

MLB Dentysta Limited

MLB DENTYSTA LTD

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection visiting the practice on 26 May 2015 and again on 30 May 2015.

The dentist, who is the registered provider, is the only person currently working at the practice and she complete all tasks. A dental nurse and receptionist are employed at the practice but they are both off work for an extended period due to sickness and maternity leave.

The practice provides primary dental services to private patients only and is open Monday to Saturday excluding Thursday. There is a mixture of appointments available both during the day and evening.

We viewed CQC comment cards that had been left for patients to complete prior to our visit about the services provided. There were 30 completed comment cards and all of them reflected positive comments about the dentist and the services provided. Patients commented that the practice was clean and hygienic, they found it easy to book an appointment and they found the quality of the dentistry to be excellent. They said explanations were clear and that the dentist was kind, caring and reassuring.

We found that this practice was providing effective, caring and responsive care in accordance with the relevant regulations. However we found that this practice was not providing safe and well-led care in accordance with the relevant regulations.

We took action to protect patients and ensure the provider was complying with all the regulations. We have since seen evidence that the dentist is providing safe and well led services in addition to them being effective, caring and responsive.

Our key findings were:

- The dentist had received safeguarding and whistleblowing training and knew the processes to follow to raise any concerns.
- The dentist had been trained to handle emergencies and appropriate medicines and life-saving equipment were readily available. Patients' care and treatment was planned and delivered in line with evidence based guidelines, best practice and current legislation.
- Patients received clear explanations about their proposed treatment, costs, benefits and risks. They were involved in making decisions about it.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- The practice sought feedback from patients about the services they provided.
- There were insufficient staff appropriately qualified at the practice to keep patients safe and recognised best practice was not being followed.
- Patient records were not being stored securely.
- There was no contract in place for the disposal of hazardous waste during the initial inspection but this had been put in place before our second visit.

Summary of findings

On our inspection we identified regulations that were not being met and the provider was required to:

- Employ sufficient staff members to ensure patient safety and there must be a minimum of two members of staff on the premises at all times patients are waiting or being treated.
- Ensure a robust system of appraisal is in place to demonstrate staff current competencies.
- Write a policy to cover the circumstances that staff are absent with short notice and how patients will be protected in these circumstances.
- Ensure appropriate measures are taken to protect patient records in terms of their handling and security when being stored.
- Contract a supplier to dispose of hazardous waste.

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 this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action

There was only one member of staff currently employed at the practice and this was not sufficient to maintain patient safety. At our first visit we found there was no contract in place to dispose of hazardous waste which meant the Code of Practice for the prevention and control of infections was not being followed. We have now seen evidence that sufficient staff with the relevant qualifications are now employed and a contract is in place to dispose of hazardous waste.

We will require the provider to maintain these levels of staff to protect the public.

We saw there was an effective range of policies at the practice and there were a range of medicines to treat patients in the event of emergency. The methods to sterilise equipment were in line with national guidance and the dentist was experienced in the procedures.

There was a health and safety policy in place and a number of surveys had been completed at the practice to keep patients safe.

Are services effective?

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

We were told that patients attending the practice received an assessment of their dental health and that the dentist was trained in methods to safeguard adults and children. Patients consent was actively sought prior to treatment and they were involved in options for their treatment.

Patients were referred to other services in a timely manner. The dentist understood the Mental Capacity Act and offered support when necessary. The dentist was aware of Gillick competency in relation to children under the age of 16.

Consultations were carried out in line with best practice guidance from the National Institute for Health and Care Excellence (NICE).

Are services caring?

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

Patients were treated with dignity and respect and they told us they liked being treated at the practice. Patients told us they were listened to and not rushed. Treatment was clearly explained and they were provided with written treatment plans. Patients were given time to consider their treatment options and felt involved in their care and treatment.

Are services responsive to people's needs?

We found this practice was providing responsive care in accordance with the relevant regulations. There were a wide range of appointments available to suit both working people and those with families. The building was well suited to the practice and there was an effective cleaning regime in place.

