Gunn Dental Care

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Inspection Report

Bramhope Medical Centre
Tredgold Crescent
Leeds
LS16 9BR
Tel: 0113 395 3000
Website: www.gunndentalcare.co.uk

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Overall summary

We carried out an announced comprehensive inspection on 7 July 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Gunn Dental Care is situated in the village of Bramhope near Leeds, West Yorkshire. It offers private dental treatments to patients of all ages but also offers. The services include preventative advice and treatment, routine restorative dental care and dental implants. Conscious sedation is also provided by a consultant from the local hospital.

The practice is located within a medical centre. It has two surgeries, a decontamination room, one waiting area and a reception area. All facilities are on the ground floor. There are accessible toilet facilities on the ground floor of the premises. The practice is about to undergo refurbishment of the waiting and reception area to enhance the appearance and make it more spacious.

There are two dentists, a dental hygiene therapist, a dental hygienist, four dental nurses and a receptionist.

The opening hours are Monday from 9-00am to 5-00pm, Tuesday and Wednesday from 9-00am to 6-30pm, Thursday from 8-00am to 4-00pm and Friday from 9-00am to 4-30pm.

The principal dentist 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'.

Summary of findings

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.

During the inspection we received feedback from 44 patients. The patients were positive about the care and treatment they received at the practice. Comments included that staff were friendly, professional and caring. Patients also commented that all treatment is discussed fully and all options are given.

Our key findings were:

- The practice appeared clean and hygienic.
- The practice had systems in place to assess and manage risks to patients and staff including infection prevention, control and health and safety and the management of medical emergencies.
- Staff were qualified and had received training appropriate to their roles.
- Dental care records were detailed and showed that treatment was planned in line with current best practice guidelines.
- Oral health advice and treatment were provided in-line with the 'Delivering Better Oral Health' toolkit (DBOH).
- Patients were involved in making decisions about their treatment and were given clear explanations about their proposed treatment including costs, benefits and risks.
- We observed that patients were treated with kindness and respect by staff. Staff ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood.
- Patients were able to make routine and emergency appointments when needed.
- There were clearly defined leadership roles within the practice.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

There was an effective system in place for reporting of incidents and accidents. These were followed up, analysed and learning was disseminated.

Staff had received training in safeguarding at the appropriate level and knew the signs of abuse and who to report them to.

Staff were suitably qualified for their roles and the practice had undertaken the relevant recruitment checks to ensure patient safety.

Patients' medical histories were obtained before any treatment took place. The dentists were aware of any health or medication issues which could affect the planning of treatment. Staff were trained to deal with medical emergencies. All emergency equipment and medicines were in date and in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines.

The decontamination procedures were effective and the equipment involved in the decontamination process was regularly serviced, validated and checked to ensure it was safe to use.

Are services effective?

No action

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

Patients' dental care records provided comprehensive information about their current dental needs and past treatment. The practice monitored any changes to the patient's oral health and provided treatment when appropriate.

The practice followed best practice guidelines when delivering dental care. These included Faculty of General Dental Practice (FGDP), National Institute for Health and Care Excellence (NICE) and guidance from the British Society of Periodontology (BSP). The practice focused strongly on prevention and the dentists were aware of the 'Delivering Better Oral Health' toolkit (DBOH) with regards to fluoride application and oral hygiene advice.

Staff were encouraged to complete training relevant to their roles. The clinical staff were up to date with their continuing professional development (CPD).

Referrals were made to secondary care services if the treatment required was not provided by the practice.

Are services caring?

No action

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

Summary of findings

During the inspection we received feedback from 44 patients. Patients commented that staff were friendly, professional and caring. Patients also commented that all treatment is discussed fully and all options are given.

We observed the staff to be welcoming and caring towards the patients.

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection.

Staff explained that enough time was allocated in order to ensure that the treatment and care was fully explained to patients in a way which they understood.

Are services responsive to people's needs?

No action 

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

The practice had an efficient appointment system in place to respond to patients' needs. There were vacant appointments slots for urgent or emergency appointments each day.

Patients commented they could access treatment for urgent and emergency care when required. There were clear instructions for patients requiring urgent care when the practice was closed.

There was a procedure in place for responding to patients' complaints. This involved acknowledging, investigating and responding to individual complaints or concerns. Staff were familiar with the complaints procedure.

The practice was fully accessible for patients with a disability or limited mobility to access dental treatment.

Are services well-led?

No action 

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

There was a clearly defined management structure in place and all staff felt supported and appreciated in their own particular roles. The principal dentist was responsible for the day to day running of the practice.

