West Earlham Dental Health Practice Limited

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Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 31 January 2017 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

West Earlham Dental Health Practice is a small, well-established dental practice that provides primarily NHS treatment to adults and children. The team consists of two dentists, two dental nurses (one of whom is also the practice manager), and a receptionist. The practice has two dental treatment rooms, a reception/waiting area, and a small staff room. It opens from 9am to 6pm on Mondays; and Tuesdays to Fridays from 8.45am to 5pm.

At time of inspection, the principal dentist (who was also the owner) was registered with the Care Quality Commission (CQC) as an individual. 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. However, an application to change the status of the practice to a partnership had been submitted to us.

Before the inspection we sent comment cards to the practice for patients to complete to tell us about their experience of the practice. We received feedback from 48 patients.

Our key findings were:

- Information from 48 completed Care Quality Commission comment cards gave us a positive picture of a friendly, professional and caring service. Patients

Summary of findings

received clear explanations about their proposed treatment and were actively involved in making decisions about it. They were treated in a way that they liked by staff.

- Staff had received safeguarding training and took action to protect vulnerable patients when needed.
- The practice had systems to help ensure patient safety. These included safeguarding children and adults from abuse, maintaining the required standards of infection prevention and control, and responding to medical emergencies.
- Members of the dental team were up-to-date with their continuing professional development and supported to meet the requirements of their professional registration.
- 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.
- Good oral health was actively promoted to patients by staff.

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

- Review the practice's system for the recording, investigating and reviewing incidents or significant events with a view to preventing further occurrences and, ensuring that improvements are made as a result
- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as, Public Health England (PHE)
- Review the practice's legionella assessment and ensure that all recommendations are implemented
- Review the practice's recruitment policy and procedures to ensure references for new staff and employment interviews are recorded.
- Populate the radiation protection file with all relevant details

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had good arrangements for essential areas such as infection control, clinical waste, the management of medical emergencies and dental radiography (X-rays). Equipment used in the dental practice was well maintained. Staff had received safeguarding training and were aware of their responsibilities regarding the protection children and vulnerable adults. However, untoward events were not always recorded or analysed to prevent their reoccurrence and recruitment procedures needed to be strengthened. The practice's radiation protection file needed to be populated with a full list of equipment and the staff trained to use equipment.

No action

Are services effective?

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

Staff had the skills, knowledge and experience to deliver effective care and treatment. The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. The staff received professional training and development appropriate to their roles and learning needs.

No action

Are services caring?

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

We collected 48 completed patient comment cards and obtained the views of a further two patients on the day of our visit. These provided a very positive view of the service the practice provided. Patients commented on friendliness and helpfulness of the staff and told us dentists were good at explaining the treatment that was proposed. They told us they were involved in decisions about their treatment, and did not feel rushed in their appointments.

Staff gave us specific examples where they had gone beyond the call of duty to support patients.

No action

Are services responsive to people's needs?

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

Appointments were easy to book and the practice offered extended opening hours if needed. The practice had made good adjustments to accommodate the needs of wheelchairs users.

There was a complaints system in place which was publicised and accessible to patients. Formal complaints were dealt with professionally and empathetically, although minor concerns that patients raised were not always recorded appropriately.

No action

Summary of findings

Are services well-led?

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

Staff told us they enjoyed working at the practice and felt well supported. The practice had a number of policies and procedures to govern its activity and held regular staff meetings. There were systems in place to monitor and improve quality, and identify risk. The practice proactively sought feedback from staff and patients, which it acted on to improve services to its patients.

No action 

West Earlham Dental Health Practice

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 was carried out on 31 January 2017 by a CQC inspector who was supported by a specialist dental adviser. During the inspection, we spoke with the dentist, the practice manager, a dental nurse and the receptionist. We reviewed policies, procedures and other documents relating to the management of the service. We received feedback from 50 patients about the quality of the service, which included comment cards and patients we spoke with during our inspection.

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

Staff we spoke with had a good understanding of their reporting requirements under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) and also their requirements to notify us, the CQC, of certain incidents. The practice had an accident book and we noted that the details of two recent accidents had been well documented. However, the practice did not have a significant incident policy in place and did not keep a specific log of any events that occurred so that learning from them could be shared across the staff team. We were aware of one serious incident when a patient had accidently inhaled a crown. There was no recorded evidence that this event had been fully investigated, or of any action taken to prevent its reoccurrence.