There was no audit of patient feedback or complaints, this meant the practice could not learn from the experience of patients but there was a comprehensive complaints policy and information how to complain.

Summary of findings

We saw comment cards from patients as well as a number of completed patient feedback forms which reflected the fact that patients were happy with the service.

Are services well-led?

We found this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action

We saw no evidence of an active recruitment process in order to replace staff and we saw there was no way of ensuring safety at the practice as the dentist worked alone with no support. There was no risk assessment in place to ensure the safety of the dentist while working alone.

We have now seen a process where staff have been employed and relevant employment contracts and policies have been provided to us by the dentist.

Patients' views had been canvassed by encouraging them to complete a feedback form post treatment but there was no evidence of an audit or action plan reflecting the results.

Patient information and data was not handled confidentially and left insecure in an area that the public had access to.

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Detailed findings

Background to this inspection

The inspection took place on 26 May 2015 and 30 May 2015 and was conducted by a CQC inspector and a dental specialist advisor.

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.

Prior to the inspection we asked the practice to send us some information which we reviewed. The practice's latest statement of purpose, the details of their staff members, their qualifications and proof of registration with their professional bodies.

We also reviewed the information we held about the practice and consulted with other stakeholders, such as the NHS England area team and Healthwatch, however we did not receive any information of concern from them.

During the inspection we spoke with the dentist and reviewed policies, procedures and other documents. We also spoke with one patient. Prior to the inspection we had left comment cards for patients to complete with their views about the services provided at the practice. During the inspection we reviewed the 30 cards that had been completed by patients, these all provided positive comments about the patients' treatment.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

We looked at the practice policy in respect of complaints and found it to be comprehensive and up to date. We asked for a list of complaints but were told there had not been any.

The practice responded to national patient safety and medicines alerts that were relevant to the dental profession. These were sent to a dedicated email address and actioned by the dentist. Where they affected patients their patient record was noted and this alerted the dentists each time the patient attended the practice.

Records we viewed reflected that the practice had undertaken a risk assessment in relation to the control of substances hazardous to health (COSHH). Each type of substance used at the practice that had a potential risk was recorded and graded as to the risk to staff and patients. Measures were clearly identified to reduce such risks including the wearing of personal protective equipment and safe storage.

There was no auditable record of complaint or significant events and we were told there had not been any. There was no system in place to record such incidents; for example absence of staff that compromises patient safety.

Prior to staff leaving the practice, there were practice meetings were held every month but there were no minutes available to view. We spoke to the registered manager about this and they stated this would be completed in the future.

Reliable safety systems and processes (including safeguarding)

There were no staff currently at work at the practice other than the dentist but we saw clear whistleblowing and safeguarding policies. We saw that there were contact numbers for the local safeguarding teams in both the policy folder and displayed on a notice in the staff room.

We were told that rubber dams were used for all root canal treatments and saw evidence of them in the consulting room. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth.

Medical emergencies

Emergency medicines, an Automated External Defibrillator AED and oxygen were readily available if required. 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. This was in line with the 'Resuscitation Council UK' guidelines. The dentist had been trained in basic life support including the use of the defibrillator and was able to respond to a medical emergency. All emergency equipment was readily available and the dentist knew how to access it. We checked the emergency medicines and found that they were of the recommended type and were all in date. A system was in place to monitor stock control and expiry dates.

The dentist could identify the signs indicating the equipment and drug use and stated they felt confident in their ability to respond should the need arise.

Staff recruitment

We saw evidence that the dentist had an up to date Disclosure and Barring (DBS) service check relevant to their role in the practice.

There were insufficient numbers of suitably qualified and skilled staff working at the practice. We were told that the dentist was at present the only employed person and was performing all the roles. On our arrival the dentist met us in reception leaving a patient alone in the nearby consulting room. We were told that there were four patients on the list to be seen on the day of our visit and three were routine patients and not requiring emergency treatment. We were told that there had been no dental nurse since December 2014 and no receptionist since mid-April 2015.

By working alone the dentist could not guarantee the presence of a chaperone when one was required by the service user. In addition consent of the patient was taken alone and exposed the dentist to potential allegations of that consent not being obtained correctly.

