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Chopra & Associates Ashford

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 10 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
Chopra and Associates Ashford provides predominately NHS dental services with private treatment options available for patients. The practice has three consulting and treatment rooms, two dentists who are supported by four dental nurses. The practice also provides minor oral surgery for its patient population and on referral from other practices in the area. This service is facilitated by a visiting oral surgeon. The practice is managed by a practice group manager with a principal dentist who is the owner, supporting the whole team.

The group manager is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

We spoke with nine patients who told us that they were satisfied with the services they had received. All stated their experiences at the practice were excellent, that staff were kind and caring and appointments were readily available both for emergencies and routine visits. They spoke about how their dignity and privacy was maintained at all times and how they were involved in decisions regarding their care and treatment.

Summary of findings

Before our inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of using the practice. We collected 8 completed cards. All provided a positive view of the service the practice provides. Patients commented the team were kind, caring, efficient and that they had received excellent care. The majority commented that the practice was very clean and staff were polite.

Our key findings were:

- Staff reported incidents and kept records of these which the practice used for shared learning.
- The practice was visibly clean and well maintained.
- Patients' needs were assessed and care was planned and delivered in line with current best practice guidance from the National Institute for Health and Care Excellence (NICE) and other published guidance.
- The practice had effective safeguarding processes and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Staff had received training appropriate to their roles and were supported in their continued professional development (CPD).
- The practice took into account any comments, concerns or complaints and used these to help them improve the practice.
- Patients were pleased with the care and treatment they received and complimentary about the dentists and all other members of the practice team.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

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

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used national guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. We saw examples of positive team work within the practice and evidence of good communication with other dental professionals. The staff received professional training and development appropriate to their roles and learning needs. Staff who were registered with the General Dental Council (GDC) were supported in their continuing professional development (CPD) and were meeting the requirements of their professional registration.

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

We spoke with four patients and discussed their experiences. All of the information we received from patients provided a positive view of the service the practice provided. Patients told us that the care and treatment they received was caring, patient and thorough. They praised the skills of the clinical staff and the professionalism of the whole practice team.

Are services responsive to people's needs?
We found that this practice was providing responsive care in accordance with the relevant regulations.

The practice provided clear information to patients about the costs of their treatment. Patients could access treatment and urgent care when required. The practice had one ground floor surgery and level access into the building for patients with mobility difficulties and families with prams and pushchairs. The team had access to telephone translation services if they needed and staff spoke a range of other languages.

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

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

Chopra & Associates Ashford

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.

The inspection took place on 10 December 2015 and was conducted by a CQC inspector and a dental specialist advisor.

We informed NHS England area team and Healthwatch that we were inspecting the practice on 29 October 2015; however we did not receive any information of concern from them.

During the inspection we spoke with one dentist, two dental nurses and the practice group manager. We spoke with four patients who were all complimentary about the services they had received.

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 system to manage significant events, safety concerns and complaints and staff could demonstrate a good understanding of the procedures to follow. There had been no reported significant events within the last year. Staff could recite that should a significant event occur a risk assessment would be completed and mitigating actions would be implemented to reduce the risk of re-occurrence. This information would then be shared with staff at a staff meeting.

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

The practice group manager received national and local safety alerts by email. Theses were shared with staff vis an internal intranet system which they could access at any time. We saw evidence for a period of two years that they checked these and recorded whether any were relevant to the practice so that staff could be informed and immediate action could be taken.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures for safeguarding children and vulnerable adults, which had been updated annually. The policies were localised and contained the direct contact details of the local authority safeguarding team and what to do out of hours. This information was displayed prominently and all staff were aware of the procedure to follow.

The principal dentist was the safeguarding lead. All staff had completed safeguarding training to the appropriate level. Staff we spoke with were confident when describing potential abuse or neglect and how they would raise concerns with the safeguarding lead.

Staff were aware of the procedure for whistleblowing if they had concerns about another member of staff's performance. Staff told us they would be confident about raising such issues with either the group manager, or principal dentist.

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.

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

Medical emergencies

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

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

Are services safe?

Staff recruitment

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

The practice's written procedures contained clear information about all of the required checks for new staff. This included protocol to follow for prospective employees explaining to them what documents they would be expected to provide and what checks the practice would carry out. These included educational certificates, a valid UK Passport or National Identity Card, General Dental Council (GDC) and professional indemnity certificates (if applicable) and Hepatitis B vaccination evidence if available.

