patients unable to attend during the working day. Appointments were available from 8am to 8pm Monday to Thursday, 8am to 5pm on Fridays and 9am to 1pm on Saturdays. The practice manager told us that as well as being flexible for patients the hours also enabled the practice to make appointments for courses of treatment in a timely way so patients did not have to wait too long and reduced pressure on appointments between 9am and 5pm. They explained that when they recruited new dentists to the practice they informed them that the practice had a rota system so it could provide these extended hours.

Concerns and complaints

The practice had a complaints process and the practice manager had detailed guidance available about effective complaints handling. They had completed face to face and online courses about dealing with complaints. The practice had a complaints log which the practice manager had to send to Oasis head office every month so that the organisation could monitor the number of complaints and the reasons for these. We noted that some patients had left negative comments about the practice on the NHS Choices website and that the practice had not used their opportunity to respond to these. The practice manager said they would begin to do this because they recognised that this was an additional way to communicate with patients.

Are services well-led?

Our findings

Leadership, openness and transparency

The practice had an appropriately qualified, experienced and empowered practice manager. They demonstrated a firm understanding of the principles of clinical governance in dentistry. They were well supported in this role by the practice's lead nurse. Oasis had recently employed a lead dentist to provide clinical leadership and support to the other dentists and hygienists working at the practice. The dentists we spoke with were happy with the facilities at the practice and felt well supported by the practice manager and lead dental nurse. The staff were interested in their work, and were proud of the service they provided to patients.

The culture of the practice was open and supportive. Staff told us they enjoyed working at the practice and received the support they needed. The dentists we spoke with told us they supported each other and provided clinical advice and support as necessary. The dental nurses appreciated and respected the knowledge and experience of the lead nurse and practice manager and told us that there was good communication at the practice.

Governance arrangements

The practice manager showed us a comprehensive file of risk assessments covering all aspects of clinical governance. These were well maintained and up to date.

Staff showed us examples of monthly staff meeting minutes which provided evidence that training took place and that information was shared with practice staff. Any staff at work on the day of a meeting took part regardless of their role within the team. This was to help ensure that all staff were included and involved in the shared learning.

The meetings were used to discuss all aspects of the running of the practice and the care and treatment it provided to patients. We looked at the minutes of a meeting in December 2014 during which staff had discussed the importance of asking patients to sign treatment plans, health and safety in respect of avoiding sharps injuries, information governance and the practice's overall performance. The practice manager explained that minutes were put in staff in trays if they were not present at a meeting. Staff we spoke with confirmed that they were kept well informed.

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

Patients were able to give their views about the practice using paper or online feedback forms. The results were collected and reviewed by Oasis head office and then passed to the practice.

We saw information from survey results compiled monthly by Oasis between June and December 2014. The questions that Oasis asked patients were about whether they felt involved in decisions about their care, were satisfied with the quality of their treatment and would recommend the practice to their family and friends. The results showed 100% positive responses to each of these most months. In one month the result for the first question was 96% and in another month 98% said they would recommend the practice.

The practice manager told us that the recent upgrading of the premises in 2014 was partly in response to negative patient comments about the facilities. In the comment cards we received from patients several specifically commented on these improvements. The registered manager told us that they had invited the Chief Executive Officer and senior Oasis managers to visit the practice to see the facilities themselves. This had helped ensure the improvements were carried out.

Staff told us that the practice manager and lead nurse were approachable and they felt they could give their views about how things were done at the practice. Staff confirmed that they had monthly meetings and could read the minutes of these if they could not attend. Staff described the meetings as allowing healthy debate and the opportunity to discuss grievances, successes and changes and improvements. They said they felt listened to.

Management lead through learning and improvement

The practice manager provided enthusiastic leadership and the staff we met described them as approachable. They were completing an NVQ level three management course to help them develop their existing management skills. The lead nurse worked closely with the practice manager and had responsibility for the clinical leadership of the dental nurses. The practice manager and lead nurse were encouraging and enabling other dental nurses at the practice to participate in the running of the practice by delegating certain duties to them. These included stock

Are services well-led?

control, monitoring safety alerts and overseeing the audits carried out at the practice. This was viewed as an important part of developing the broader knowledge and skills of the dental nurses.

We saw evidence of systems to identify staff learning needs. For example, results of clinical audits were used to identify additional training or clinical supervision needs and improve confidence and competence in particular clinical techniques.