There was a danger to the patients that existed should there be a medical emergency with either the service user or dentist whilst procedures were taking place.

On our original visit on 26 May we saw the front door to the practice was left unlocked and patients entered and sat in a waiting area; there were no members of staff to supervise

Are services safe?

them when they were there. On our second visit on 30 May there was a receptionist present. The receptionist told us she was only at the practice for a short while and would not be there all day.

Between our visits on 26 May and 30 May we received correspondence from the dentist to indicate suitably qualified staff would be employed. When we visited on 30 May we found that the undertaking from the dentist that that suitable staff would be employed had not been effectively acted upon and routine patients were still being treated. We asked the dentist what measures had been taken to employ qualified staff and were told that an advertisement had been placed but with no response so far.

As there had been no increase in staff levels fundamental to patient safety since our first visit we believed that the level of risk this posed to patients was unacceptable. We therefore took action to ensure patients were protected and we have now seen evidence that suitably qualified staff have been employed.

Monitoring health & safety and responding to risks

A health and safety policy and risk assessment was in place. This covered the risk to patients and staff who attended the practice. The risks had been identified and control measures put in place to reduce them. Regular health and safety audits took place to ensure the environment was safe for both patients and staff. Where issues had been identified remedial action had been taken in a timely manner.

There were also other policies and procedures in place to manage risks at the practice. These included infection prevention and control, a legionella risk assessment, fire evacuation procedures and risks associated with Hepatitis B. Processes were in place to monitor and reduce these risks so that the dentist and patients were safe.

The practice had an induction process for all new staff members and this included familiarisation with health and safety issues.

Infection control

The practice was visibly clean, tidy and uncluttered. An infection control policy was in place and a lead had been identified. The policy clearly described how cleaning was to be undertaken at the premises including the surgeries and the general areas of the practice. The types of cleaning and

frequency were detailed and checklists were available for staff to follow. We looked at the records kept and found that they had been completed correctly. Records held reflected that the quality of the cleaning was being monitored and feedback given accordingly.

An infection control audit had been carried out on an annual basis and we saw evidence of this year's audit.

We found that there were adequate supplies of liquid soaps and hand towels throughout the premises and hand washing techniques were displayed in the toilet facilities. Sharps bins were located in the consulting room. The ones we found were loose and on the floor and good practice is that they are easily accessible; however they were signed, dated and not overfilled.

We looked at the procedures in place for the decontamination of used dental instruments. The practice had a dedicated decontamination room that was set out according to the

Department of Health's guidance, Health Technical Memorandum 01-05 (HTM 01-05):

Decontamination in primary care dental practices.

We found that instruments were being cleaned and sterilised in line with published guidance (HTM 01:05). On the day of our inspection, the dentist demonstrated the decontamination process to us and used the correct procedures. There was a minor infringement in respect that the initial cleaning was taking place above the surface of the water and there was a potential for contaminated water to be splashed. This initial clean should take place below the surface of the water to avoid this. We spoke with the dentist regarding this and they stated they would ensure was addressed in the future.

The practice cleaned their instruments manually then placed them in an ultra-sonic cleaner. They were then rinsed and examined visually with a magnifying glass, then sterilised in an autoclave. At the end of the sterilising procedure the instruments were correctly packaged, sealed, stored and dated with an expiry date. We looked at the sealed instruments in the surgeries and found that they all contained an expiry date that met the recommendations from the Department of Health.

The decontamination room had clearly defined dirty and clean zones in operation to reduce the risk of cross

Are services safe?

contamination. The dentist wore appropriate personal protective equipment during the process and these included disposable gloves, aprons and protective eye wear.

The equipment used for cleaning and sterilising was maintained and serviced as set out by the manufacturers. Daily, weekly and monthly records were kept of sterilisation cycles and tests. When we checked those records it was evident that the equipment was in good working order and being effectively maintained.

The dentist was well presented and told us they wore a clean uniform daily. They also told us that they wore personal protective equipment when cleaning instruments and treating people who used the service. Staff files examined showed that the dentist was up to date with Hepatitis B immunity.