Effective arrangements were in place to share information with staff by means of six-weekly practice meetings which were well minuted for those staff unable to attend.

The practice regularly audited clinical and non-clinical areas as part of a system of continuous improvement and learning.

They conducted staff and patient satisfaction surveys and there was a comments box in the waiting room for patients to make suggestions to the practice.

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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 led by a CQC inspector who was supported by a specialist dental adviser.

During the inspection we received feedback from 44 patients. We also spoke with two dentists, three dental nurses and the receptionist. To assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

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 clear guidance for staff about how to report incidents and accidents. Staff described an incident which had occurred in the last year and this had been well investigated and reflected upon by the dental practice. We saw that as a result of a particular incident that the practice had made changes to prevent this event from occurring again. Any accidents or incidents would be reported to the principal dentist and would be discussed at staff meetings in order to disseminate learning.

The principal dentist understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR) and notifications which need to be made to the CQC.

On the day of inspection there was not a procedure for receiving national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) that affected the dental profession. We saw by the end of the inspection that an account with the MHRA was set up.

Reliable safety systems and processes (including safeguarding)

The practice had child and vulnerable adult safeguarding policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff. Staff had access to contact details for both child protection and adult safeguarding teams. The principal dentist was the safeguarding lead for the practice and all staff had undertaken level two safeguarding training.

The practice had systems in place to help ensure the safety of staff and patients. These included the use of a safe sharps system, a protocol that only the dentists or the dental hygiene therapist handle sharps and guidelines about responding to a sharps injury (needles and sharp instruments).

Rubber dam (this is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth) was used in root canal treatment in line with guidance from the British Endodontic Society.

We saw that patients' clinical records were computerised; password protected and securely backed up to secure storage to keep people safe and protect them from abuse.

Medical emergencies

The practice had procedures in place which provided staff with clear guidance about how to deal with medical emergencies. This was in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). Staff were knowledgeable about what to do in a medical emergency and had completed training in emergency resuscitation and basic life support within the last 12 months. One of the dental nurses had also completed immediate life support training to assist with the provision of conscious sedation.

The kept an emergency resuscitation kit and oxygen. Staff knew where the emergency kits were kept. The practice did not have an Automated External Defibrillator (AED). The practice had undertaken a risk assessment for not having an AED as there was one kept in the medical centre and was available within less than a minute. An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.

Records showed regular checks were carried out on the oxygen cylinder and the emergency drugs. These checks ensured that the oxygen cylinder was full and the emergency medicines were in date.

Staff recruitment

The practice had a policy and a set of procedures for the safe recruitment of staff which included seeking references, proof of identity, checking relevant qualifications and professional registration. We reviewed a sample of staff files and found the recruitment procedure had been followed. The principal dentist told us they carried out Disclosure and Barring Service (DBS) checks for all newly employed staff. These checks 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. We reviewed records of staff recruitment and these showed that all checks were in place.

Are services safe?

All clinical staff at this practice were qualified and registered with the General Dental Council (GDC). There were copies of current registration certificates and personal indemnity insurance (insurance professionals are required to have in place to cover their working practice).

Monitoring health & safety and responding to risks

A health and safety policy and risk assessment was in place at the practice. This identified the risks to patients and staff who attended the practice. The risks had been identified and control measures put in place to reduce them. The practice carried out an annual health and safety audit. This included checks on slips, trips and falls and issues relating to fire safety.

There were policies and procedures in place to manage risks at the practice. These included infection prevention and control, waste disposal and risks associated with Hepatitis B. Fire safety checks were completed by the medical centre. This included fire alarm tests and fire drills

The practice maintained a file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including substances such as disinfectants, and dental materials in use in the practice. The practice identified how they managed hazardous substances in its health and safety and infection control policies and in specific guidelines for staff, for example in its blood spillage and waste disposal procedures. The COSHH folder was reviewed every year by one of the dental nurses to check whether any new hazards had been identified for the substances included in the folder. Any new materials or substances would be added to the COSHH folder.

Infection control

There was an infection control policy and procedures to keep patients safe. These included hand hygiene, safe handling of instruments, managing waste products and decontamination guidance. The practice followed the guidance about decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 -Decontamination in primary care dental practices (HTM 01-05)'. One of the dental nurses was the infection control lead.

Staff had received training in infection prevention and control. We saw evidence that staff were immunised against blood borne viruses (Hepatitis B) to ensure the safety of patients and staff.