The principal dentist told us he was emailed patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA). However neither he, nor the practice manager, were aware of recent alerts affecting dental practice.

Reliable safety systems and processes (including safeguarding)

Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff and clearly outlined who to contact for further guidance if they had concerns about a patient's welfare. We noted good information in the reception area in relation to agencies involved in the protection of children and vulnerable adults making it easily accessible to staff

Records showed that staff had received safeguarding training for both vulnerable adults and children. Staff we spoke with demonstrated their awareness of the different types of abuse, and understood the importance of safeguarding issues. The principal dentist told us he had previously called protection agencies for advice when concerned about a child's possible dental neglect . He also stated that he implemented shorter recall frequencies for these patients so they could be monitored more closely. One dental nurse told us the dentist always asked patients about any bruising and how they sustained it.

The practice had minimised risks in relation to used sharps (needles and other sharp objects, which may be contaminated). Only the dentist handled sharps and they used a sharps safety system which allowed staff to discard needles without the need to re-sheath them. Staff spoke knowledgeably about action they would take following a sharps' injury and a sharps' risk assessment had been completed for the practice. Guidance about dealing with sharps' injuries was on display near where they were used. Sharps bins were sited safely and their labels had been completed correctly.

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 dentist confirmed that rubber dams were used whenever possible.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. An automated external defibrillator (AED) was available and staff had access to oxygen, along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The practice held training sessions each year in April for the whole team so that they could maintain their competence in dealing with medical emergencies. However, staff did not regularly rehearse emergency medical simulations so that they could keep their skills up to date.

The practice held emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The emergency medicines we saw were all in date and stored in a central location known to all staff. Weekly recorded checks were completed to ensure all equipment and medicines were fit for safe use.

Staff also had access to a first aid kit, bodily and mercury spillage kits and eye wash equipment.

Staff recruitment

We checked personnel records for two staff which contained proof of their identity, their employment contract and a disclosure and barring check (DBS). The

Are services safe?

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. However written references had not been obtained for either member of staff, and no record had been made of the verbal references received. Notes from their interviews were not kept to demonstrate they had been conducted in line with employment legislation. There was no formal induction procedure in place to ensure staff had the skills and knowledge for their new role.

The practice had recently recruited a new associate dentist and the principal dentist told us he had actively involved all staff in their selection.

Monitoring health & safety and responding to risks

There was a health and safety policy available with a poster, which identified local health and safety representatives. There was a general risk assessment which covered a wide range of identified hazards in the practice, and detailed the control measures that had been put in place to reduce the risks to patients and staff.

Firefighting equipment such as extinguishers was regularly tested, evidence of which we viewed. A fire risk assessment for the practice had been undertaken in 2011, although it had not been reviewed since this date. Staff had not received any specific fire training and no evacuations were practiced so that staff knew what to do in the event of a fire.

A Legionella risk assessment had been completed in February 2015, although we found no evidence that its recommendations had been implemented. However, hot and cold water temperatures were monitored monthly, and the incoming water supply temperature was checked every six months. Dental unit water lines were continually disinfected with a biocide in the water supply bottle, and staff ran the water lines each day in accordance with national guidance to reduce the risk of legionella bacteria forming.

There was a control of substances hazardous to health file in place containing chemical safety data sheets for materials used within the practice, including domestic cleaning products. This had been reviewed recently to ensure that it only contained up to date information.

The practice had a business continuity plan to deal with any emergencies that might occur which could disrupt the safe and smooth running of the service. It included essential contact details of relevant utility companies.

Infection control

Patients who completed our comment cards told us that they were happy with the standards of hygiene and cleanliness at the practice.

The practice had infection control policies in place to provide guidance for staff on essential areas such as minimising blood borne viruses, waste disposal, blood spillage, hand hygiene and the use of personal protective equipment. We viewed a recently completed infection control audit undertaken by the practice manager. An action plan had been implemented to address identified shortfalls such as the use of aprons when scrubbing instruments and the installation of wall mounted sharps bins.