The practice had a legionella risk assessment in place and conducted regular tests on the water supply. Legionella is a term for particular bacteria which can contaminate water systems in buildings. This included maintaining records and checking on the hot and cold water temperatures achieved. An external contractor attended annually to ensure that procedures were in place to reduce the risk to staff or patients. The last visit took place in June 2013 and the practice was graded as meeting the necessary requirements, the next inspection was due in June 2015.

We looked at the contract to dispose of clinical waste and we were originally told that the waste was collected monthly; on enquiring further we were told that there was no current contract in place. We looked at the consignment notice and found evidence of disposal up to September 2014, but no evidence of collections after that date. The practice told us there was no longer a contract in place for the removal of hazardous waste. After the inspection the practice sent us evidence that they had signed a new contract with a waste disposal company. We checked this when we carried out our second visit on 30 May and were satisfied that suitable arrangements were in place to dispose of hazardous waste.

Equipment and medicines

The premises were suitable for use but left insecure whilst the dentist saw patients in order that other patients could gain access. Security was further compromised by the lack of a receptionist.

Records we viewed reflected that equipment in use at the practice was regularly maintained and serviced in line with manufacturers guidelines. Portable appliance testing (PAT) took place on all electrical equipment. Fire extinguishers were checked and serviced regularly by an external company and the dentist had been trained in the use of equipment and evacuation procedures.

Medicines in use at the practice were stored and, when out of date, disposed of in line with published guidance. Medicines in use were checked and found to be in date. There were sufficient stocks available for use and these were rotated regularly. The medicines were packaged in accordance for conditions indicating their use. The ordering system was effective. Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities. We spoke with the dentist who understood the indications for the use of emergency medicines and stated they felt confident to intervene in the event of emergency.

Radiography (X-rays)

X-rays were carried out safely and in line with local rules that were relevant to the practice and equipment and these were clearly displayed.

X-ray machines were the subject of regular visible checks and records had been kept. A specialist company attended at regular intervals to calibrate all X-ray equipment to ensure they were operating safely. Where faults or repairs were required these were actioned in a timely fashion. A radiation protection advisor and a radiation protection supervisor had been appointed to ensure that the equipment was operated safely and by qualified staff only. Those authorised to carry out X-ray procedures were clearly named in all documentation. This protected people who required X-rays to be taken as part of their treatment. The practice's radiation protection file contained the necessary documentation demonstrating the maintenance of the X-ray equipment at the recommended intervals. Records we viewed demonstrated that the X-ray equipment was regularly tested serviced and repairs undertaken when necessary. We saw records that indicated the practice was certified until July 2015 before the next inspection of its radiation equipment was due.

We looked at the training records and saw the appropriate clinicians had received up to date training in the procedures for x-rays.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Patients attending the practice for a consultation received an assessment of their dental health after supplying a medical history covering health conditions, current medicines being taken and whether they had any allergies. There was also consideration made whether the patient required an X-ray and whether this might put them at risk, such as if a patient may be pregnant.

The dental assessments were carried out in line with recognised guidance from the National Institute for Health and Care Excellence (NICE) and General Dental Council (GDC) guidelines. This assessment included an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment.

Following clinical assessment, the dentists followed the guidance from the Faculty of General Dental Practice before taking X-rays to ensure they were required and necessary. A diagnosis was then discussed with the patient and treatment options explained. Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included smoking cessation advice, alcohol consumption guidance and general dental hygiene procedures such as prescribing dental fluoride treatments. The patient notes were updated with the proposed treatment after discussing options with the patient. Patients were monitored through follow-up appointments and these were scheduled in line with National Institute of Health and Care Excellence (NICE) recommendations. Patients requiring specialised treatment such as conscious sedation were referred to other dental specialists. Their treatment was then monitored after being referred back to the practice once it had taken place to ensure they received a satisfactory outcome and all necessary post procedure care. The patient we spoke with and comments received on CQC comment cards reflected that patients were very satisfied with the assessments, explanations, the quality of the dentistry and outcomes.