We observed the treatment rooms and the decontamination room to be clean and hygienic. Work surfaces were free from clutter. Staff told us they cleaned the treatment areas and surfaces between each patient and at the end of the morning and afternoon sessions to help maintain infection control standards. There was a cleaning schedule which identified and monitored areas to be cleaned.

There were hand washing facilities in the treatment rooms and staff had access to supplies of personal protective equipment (PPE) for patients and staff members. Posters promoting good hand hygiene and the decontamination procedures were clearly displayed to support staff in following practice procedures. Sharps bins were appropriately located, signed and dated and not overfilled. We observed waste was separated into safe containers for disposal by a registered waste carrier and appropriate documentation retained. A clinical waste audit was completed on an annual basis to ensure the contract was adequate for the amount of waste produced.

Decontamination procedures were carried out in a dedicated decontamination room in accordance with HTM 01-05 guidance. An instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which minimised the risk of the spread of infection.

One of the dental nurses showed us the procedures involved in disinfecting, inspecting and sterilising dirty instruments; packaging and storing clean instruments. The practice routinely used an ultrasonic bath to clean the used instruments, examined them visually with an illuminated magnifying glass, and then sterilised them in a validated autoclave (a device for sterilising dental and medical instruments). The decontamination room had clearly defined dirty and clean zones in operation to reduce the risk of cross contamination. Staff wore appropriate PPE during the process and these included disposable gloves, aprons and protective eye wear.

The practice had systems in place for daily and weekly quality testing the decontamination equipment and we saw records which confirmed these had taken place. There were sufficient instruments available to ensure the services provided to patients were uninterrupted.

Are services safe?

The practice had been carrying out an Infection Prevention Society (IPS) self- assessment audit every six months relating to the Department of Health's guidance on decontamination in dental services (HTM01-05).This is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. The audit showed the practice was meeting the required standards. We saw that an action plan had been identified and actioned.

Records showed a risk assessment process for Legionella had been carried out (Legionella is a term for particular bacteria which can contaminate water systems in buildings). The practice undertook processes to reduce the likelihood of legionella developing which included running the water lines in the treatment rooms at the beginning and end of each session and between patients, monitoring hot and cold water temperatures each month and the use of a water conditioning agent in the water lines. The infection control lead had completed training in Legionella awareness.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as X-ray sets, the autoclave and the compressor. The practice maintained a comprehensive list of all equipment including dates when maintenance contracts which required renewal. We saw evidence of validation of the autoclave and the compressor. Portable appliance testing (PAT) had been completed in December 2015 (PAT confirms that portable electrical appliances are routinely checked for safety).

The practice held a supply of antibiotics and painkillers to be dispensed to patients. These were kept locked away and a log of which antibiotics was kept. Medicines relating to the provision of conscious sedation were brought to the practice by the visiting dentist.

Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. Records we viewed demonstrated that the X-ray equipment was regularly tested, serviced and repairs undertaken when necessary. A Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure that the equipment was operated safely and by qualified staff only. We noticed in one of the treatment rooms the X-ray machine did not have a rectangular collimator. This was discussed with the principal dentist and we were informed that they could not source a rectangular collimator to retrofit to the X-ray machine. The principal dentist was looking at getting a new X-ray machine for this treatment room which would have a rectangular collimator.

Local rules were available in all treatment rooms and within the radiation protection folder for staff to reference if needed. We saw that a justification, grade and a report was documented in the dental care records for all X-rays which had been taken.

X-ray audits were carried out every year. This included assessing the quality of the X-rays which had been taken. The results of the most recent audit undertaken confirmed they were compliant with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept up to date detailed electronic dental care records. They contained information about the patient's current dental needs and past treatment. The dentists carried out an assessment in line with recognised guidance from the Faculty of General Dental Practice (FGDP). This was repeated at each examination in order to monitor any changes in the patient's oral health. The dentists used NICE guidance to determine a suitable recall interval for the patients. This takes into account the likelihood of the patient experiencing dental disease (including decay and gum disease).

During the course of our inspection we discussed patient care with the dentists and checked dental care records to confirm the findings. Clinical records were comprehensive and included details of the condition of the teeth, soft tissue lining the mouth, gums and any signs of mouth cancer. If the patient had more advanced gum disease then a more detailed inspection of the gums was undertaken.

Records showed patients were made aware of the condition of their oral health and whether it had changed since the last appointment. Medical history checks were updated by each patient every time they attended for treatment and entered in to their electronic dental care record. This included an update on their health conditions, current medicines being taken and whether they had any allergies.

The practice used current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, following clinical assessment, the dentists followed the guidance from the FGDP before taking X-rays to ensure they were required and necessary. Justification for the taking of an X-ray, quality assurance of each x-ray and a detailed report was recorded in the patient's care record.