Most areas of the practice we viewed were visibly clean and hygienic, including the waiting area, toilet and staff room. However it was not clear when cushion covers in the waiting area had been cleaned and we noted a build-up of lime scale around the taps in the toilet. Some window blinds and cupboard tops were dusty. We checked both treatment rooms and surfaces including walls, floors and cupboard doors were free from visible dirt. The rooms had sealed flooring and modern sealed work surfaces so they could be cleaned easily. There were separate hand washing sinks for staff. Dirty and clean zones were clearly identifiable and there was plenty personal protective equipment available for staff and patients. We noted that fabric covered chairs in each treatment room: these were difficult to clean effectively and should be removed.

The practice did not have a separate decontamination room for the processing of dirty instruments so all instruments were cleaned in the treatment rooms. Specific times were set aside to do this each day at 11am,1pm, 3pm and the end of the day, when no patients were present, and instruments were kept moist whilst awaiting reprocessing. Nurses told us they found this system manageable and appointments were managed effectively to prevent a build-up of instruments.

The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean. The dental nurses

used a system of manual scrubbing for the initial cleaning process and instruments were then inspected under an illuminated magnifier. Following this they were placed in an autoclave (a device used to sterilise medical and dental instruments). When the instruments had been sterilized, they were pouched and stored hygienically until required. All pouches were dated with an expiry date in accordance with current guidelines. We noted that the dental nurse wore appropriate personal protective equipment throughout the process. We were shown the systems in place to ensure that the autoclaves used in the decontamination process were working effectively. Data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were complete and up to date.

The segregation and storage of clinical waste in the practice was in line with current guidelines laid down by the Department of Health. Clinical waste was stored outside the practice, although the bins was not secured safely. The practice used an appropriate contractor to remove clinical waste and waste consignment notices were available for inspection.

Records showed that all dental staff had been immunised against Hepatitis B. We noted that staff uniforms were clean, and their arms were bare below the elbows to reduce the risk of cross contamination. The dental nurses told us they were given enough uniforms for their work and changed out of them whenever leaving the practice. However, the dentist did not change into different trousers when treating patients, thereby compromising good infection control.

Equipment and medicines

Staff told us they had enough equipment to do their job and that repairs were undertaken swiftly.

The equipment used for sterilising instruments was checked, maintained and serviced in line with the manufacturer's instructions. All other types of equipment were tested and serviced regularly and we saw maintenance logs and other records that confirmed this.

For example, portable appliance testing had been completed in June 2016, surgery chairs serviced in January 2017, the gas boiler in January 2017 and the compressor in January 2017.

Medical consumables we checked in cupboards and drawers were in date for safe use.

The dentist we spoke with was aware of on-line reporting systems to the British National Formulary and of the yellow card scheme to report any adverse reactions to medicines. We saw from a sample of dental care records that the batch numbers and expiry dates for local anaesthetics were recorded in patients' clinical notes. The practice stored prescription pads safely to prevent loss due to theft and a logging system was in place to account for the prescriptions issued.

The practice did not have a separate fridge for medical consumables, which required cool storage, and we found some stored alongside food in the staff room. The temperature of the fridge was not monitored to ensure it operated effectively.

Radiography (X-rays)

We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the local rules for each unit. Included in the file were the critical examination packs for each X-ray set and the necessary documentation pertaining to the maintenance of the X-ray equipment was sent to us shortly after our inspection. However, rectangular collimation was not used to confine x-ray beams and reduce dosage to patients in either surgery

Training records showed all staff where appropriate had received training for core radiological knowledge under IRMER 2000 Regulations. The practice manager had introduced a helpful daily check list for each unit but this was not being used routinely by the nurses or dentist.

Dental care records we viewed showed that dental X-rays were justified, reported on and quality assured.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We spoke with two patients during our inspection and received 48 comments cards that had been completed by patients prior to our inspection. All the comments received reflected that patients were very satisfied with the quality of their dental treatment.

We found that the care and treatment of patients was planned and delivered in a way that ensured their safety and welfare. Our discussion with the dentist and review of dental care records demonstrated that patients' dental assessments and treatments were carried out in line with recognised guidance from the National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC) guidelines. This assessment included an examination covering the condition of the patient's teeth, gums and soft tissues. Antibiotic prescribing, wisdom tooth extraction and patients' recall frequencies also met national guidance. Where relevant, preventative dental information was given in order to improve the outcome for the patient. Dental records we were shown were detailed and of a good standard generally.