Health promotion & prevention

The dentist we spoke with confirmed that adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. The dentist was aware of the NHS England publication for delivering better oral health which is an evidence based toolkit to support dental practices in improving their patient's oral and general health. CQC comment cards that we viewed reflected that patients were happy with the service and parents were satisfied with the services provided for their children; they had made positive comments about the advice they received.

There was no dental hygienist employed at the practice and the dentist performed procedures to ensure dental hygiene was appropriately delivered.

Staffing

There was evidence of recent compliance with online continuing professional development training and these courses included radiography, safeguarding children, needle stick injury, medical emergencies and infection control.

On our inspection and subsequent visit there was no appraisal process in place to check the competence of the dentist and no staff to provide feedback. Since our visit on 30 May we have now seen evidence of an appraisal system in place and suitably qualified staff employed.

Working with other services

There was a policy in place to refer patients to other practices or specialists if the treatment required was not provided by the practice. This included conscious sedation for nervous patients. We viewed records containing valid consent and patient leaflets were available with up to date British Dental Association (BDA) advice sheets.

The dentist told us that they would make a written referral when the patient was transferred for treatment and they would review the patient on their return.

Consent to care and treatment

The practice had a consent policy to support staff in understanding the different types of consent a patient could give and whether it could be taken verbally or in writing. The dentist we spoke with told us they had authored the policy and they had ready access to it. The dentist had a clear understanding of consent issues. They understood that consent could be withdrawn by a patient

Are services effective?

(for example, treatment is effective)

at any time. The dentist was aware about consent in relation to children under the age of 16 who attended for treatment without a parent or guardian. They told us that children of this age could be seen without their parent/guardian and told us that they would ask them questions to ensure they understood the care and treatment proposed before providing it. This is known as the Gillick competency test. The dentist we spoke with also explained how they would take consent from a patient if their mental capacity was diminished. This followed the guidelines of the Mental Capacity Act 2005 and included involving any

carer to ensure that procedures were explained in a way the patient could understand. We saw evidence of training completed in the last 6 months which involved the Mental Capacity Act 2005.

The patient feedback cards we reviewed indicated the patients were supported in the decision making process. All of the comment cards we received indicated that patients were asked for consent and allowed time to consider their options.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We examined 30 feedback cards that had been left to gain the opinions of patients. The content of these cards revealed the patients felt that the dentist was kind, caring and that they were treated with dignity and respect. One patient card showed the patient was nervous about seeing the dentist but had been reassured on each occasion making their experience less stressful. This patient had moved home but travelled a considerable distance to remain being treated by this dentist. Comment cards and the patient we spoke with stated they did not feel rushed and the dentist always gave them time.

A data protection and confidentiality policy was in place; we looked at this policy and found it up to date and regularly reviewed. This covered disclosure of patient information and the secure handling of patient

information. We observed the interaction between the dentist and a patient, finding that confidentiality was not being maintained. The door to the consulting room was left open during examination and conversation could clearly be overheard from the waiting area meaning that the privacy and dignity of that patient was not upheld.

Involvement in decisions about care and treatment

Feedback cards we read informed us that the dentist listened to them and they felt involved with the decisions about their care and treatment. They told us that consultations and treatment were explained to them in a way they understood, they felt that they had options regarding their treatment. We looked at care plans and examined comment cards all of which showed evidence that the patients were valued and their wishes considered.

We found clear evidence that pricing plans and overall costs were explained to patients; these were also clearly displayed in the waiting area and in information leaflets.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patient's needs

The practice was located in a large converted business premises. The practice was well lit and contained a range of literature available for patients to read while they waited for treatment. The practice information leaflet and practice booklet described the range of services offered to patients, the complaints procedure, information about patient confidentiality and record keeping.

The practice offered only private treatment and the costs of each were clearly displayed in the booklet and on boards in each of the waiting rooms.

There were treatments available in the evenings and at weekends to suit working people and families with children.

We saw a patient feedback form in the reception area which we were told patients were encouraged to fill in. There were in excess of 30 completed forms but we saw no evidence of the practice auditing the results and learning from the experiences of the patients to improve the service.