Health promotion & prevention

The practice had a strong focus on preventative care and supporting patients to ensure better oral health in line with the 'Delivering Better Oral Health' toolkit (DBOH). DBOH is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. For example, the dentists applied fluoride varnish to children who attended for an examination. Fissure sealants were also applied to children at high risk of dental decay. High fluoride toothpastes were prescribed for patients at high risk of dental decay.

The practice had a selection of dental products on sale in the reception area to assist patients with their oral health.

The medical history form patients completed included questions about smoking and alcohol consumption. We were told by the dentists and saw in dental care records that smoking cessation advice was given to patients where appropriate. Patients were made aware of the link between smoking and gum disease and oral cancer.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. The induction process included getting the new member of staff aware of the location of emergency medicines and the fire evacuation procedures. New members of staff were asked to complete the health and safety risk assessment. The principal dentist felt this was a robust process which ensured the new member of staff was fully aware of the health and safety matters within the practice.

Staff told us they had good access to on-going training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). The practice organised in house training for medical emergencies to help staff keep up to date with current guidance on treatment of medical emergencies in the dental environment. Records showed professional registration with the GDC was up to date for all staff and we saw evidence of on-going CPD.

The practice used a dental hygiene therapist. Dental hygiene therapists are trained dental care professionals who are qualified to undertake certain treatments, for example, fillings, periodontal treatments and the extraction of deciduous teeth. The dentists would refer patients for such treatments to the dental hygiene therapist. We saw that prescriptions from the dentist to the dental hygiene therapist were detailed.

Staff had annual appraisals and training requirements were discussed at these. We saw evidence of completed appraisal documents.

Working with other services

Are services effective?

(for example, treatment is effective)

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. For example, referrals were made to hospitals and specialist dental services for further investigations or specialist treatment including cone beam CT scans and oral surgery. The practice completed detailed proformas or referral letters to ensure the specialist service had all the relevant information required. A copy of the referral letter was kept in the patient's dental care records. Letters received back relating to the referral were first seen by the referring dentist to see if any action was required and then stored in the patient's dental care records.

The practice had a procedure for the referral of a patient with a suspected malignancy. This involved a telephone call to the hospital which was followed up by an e-mail.

Consent to care and treatment

Patients were given appropriate information to support them to make decisions about the treatment they received. The dentists were knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent. The dentists described to us how valid consent was obtained for all care and treatment and the role family members and carers might have in supporting the patient to understand and make decisions. We were told that they would use language which patients would understand and get the patient to repeat back the options provided to ensure they had a full understanding of the treatment options which had been provided.

Staff had received training and had an understanding of the principles of the Mental Capacity Act (MCA) 2005 and how it was relevant to ensuring patients had the capacity to consent to their dental treatment.

The dentists ensured patients gave their consent before treatment began and this was recorded in the dental care records. We were told that individual treatment options, risks, benefits and costs were discussed with each patient. A treatment plan was signed by patients which included details of the proposed treatment and the associated costs. Details of the risks and benefits of each treatment option proposed by the dentist were not clear in the dental care records. This was brought to the attention of the principal dentist and we were told that these would now be documented.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Feedback from patients was positive and they commented that they were treated with care, respect and dignity. Staff told us that they always interacted with patients in a respectful, appropriate and kind manner. We observed staff to be friendly and respectful towards patients during interactions at the reception desk and over the telephone.

Staff were very aware of the issues of confidentiality in a small reception and waiting area and we observed privacy and confidentiality were maintained for patients who used the service on the day of inspection. Dental care records were not visible to the public on the reception desk. We observed staff were helpful, discreet and respectful to patients. Staff said that if a patient wished to speak in private, an empty room would be found to speak with them. Private phone calls were made in the office so conversations could not be overheard. There was a television in the waiting room which provided a form of distraction to those waiting and improve confidentiality.

Patients' electronic care records were password protected and regularly backed up to secure storage.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients commented they felt involved in their treatment and it was fully explained to them. Staff described to us how they involved patients' relatives or carers when required and ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood.

When treating children the dentist told us that he would use the "tell-show-do" technique in order to help children overcome any anxieties. The dentists understood the concept of Gillick competency with regarding to gaining consent from children under the age of 16.

Patients were informed of the range of treatments available in the on the practice website and on information in the waiting room.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We found the practice had an efficient appointment system in place to respond to patients' needs. Staff told us that patients who requested an urgent appointment would be seen the same day. We saw evidence in the appointment book that there were dedicated emergency slots available each day. If the emergency slots had already been taken for the day then the patient was offered to sit and wait for an appointment if they wished.

