Hampshire Dentists Ltd

Hampshire Dentists in Southampton

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 30 March 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.

We carried out an announced comprehensive inspection on 30 March 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Hampshire Dentists in Southampton provides family dental care to both adults and children on a private contract basis.

The practice is situated in a business premises on the first floor. The practice had three dental treatment rooms and a separate decontamination room for cleaning, sterilising and packing dental instruments. The practice is part of the provider brand Hampshire Dentists Ltd.

The Principal Dentist is registered with the Care Quality Commission as the registered manager. They were legally responsible for making sure the practice meets the regulations from the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to the quality and safety of care.

The practice had three dentists who work throughout the normal working week, a dental therapist, a lead dental nurse, three dental nurses, a clinical dental technician, a part-time dental hygienist supported by a practice manager and two receptionists. The practice displayed its

Summary of findings

opening hours in their premises, in the practice information leaflet and on the practice website. Opening hours were Monday to Wednesday from 8am until 5pm. Thursday 8am until 7pm and on Friday from 9am until 4pm, excluding bank holidays.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice. We collected thirty five completed cards and spoke with one patient. These provided a positive view of the service the practice provides.

Our key findings were:

• Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.

• The practice was visibly clean.

• All equipment used in the practice was maintained in accordance with the manufacturer's instructions.

• Infection control procedures were robust and the practice followed the guidance in the Healthcare Technical Memorandum HTM 01-05.

• Patients' needs were assessed and care was planned and delivered in line with current professional guidelines

• The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.

• Staff reported incidents and kept records of these which the practice used for shared learning.

• The practice had enough staff to deliver the service.

• The practice placed an emphasis on the promotion of good oral health and provided regular oral health instruction to patients.

• Staff had received training appropriate to their roles and were supported in their continued professional development (CPD).

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 care which was safe in accordance with the relevant regulations. The practice had robust arrangements for managing essential areas such as infection control, clinical waste control, medical emergencies and dental radiography (X-rays). All the equipment used in the dental practice was properly maintained. There were sufficient numbers of suitably qualified staff working at the practice. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations. The dental care provided was evidence based and focused 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. Staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations. Patients commented positively on the caring compassionate staff, describing them as friendly, reassuring and professional. Patients felt listened to by all staff and were given appropriate information and support regarding their care or treatment. They felt their dentist explained the treatment they needed in a way they could understand.

Are services responsive to people's needs?

We found that this practice was providing responsive care in accordance with the relevant regulations. The service was aware of the needs of the local population and took these into account when determining how the practice was run. Patients could access treatment and urgent and emergency care when required. The practice had first floor treatment rooms with lifts available and level access into the building for patients with mobility difficulties and families with prams and pushchairs.

Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations. There were systems in place to maintain clinical governance. The practice audited aspects of the service to monitor the quality of the service and to identify areas for improvement.

Staff felt supported and empowered to make suggestions for the improvement of the practice. There was a culture of openness and transparency. Staff at the practice were supported to complete training for the benefit of the patients and for their continuous professional development.

Hampshire Dentists in Southampton

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008

The inspection took place on 30 March 2016 and was conducted by a CQC inspector and a specialist dental adviser.

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. This included the complaints they had received in the last 12 months, their latest statement of purpose, and the details of their staff members and proof of registration with their professional bodies.

During the inspection we spoke with the practice manager, the owner dentist, dental nurses and received feedback from members of staff. We reviewed policies, procedures and other documents. We also spoke with patients. We reviewed thirty five comment cards that we had left prior to the inspection for patients to complete about the services provided at the practice.

This practice was previously inspected by the Care Quality Commission in July 2013 and was found to be compliant with the regulations.

Are services safe?

Our findings

Reporting, learning and improvement from incidents.
The practice had systems in place to learn from and make improvements following any accidents or incidents. The practice had accident and significant event reporting policies which included information and guidance about the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR).Clear procedures were in place for reporting adverse drug reactions and medicines related adverse events and errors. The practice maintained significant event folders in each treatment room which included a detailed description, the learning that had taken place and the actions taken by the practice as a result. Records showed that accidents and significant events were discussed and learning shared at practice, clinical and management meetings.

The practice manager told us if there was an incident or accident that affected a patient; they would give an apology and inform them of any actions taken to prevent a reoccurrence. Staff reported there was an open and transparent culture at the practice which encouraged candour and honesty.

The practice responded to national patient safety and medicines alerts that affected the dental profession. The principal dentist told us they reviewed all alerts and spoke with staff to ensure they were acted upon. A record of the alerts was maintained and accessible to staff.