The Disclosure and Barring Service carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The practice had obtained DBS checks for all staff employed there.

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

Monitoring health & safety and responding to risks

The practice had a comprehensive business continuity plan which described situations which might interfere with the day to day running of the practice and treatment of patients. This included extreme situations such as loss of the premises due to fire, flood or utilities. The document contained essential information including contact details for utility companies and practice staff. The group manager and principal dentist had copies of the plan at home so that essential information was always available. The practice had a comprehensive fire marshall/disaster kit stored in a central location, which contained signage, loud hailer, high visability clothing, glow sticks, floor plans and a safety action plan. All staff had been trained to use this disaster pack.

The practice had a practice wide risk assessment which addressed specific risks associated with dentistry as well as general day to day health and safety topics. This was reviewed annually to ensure that it reflected current guidance.

We saw that there was a fire risk assessment carried out in October 2014. The fire safety records showed that the practice had carried out fire checks and tests every month and that they tested the fire alarm every week. We did not see evidence of regular fire drills but staff could demonstrate a good understanding of what to do if a fire was suspected.

We saw an online record containing detailed information about the control of substances hazardous to health (COSHH). They showed us that this included clear information to make it easier for staff to take prompt action in the event of an incident involving substances containing chemicals.

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

Infection control

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

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

Are services safe?

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

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

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

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

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

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

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

The practice had a record of staff immunisation status in respect of Hepatitis B a serious illness that is transmitted by 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 adopted a policy that all staff should attend occupational health to be checked following a sharps injury even where the risk of infection was assessed as low. The practice manager would contact the patient for whom the instrument had been used to ask them to consider taking a blood test. The practice manager told us that all sharps injuries were recorded as accidents and we saw evidence that this was done.

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

Are services safe?

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

Equipment and medicines

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

Prescription pads held by the practice were securely stored. We saw that the practice had written records of prescription pads to ensure that the use of these was monitored and controlled.

The batch numbers and expiry dates for local anaesthetics were always recorded in the dental care records.

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

Radiography (X-rays)

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

We saw evidence of recorded reasons why each image (X-ray) was taken and that X-rays were always checked to ensure their quality and accuracy. The dentists graded each image taken to quality assured this process. Staff showed us their ongoing clinical audit records for the quality of the X-rays they took; this showed they were using this process to monitor their own performance in this aspect of dentistry.

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

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

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

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

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

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

Health promotion & prevention

The practice was aware of the Public Health England 'Delivering Better Oral Health' guidelines and were proactive in providing preventative dental care as well as carrying out restorative treatments. Staff told us that they discussed oral health with their patients. For example, effective tooth brushing, oral hygiene, prevention of gum disease, and dietary / lifestyle advice. We looked at dental care records for eight patients and saw that oral health advice given was not routinely recorded. Patients we spoke with said that they had all been given oral health and dietary advice.

We observed that the practice provided targeted health promotion materials, by issuing and discussing advice sheets and leaflets to patients during consultations.

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

Staffing

The practice benefited from employing a range of experienced staff. Staff who were under training were supported by experienced and trained senior members. New staff underwent induction to ensure they understood how the practice operated and that they were competent in their role. All staff had received an annual appraisal. We looked at six staff files and found that their appraisals had covered performance, training and development needs which had been addressed.

Staff told us they felt supported and confirmed that training was available for them to undertake for both practice / patient specific needs, such as oral health training and to further their future development if they wanted to. The practice group manager informed us that all types of training were available to staff and routinely offered but there was a low uptake. Records we examined confirmed this. Support staff said that the dentists at the practice were supportive and always available for advice and guidance.

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

Working with other services

We saw evidence that the practice liaised with other dental professionals and made appropriate referrals to other services when this was needed. For example, they referred children who needed orthodontic treatment to specialists in this aspect of dentistry. The practice had arrangements with the local out of hours dental provision for emergency treatment when the practice was closed and details on how to access this service was displayed inside and outside the practice, on the practice website and in the patient information leaflet.

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

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

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

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The patients we spoke with were complimentary about the care and treatment they received at the practice. Some highlighted that they had been patients for many years. Patients commented on the kindness and gentleness of their dentist as well as the positive attitudes approach of the whole team. All the staff we met spoke about patients in a respectful and caring way and were aware of the importance of protecting patients' privacy and dignity. This view was reflected in information patients had written in compliments made directly to the service.