We observed the clinics ran smoothly on the day of the inspection and patients were not kept waiting.

Tackling inequity and promoting equality

The practice had equality and diversity, and disability policies to support staff in understanding and meeting the needs of patients. Reasonable adjustments had been made to the premises to accommodate patients with mobility difficulties. A DDA audit had been completed as required by the Disability Act 2005. These included step free access to the premises, an automatic door opener and a ground floor accessible toilet. The ground floor surgeries were large enough to accommodate a wheelchair or a pram.

Access to the service

The practice displayed its opening hours in the premises and on the practice website. The opening hours are Monday from 9-00am to 5-00pm, Tuesday and Wednesday from 9-00am to 6-30pm, Thursday from 8-00am to 4-00pm and Friday from 9-00am to 4-30pm.

Patients could access care and treatment in a timely way and the appointment system met their needs. Where treatment was urgent patients would be seen the same day. The practice had a system in place for patients requiring urgent dental care when the practice was closed. Monday to Thursday evenings, patients were signposted to the principal dentist's mobile phone number. Between Friday evening and Monday morning and bank holidays the practice had an arrangement with other local practices to see emergency patients on a rota basis.

Concerns & complaints

The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. There were details of how patients could make a complaint displayed in the waiting room and in the practice's information leaflet. The principal dentist was in charge of dealing with complaints when they arose. Staff told us they raised any formal or informal comments or concerns with the practice manager to ensure responses were made in a timely manner. Staff told us that they aimed to resolve complaints in-house initially. The practice had not received any complaints in the previous 12 months.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients. We found there was an effective system in place which helped ensure a timely response. This included acknowledging the complaint within two working days and providing a formal response within 10 days. If the practice was unable to provide a response within 10 days then the patient would be made aware of this.

Are services well-led?

Our findings

Governance arrangements

The practice manager was in charge of the day to day running of the service. There was a range of policies and procedures in use at the practice. We saw they had systems in place to monitor the quality of the service and to make improvements. The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately.

The practice had an effective approach for identifying where quality or safety was being affected and addressing any issues**.** Health and safety and risk management policies were in place and we saw a risk management process to ensure the safety of patients and staff members. For example, we saw risk assessments relating to infection prevention and control, waste disposal and risks associated with Hepatitis B.

There was an effective management structure in place to ensure that responsibilities of staff were clear. Staff told us that they felt supported and were clear about their roles and responsibilities.

Leadership, openness and transparency

The culture of the practice encouraged candour, openness and honesty to promote the delivery of high quality care and to challenge poor practice. Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. These were discussed openly at staff meetings where relevant and it was evident that the practice worked as a team and dealt with any issue in a professional manner.

The practice held monthly staff meetings. These meetings were minuted for those who were unable to attend. The minutes were posted on the practice intranet system for staff to reference at a later date. During these staff meetings topics such as actions from the last meeting, reception issues and any areas for improvement. The comment box was also opened at these meetings and have a discussion to see if any action was required.

All staff were aware of with whom to raise any issue and told us that the principal dentist was approachable, would listen to their concerns and act appropriately. We were told that there was a no blame culture at the practice and that the delivery of high quality care was part of the practice's ethos.

Learning and improvement

Quality assurance processes were used at the practice to encourage continuous improvement. The practice audited areas of their practice as part of a system of continuous improvement and learning. This included clinical audits such as dental care records, X-rays and infection control. The visiting clinician had also audited completed sedation cases. We looked at the audits and saw that the practice was performing well. However, where improvements could be made these were identified and followed up by a repeat audit. Results of audits were regularly discussed at staff meetings in order to disseminate learning to all staff.

Staff told us they had access to training and this was monitored to ensure essential training was completed each year; this included medical emergencies and basic life support. Training was completed on a variety of levels including online and attending courses. Staff working at the practice were supported to maintain their continuous professional development as required by the General Dental Council.

All staff had annual appraisals at which learning needs, general wellbeing and aspirations were discussed. We saw evidence of completed appraisal forms in the staff folders

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

The practice had systems in place to involve, seek and act upon feedback from people using the service including carrying out annual patient satisfaction surveys and a comment box in the waiting room. The satisfaction survey included questions about whether treatment options were well explained, the cleanliness of the surgeries, whether they were seen on time and whether the staff were friendly. The most recent patient survey showed a high level of satisfaction with the quality of the service provided. It was clearly evident that the principal dentist was very proactive in responding to patient feedback and the patient experience was central to the practice's ethos.