We saw a range of clinical audits that the practice regularly carried out to help them monitor the effectiveness of the service. These included the quality of dental radiographs and infection control. A dental care records' audit undertaken by the practice manager just prior to out inspection showed that the dentists recorded smoking cessation advice, patients' consent and medical histories well.

The practice had been selected as a 'prototype' practice as part of a pilot scheme to help the NHS make improvements to dental services.

Health promotion & prevention

A number of oral health care products were available for sale to patients including interdental brushes, mouthwash and floss. Free samples of toothpaste were also available and the receptionist told us she regularly gave these out to patients. The practice took part in a number of local oral health initiatives, including a scheme where parents could swap their child's old toothbrush for a new one; and swap babies' bottles for a cup. We noted a number of oral hygiene leaflets available in the waiting room and a large poster aimed at children about sugar intake.

Although the dentist we spoke with was not aware of guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention', we observed him give one patient good advice about tooth brushing techniques and the use of high fluoride toothpaste. The dental nurse told us the dentist regularly asked patients about their smoking, alcohol intake and diet and gave advice about how to manage these. We noted leaflets about smoking cessation services in the waiting area, making them easily available to patients.

Staffing

Staff told us they were enough of them for the smooth running of the practice although they acknowledged the additional pressure they had faced recently due to the departure of one of the dentists and a nurse. Locum dentists had been employed to cover gaps and a new dentist had recently been employed and was due to start at the practice soon.

Files we viewed demonstrated that staff were appropriately qualified, trained had current professional validation and professional indemnity insurance. The receptionist told us she had undertaken a customer care skills course which she had found useful. The practice had appropriate Employer's Liability insurance in place.

All staff received an annual appraisal of their performance which they described as useful.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves and there were clear referral pathways in place. A log of the referrals made was kept so they could be could be tracked, although patients were not offered a copy of the referral for their information.

Consent to care and treatment

Patients told us that they were provided with good information during their consultation and they had the opportunity to ask questions before agreeing to a particular treatment. Dental records we reviewed

Are services effective?

(for example, treatment is effective)

demonstrated that treatment options had been explained to patients. The practice's own recording keeping audit had identified that the dentists routinely recorded patients' consent to their treatment. Additional consent forms were used for some procedures such as tooth whitening.

The Mental Capacity Act 2005 (MCA) provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Dental staff had undertaken training in relation to the MCA and had a clear understanding of patient consent issues. The practice had a specific policy in place to guide staff.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Before the inspection we sent comment cards so patients could tell us about their experience of the practice. We collected 48 completed cards and obtained the views of a further two patients on the day of our visit. These provided a very positive view of the practice. Patients told us they were treated in a way that they liked by staff and many comment cards we received described staff as caring, friendly and considerate of their needs. One patient told us that staff always spoke slowly and clearly to her mother who had a hearing impairment. Three patients told us that they were nervous about visiting the dentist, but that staff always helped them feel relaxed and comfortable.

We observed the receptionists interact with about 8 patients both on the phone and face to face and noted she was consistently polite and helpful towards them, creating a welcoming and friendly atmosphere. Staff gave us examples of where they had gone out their way to support patients such as hand delivering patients' dentures to the lab so they could be repaired quicker, arranging emergency appointments out of hours, calling patients to check on their welfare and supporting the parent of a child patient who had feinted.

The reception area was not particularly private but we noted that radio music was played to distract patients. Staff told us they tried not give out personal details when speaking to patients on the phone and all answer phone messages were played back in the office so they could not be overheard. The receptionist told us she sometimes asked people to stand back from the desk to give patients privacy and we noted that patients' paperwork was turned face down so it could not be read. The computer screen was not overlooked and was password protected.

All consultations were carried out in the privacy of the treatment rooms and we noted that doors were closed during procedures to protect patients' privacy. Window blinds were in place to prevent passerbys from looking in.

Involvement in decisions about care and treatment

Patients told us that their dental health issues were discussed with them and they felt well informed about the options available to them and their costs. One patient told us the dentist had shown him his x-ray results which had increased his understanding of his treatment.

The dentist told us he often used study models and photos to help explain treatment and referred patients to the internet for further information. He also stated he never started complex treatment on the same day as an initial examination appointment to give patients time to consider it. We noted leaflets on a range of dental treatment available to patients in the waiting room. During our inspection we overheard the dentist explaining in some detail the range of treatment options available to a patient .