We observed that the staff provided a personable service as they knew their patients well. They were welcoming and helpful when patients arrived for their appointments and when speaking with patients on the telephone.

Patients indicated that they were treated with dignity and respect at all times. Doors were always closed when patients were in the treatment rooms. Patients we spoke with told us that they had no concerns with regard to confidentiality; we noted that there had been no complaints or incidents related to confidentiality and that dental care records were stored securely.

Involvement in decisions about care and treatment

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

Patients told us that they felt involved in their care and had been given adequate information about their treatment, options and fees. Staff told us and we saw they took time to explain the treatment options available.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided NHS dental treatment and private dental treatment. The practice statement of purpose and website provided information about the types of treatments that the practice offered.

The practice had a system to schedule enough time to assess and meet patient's needs. Each dentist had their own time frames for different treatment types and procedures. Staff told us that although they were busy they had enough time to carry out treatments without rushing. The practice were able to book longer appointments for those who requested or needed them, such as those with a learning disability.

We found that the practice was flexible and able to adapt to the needs of the patients, and to accommodate emergency appointments. Patients we spoke with confirmed this and told us that they could usually get an appointment when they needed one and that they had been able to access emergency appointments on the same day.

Tackling inequity and promoting equality

The practice had recognised the needs of its patient population. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions.

The practice was accessible to wheelchairs and patients with pushchairs by a level entrance and a ground floor treatment rooms. The ground floor waiting area could accommodate a wheel chair or pushchair even though the area was small.

Access to the service

Appointment times and availability met the needs of the patients. The practice surgery hours were Monday to Friday 9am to 5:30pm and 9am – 12pm 1st and 3rd Saturday of every month. Information about opening times was displayed at the entrance to the practice in both waiting rooms, on the practice website and patient information leaflet.

Patients needing an appointment could book by phone, in person or request a call from staff on the practice website. Patients with emergencies were seen on the same day even if there were no appointments available, staff would work later to accommodate them.

If patients required emergency treatment when the practice was closed, the answer phone message would direct them to the local NHS dental out of hours service. This was also displayed in the waiting room, on the entrance door and on both the website and patient information leaflet.

Concerns & complaints

The practice had a complaints process which was available on the practice website as well as in print at the practice. We looked at information available about comments, compliments and complaints for the last year. We noted that there were far more compliments recorded than concerns and that the practice recorded informal concerns as well as more significant ones. The practice had only received one complaint in the last year and we saw it had been handled in accordance with the practice complaints policy and resolved to the patient's satisfaction.

We also looked at the practices summary of more formal complaints. These showed that the practice had listened to patients views and concerns, investigated and offered explanations and where necessary an apology. The complaint summary identified the learning for the practice such as improving communication with patients.

Are services well-led?

Our findings

Governance arrangements

There was a full range of operational policies, procedures and protocols to govern activity. All of these policies, procedures and protocols were subject to annual review and staff had signed to indicate that they had read and understood each document. Staff we spoke with were aware of the policies, procedures and protocols, their content and how to access them when required.

The practice undertook a series of practice wide audits to monitor and assess the quality of the services they provided. These audits had been repeated to evidence that improvements had been made where gaps had been identified. Records we looked at related to audits for infection control, the quality of X-rays taken and record keeping. There was clear evidence that these were taking place regularly. The findings of the audits documented an analysis of results, areas identified for improvement, and actions taken. Results and findings were discussed at practice meetings and it was clear that these audits were driving improvement and maintaining standards.

Leadership, openness and transparency

The practice had a group practice manager who worked closely with the principal dentist. The group manager was responsible for the oversight of all matters relating to governance. There was a clear understanding of the requirements of the regulations under the Health and Social Care Act 2008 and how these applied to dental practices.

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

Learning and improvement

The practice took learning and development seriously and encouraged staff to take part in activities to develop their knowledge and skills. We found that the clinical dental team all undertook the necessary learning to maintain their continued professional development which is a requirement of their registration with the General Dental Council (GDC). However, we saw that although training had been routinely offered, staff had declined to undertake further development .

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

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

The practice gathered feedback from patients via the monthly NHS friends and family test. Results from the most recent months were very positive scoring between 98 and 100% of patients happy to recommend the practice to others. Other feedback was collected throughsurveys from patients and results were available. All of the feedback was positive especially where patients had been extremely anxious and in some cases phobic but could now attend without the stress and anxiety previously experienced. As a result of the last survey the practice had been re-decorated.

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