Reliable safety systems and processes (including safeguarding).
We spoke with the principal dentist about the reporting of incidents that could occur in a primary dental care setting. This included needle stick injuries and medical emergency incidents. We saw that the treatment of sharps and sharps waste was in accordance with the current EU Directive with respect to safe sharp guidelines, thus protecting staff against blood borne viruses. The practice used a system whereby needles were not resheathed using the hands following administration of a local anaesthetic to a patient. A single use delivery system was used to deliver local anaesthetics to patients. We saw a protocol displayed in the treatment room should a needle stick injury occur. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps.

The practice has policies and procedures in place to safeguard vulnerable adults and children from abuse. We discussed with a dentist on duty the different types of abuse that could affect a patient and who to report them to if they came across abuse of a vulnerable child or adult. They were able to describe the types of behaviour a child would display that would alert them if there were possible signs of abuse or neglect. They also had a good awareness of the issues around vulnerable elderly patients who present with dementia that require dental care and treatment. The practice had evidence that staff had undergone training in safeguarding issues. Telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations was available. This information was displayed in various parts of the practice.

Medical emergencies.
The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Staff received annual training in how to use this. The practice had in place the emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. Oxygen and other related items such as manual breathing aids and portable suction were available in line with the Resuscitation Council UK guidelines. The emergency medicines were all in date and stored securely with emergency oxygen in a central location known to all staff.

The expiry dates of medicines, oxygen and equipment was monitored using a daily and monthly check sheet which enabled the staff to replace out of date drugs and equipment promptly. The practice held training sessions for the whole team to maintain their competence in dealing with medical emergencies on an annual basis. We saw records showing that staff had training in 2015 and 2016.

Staff recruitment.
The practice had systems in place for the safe recruitment of staff which included seeking references, proof of identity and checking qualifications, immunisation status and professional registration. It was the practice's policy to carry out Disclosure and Barring service (DBS) checks for all newly appointed staff. These checks identify whether a

Are services safe?

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. Records confirmed these checks were in place. We looked at the staff recruitment files of three members of staff and found they contained appropriate recruitment documentation.

Newly employed staff had an induction period to familiarise themselves with the way the practice ran before being allowed to work unsupervised. Newly employed staff met with the practice manager, lead nurse and principal dentist to ensure they felt supported to carry out their role.

The practice had a system in place for ensuring that staff had up to date medical indemnity insurance and professional registration with the General Dental Council (GDC) The GDC registers all dental care professionals to make sure they are appropriately qualified and competent to work in the United Kingdom. Records we looked at confirmed these were up to date.

Monitoring health & safety and responding to risks.
The practice had systems to monitor health and safety and deal with foreseeable emergencies. There were comprehensive health and safety policies and procedures in place to support staff, including for the risk of fire, lone working and patient safety. Records showed that fire detection and fire fighting equipment such as fire alarms, smoke detectors, emergency lighting and fire extinguishers were regularly tested. Fire drills were carried out every six months.

The practice had a comprehensive risk management process, including a detailed log of all risks identified, to ensure the safety of patients and staff members. For example, we saw a fire risk assessment and a practice risk assessment. They identified significant hazards and the controls or actions taken to manage the risks. The risk assessments were reviewed annually. The practice had a comprehensive file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including substances such as disinfectants, blood and saliva.

The practice had a detailed business continuity plan to support staff to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service. The plan included staffing, electronic systems and environmental events.

Infection control.
The lead nurse was the infection control lead and they ensured there was a comprehensive infection control policy and set of procedures to minimise the risk of infection. These included hand hygiene, manual cleaning, managing waste products and decontamination guidance. We observed waste was separated into safe containers for disposal by a registered waste carrier and appropriate documentation retained.

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)' and the 'Code of Practice about the prevention and control of infections and related guidance'. These documents and the practice's policy and procedures relating to infection prevention and control were accessible to staff. Posters about good hand hygiene, safe handling of sharps and the decontamination procedures were clearly displayed to support staff in following practice procedures.

We looked around the premises during the inspection and found the treatment rooms and the decontamination suite appeared clean and hygienic. They were free from clutter and had sealed floors and work surfaces that could be cleaned with ease to promote good standards of infection control. The practice had cleaning schedules and infection control daily checks for each treatment room which were complete and up to date. Staff 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 were hand washing facilities in the treatment rooms and staff had access to supplies of protective equipment for patients and staff members. Patients we spoke with and who completed Care Quality Commission comments cards were positive about how clean the practice was.

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 the treatment room and the decontamination suite which minimised the risk of the spread of infection.

Are services safe?

A nurse showed us the procedures involved in rinsing; cleaning, inspecting and sterilising dirty instruments and packaging and storing clean instruments.