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice was next door to the local health centre and accessibly by public transport. There was good on street parking nearby. It offered a full range of NHS treatments and patients had access to some private cosmetic treatments including teeth whitening.

We found good information about the practice contained in a folder in the waiting room which included details about the dental clinicians, how to make an appointment, the practice's patient consent policy and data protection arrangements. Information about emergency out of hours' service was available on the practice's answer phone message, although this was not displayed on the front door should a patient come to the practice when it was closed.

The practice opened from 9 am to 6pm on Mondays; and from 8.45am to 5pm on Tuesday to Fridays. It had also recently started to provide Saturday morning appointments by request for patients who struggled to get there during normal working hours. One of the dental nurses identified available emergency slots each week, although the practice manager told us she was going to implement a standard half hour slot each day for patients needing urgent appointments.

Both staff and patients told us they did not feel rushed during appointments and that appointments rarely ran overtime. We viewed the appointments' schedule that showed the practice was not overbooked and the dentists saw about 25-30 patients per day.

Tackling inequity and promoting equality

The practice offered good access to wheel chair users. There was level access into the premises and ground floor treatment rooms. The reception desk had been lowered to make communication with wheelchair users easier and the toilet was fully accessible. However, there was no portable hearing loop available despite a number of patients with hearing aids, or easy riser chairs in the waiting area for patients with mobility needs.

Staff were aware of local translation services and told us they occasionally used them especially in relation to a number of Lithuanian patients that came to the practice. However it did not have any information in other languages or formats such as large print.

Concerns & complaints

The practice had a policy and a procedure that set out how complaints would be addressed, and staff spoke knowledgeably about how they would handle a patient's concerns. Information about the procedure was available in the patient waiting area and this included details of the timescales by which they would be responded to and other organisations that could be contacted.

The practice had only received one formal complaint in the previous year to our inspection. We reviewed the paperwork in relation to this complaint and found it had been managed in a professional and empathetic way. The practice's response outlined a number of options available to the patient to help resolve the situation. The practice manager told us the practice had received an number of informal complaints, however no central log of them had been kept so that they could be monitored for common themes and patterns.

Are services well-led?

Our findings

Governance arrangements

The principal dentist had day to day responsibility for the running of the service, supported by a part-time practice manager. The practice manager had only been in post a few months at the time of our inspection but it was clear that she had already implemented a number of changes to improve the running of the service and was keen to improve it more.

The practice had a list of policies and procedures in place to govern its activity, some of which had been reviewed and others needed to be updated. Not all the polices had been signed by staff to demonstrate they had read, understood and had agreed to abide by them. The practice manager told us she was going to use forthcoming staff meetings to discuss the practice's polices to ensure staff understood them.

Communication across the practice was structured around practice meetings which all staff attended. These had not been happening regularly before the new practice manager had been appointed but were now minuted, and staff told us they felt able to raise any concerns at them. The dentist had also introduced 10 minute daily staff 'huddles' as a way of improving communication between the team.

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 dental radiographs, infection control procedures and the quality of dental care records. The practice manager assured us these would be undertaken more frequently than before.

Staff received regular appraisal of their performance, which identified their objectives, development needs, training and contribution to the practice. We saw that action had been taken to address staff's poor performance.

Leadership, openness and transparency

Staff told us they enjoyed their work and described the principal dentist as approachable, caring and 'laid back'. One nurse told us it was the friendliest and best run practice she had worked at. Results from NHS Choices showed the practice had scored five out of five stars based on 13 patient reviews.

Staff told us they felt involved in the running of the practice. The practice had recently recruited a new associate dentist and the principal dentist told us he had actively involved all staff in their selection.

The practice had a duty of candour policy in place and staff understood the importance about being honest and transparent to patients if things went wrong.

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

Patients were asked to complete a survey which asked them for their views on a range of issues including the friendliness of reception staff; the cleanliness of the practice and the length of their waiting time. The practice had also introduced the NHS Friends and Family test as a way for patients to let them know how well they were doing. Patients' suggestions for the practice to open on a Saturday, to be able to email the practice and to have a card payment machine had been implemented by the principal dentist.

The practice gathered feedback from staff generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and the principal dentist. We were provided with examples of how the principle dentist had implemented staff suggestions such as increasing the frequency of meetings, and undertaking shared activities out of the practice.