Tackling inequity and promoting equality

The practice was accessible for those patients with mobility issues, using wheelchairs or mobility scooters. There was a separate door leading to one of the consulting rooms that enabled direct access from patients using wheel chairs. All the consulting rooms were on the ground floor and could be accessed without the need to negotiate steps.

There was a waiting area, patient toilet, and a dentist surgery on the ground floor which meant patients could be accommodated according to their needs. Appointments were available at various times of the day and all emergency patients or those with specific needs could be met.

Access to the service

Patients could access care and treatment in a timely way and the appointment system met the needs of patients. The practice receptionist was on maternity leave and had diverted the surgery main telephone to her personal mobile phone. There was an arrangement that these appointments would then be passed to the dentists and written in an appointment book kept at the practice. We called this phone on several occasions during the first visit but none of the calls were answered.

We saw comment cards from patients that commented they were always able to get an appointment when they wanted one and emergency appointments were always available on the same day.

The dentist did offer an out of hours emergency service and this could be accessed by patients calling the practice telephone.

Concerns & complaints

The practice did have a complaints policy but no method of recording complaints made by patients. We were told that there had not been any complaints made about the practice or dentist and hence there was not a complaints folder.

The feedback forms that were given to the patients by the practice had been filled in and we looked at 30. There were none that were dated so we could not be sure of the period of the survey and there had been no attempt to audit the data from them.

We did see information in the reception and patient leaflets about how to make a complaint if they wished to do so.

Are services well-led?

Our findings

Governance arrangements

On 26 May and 30 May 2015 there was only one member of staff employed at the premises who was the dentist and registered provider.

The General Dental Council states in their document 'Standards for the Dental Team' that the dentist must be appropriately supported. There is a risk to patients attending the practice should a medical emergency occur with either the dentist or patient. There is also a requirement to provide a chaperone if one is requested and this cannot be done with one member of staff working alone.

As there was only one member of staff employed there was no effective way of minimising risks to safety in the practice. We spoke with the dentist and they understood the need for self-reflecting practice. We were told by the dentist that they were also employed elsewhere and they could discuss cases with other dentists but there was no evidence of that happening.

We saw the dentist's employment file which contained the relevant information such as pre-employment checks, identity checking, DBS checks, professional registration and learning certificates. As the dentist was the only person employed at the practice there was no opportunity to have them appraised.

The records were complete in their composition, legible and accurate. We saw that patient records were not kept secure. They were in a public area and kept in an unlocked metal cabinet, we also saw one patient record that was handwritten and left on the reception desk. We have subsequently seen a process to ensure the records are kept securely and patient's confidentiality maintained.

There was a full range of policies and procedures in use at the practice. These included health and safety, infection prevention and control, patient confidentiality and recruitment. The dentist we spoke with was aware of the

policies and they were readily available for them to access. We looked at a range of policies and found them to all be up to date; there was a system in place to ensure they were updated regularly and to indicate staff had read them.

Leadership, openness and transparency

There were no complaints, compliments or adverse incident recording taking place. We were told that there had not been any. We did see policies that would support those areas if they needed to be addressed but no incidents recorded.

None of the patient comment cards indicated that there had been any complaints.

There was no evidence of poor performance; however, there was no opportunity to challenge poor performance as there was only one member of staff employed.

Management lead through learning and improvement

There was limited evidence of clinical audits taking place and no evidence of administrative audits, for example access to the service. There were records that indicated there has a daily x-ray audit taking place but no other clinical audit was shown to us.

Staff had been absent for up to five months and not replaced. We saw no evidence of effective attempts to replace them or put robust control measures in place whilst they were not at work. There was no risk assessment of lone working, no assessment of the risks to patients whilst waiting alone and no assessment of the risks to the dentist.

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

We saw patient feedback forms that allowed the patients to share their experiences and opinions. There were a supply of forms on the reception desk and we were told patients were encouraged to complete them. We did see in excess of 30 forms that had been completed but no evidence of an audit of results from the forms.

There was no opportunity for internal reflection of individual's performance due to the registered provider being the only member of staff employed at the practice.