The practice had systems in place for daily 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.

Records showed risk assessments for Legionella were carried out by an external company. (Legionella is a bacteria found in the environment which can contaminate water systems in buildings). This ensured the risks of Legionella developing in water systems within the premises had been identified and preventive measures taken to minimise the risk to patients and staff of developing Legionnaires' disease. These included running the water lines in the treatment rooms at the beginning of each session and between patients, water testing weekly and monitoring cold and hot water temperatures each month.

The lead nurse helped to ensure staff had the right knowledge and skills to maintain hygiene standards. Records showed they carried out staff observations at least every three months, for example regarding hand washing and the correct disposal of clinical waste and provided staff with on-going training.

The practice carried out a range of audits to ensure standards were being maintained and to identify areas for further improvement. For example, the self- assessment audit relating to the Department of Health's guidance about decontamination in dental services (HTM01-05) was completed every six months. This is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. Records showed a decontamination audit was carried out in January 2016. Audit results indicated the practice was meeting the required standards.

Equipment and medicines.
Records reviewed reflected that equipment in use at the practice was regularly maintained and serviced in line with manufacturer's guidelines. We observed the maintenance schedules ensuring that the autoclaves were maintained to the standards set out in the Pressure Systems Safety Regulations 2000 and were within the normal 12-14 month time interval. X-ray machines were the subject of regular visible checks and records had been kept. A specialist company attended at regular intervals to calibrate and review all X-ray equipment to ensure they were operating safely. The maintenance log was within the current recommended interval of 3 years which was in accordance with the Ionising Radiation Regulations 1999. An on-going maintenance contract was in place for the replacement of the emergency oxygen ensuring that the contents and the metal oxygen cylinder did not deteriorate over time.

Radiography (X-rays).
The practice had in place a named Radiation Protection Adviser and a Radiation Protection Supervisor in accordance with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). A radiation protection file in line with these regulations was observed. This file was well maintained and included in the file were the critical examination pack for each X-ray set used along with the three yearly maintenance logs and a copy of the local rules and notification to the Health and Safety Executive.

Radiological audit for each dentist was on-going and available for inspection, we saw that a high percentage of radiographs were of grade 1 standard. A sample of dental care records where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured every time. The X-rays we observed were of a good quality. These findings showed that practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients.
The dentists working at the practice carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. A dentist we spoke with described how they carried out patient assessments using a typical patient journey scenario. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. The assessment included details of their dental and social history. We saw evidence that the medical history was updated at subsequent visits. This was followed by 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 the clinical assessment the diagnosis was then discussed with the patient and treatment options explained to the patient.

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 brushing techniques or using recommended tooth care products. The patient dental care record was updated with the proposed treatment options after discussing them with the patient. A treatment plan was then given to each patient that included a breakdown of the proposed costs involved in each treatment option. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements. Dental recall intervals were based around current National Institute for Health and Care Excellence (NICE) guidance.

Dental care records showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. The dental care records observed were structured and contained sufficient detail about each patient's dental treatment. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need).These were carried out at each dental health assessment. The records we saw showed that dental X-rays were justified, reported on and quality assured every time. Patients who required any specialised treatment were referred to other dental specialists as necessary. Their treatment was then monitored after being referred back to the practice after it had taken place to ensure they received a satisfactory outcome and all necessary post procedure care. Details of the treatment were also documented and included local anaesthetic details including type, the site of administration and batch number and expiry date.

Health promotion & prevention.
The practice had a range of products that patients could purchase that were suitable for both adults and children. Adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. Tooth brushing techniques were explained to them in a way they understood and dietary, smoking and alcohol advice was also given to them. Dental care records we reviewed all demonstrated that dentists had given tooth brushing instructions and dietary advice to patients.

A dental hygienist was available to provide a range of advice and treatments in the prevention of dental disease under the prescription from the dentists; we saw that detailed prescriptions to the hygienist were provided by the dentists.

Staffing.
The practice had three dentists who work throughout the normal working week, a dental therapist three dental nurses, a clinical dental technician and a part-time dental hygienist. The practice was supported by a practice manger, a secretary & marketing coordinator and two practice host & patient care coordinators.

The practice manager kept a record of all training carried out by staff to ensure they had the right skills to carry out their work. Mandatory training included basic life support and infection prevention and control.

Staff had access to policies which contained information that further supported them in the workplace. All clinical staff were required to maintain an on-going programme of continuous professional development as part of their registration with the General Dental Council. Records showed professional registration was up to date for all staff.

Are services effective?

(for example, treatment is effective)

There was an effective appraisal system in place which was used to identify training and development needs. Staff we spoke with told us they had accessed specific training in the last 12 months in line with their professional development plan.

Working with other services.
The dentist on duty explained how they would work with other services if required. Dentists were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. Systems had been put into place by local commissioners of services and secondary care providers whereby referring practitioners would use bespoke deigned referral forms. This helped ensure that the patient was seen in the right place at the right time, which included referrals for oral surgery, suspected mouth cancer, orthodontics and referrals for patients who required special care dental services as a result of physical and mental impairment. When the patient had received their treatment they would be discharged back to the practice for further follow-up and monitoring.

Consent to care and treatment.
The Mental Capacity Act 2005 provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Staff were aware of the Mental Capacity Act and explained how they would manage a patient who lacked the capacity to consent to dental treatment. They explained how they would involve the patient's family and other professionals involved in the care of the patient to ensure that the best interests of the patient were met. They were therefore able to demonstrate a clear understanding of requirements of the Act. The dentist explained how they obtained valid informed consent. They explained how they explained their findings to patients and kept detailed clinical records showing that they had discussed the available options with them.

Are services caring?

Our findings

Respect, dignity, compassion & empathy.
Before the inspection we sent Care Quality Commission comment cards to the practice for patients to tell us about their experience of the practice. We collected thirty five completed cards. These provided a positive view of the service the practice provided. Patients commented that the team were courteous, efficient and kind and patients were very happy with the quality of treatment provided. During the inspection we observed staff in the reception area. We observed that they were polite and helpful towards patients and that the general atmosphere was welcoming and friendly. The dentist we spoke with, spoke about patients in a respectful and caring way and were aware of the importance of protecting patients' privacy and dignity.

Involvement in decisions about care and treatment.
The dentist we spoke with had a clear understanding of consent. They stressed the importance of communication skills when explaining care and treatment to patients and explaining in a way and language those patients could understand. Costs were made clear in the treatment plan and in the dental care record.

Staff explained how they would take consent from a patient who suffered with any mental impairment which may mean that they might be unable to fully understand the implications of their treatment. They told us how he would manage such patients. The dentist explained if there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed. They explained that they would involve relatives and carers to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs.
Services were planned and delivered to meet the needs of patients. The practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The practice had a clear understanding of who their population were and understood their needs including, making appointments long enough to carry out investigations and treatment. Most examinations appointments were at least 10 minutes long and filling appointments were at least 20 minutes long. We did not see evidence of routine double booking of patients. This only occurred when patients were asked to come and sit and wait if they were in pain. Generally the practice had dedicated urgent slots as well as asking patients to come and sit and wait. The dentist provided a dedicated mobile phone number for patients after treatment so that they could make contact with the dentist if they needed to.

Tackling inequity and promoting equality.
The practice had an equality and diversity policy in place and provided training to support staff in understanding and meeting the needs of patients. The practice audited the suitability of the premises and had made adjustments. The practice also has dentists who are able to converse with patients where English is a second language. Dental care records included alerts about the type of assistance patients required.

Access to the service.
The practice displayed its opening hours in their premises, in the practice information leaflet and on the practice website.

Staff told us patients were seen as soon as possible for urgent care during practice opening hours and this was normally within 24 hours. Appointments were available each day to accommodate this. Patient's comment cards reflected that they felt they had good access to routine and urgent dental care. There were clear instructions in the practice and via the practice's answer machine for patients requiring urgent dental care when the practice was closed.

The practice supported patients to attend their forthcoming appointment by having a reminder system in place. This included telephoning patients and sending text message reminders. Patients we spoke with told us this was very helpful.

Concerns & complaints.
The practice had a complaints policy which provided staff with clear guidance about how to manage complaints. Staff told us they raised any formal or informal comments or concerns with the practice manager to ensure these were responded to.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients. We found there was a system in place which ensured a timely response. Information for patients about how to raise a concern or offer suggestions was available in the practice and in the practice information leaflet.

Are services well-led?

Our findings

Governance arrangements.
The Principal Dentist was registered with the Care Quality Commission to manage the service. (Registered providers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run). The practice manager and principal dentist shared the day to day running of the service. They took lead roles relating to the individual aspects of governance such as complaints, equipment maintenance, risk management and audits within the practice. Staff we spoke with were clear about their roles and responsibilities within the practice and of lines of accountability.

We looked in detail at how the practice identified, assessed and managed clinical and environmental risks related to the service provided. We saw risk assessments and control measures in place to manage risks for example fire, use of equipment and infection control. Lead roles, for example in infection control and safeguarding supported the practice to identify and manage risks and helped ensure information was shared with all team members.

There was a full range of policies and procedures in use at the practice and accessible to staff on the practice computers and in paper files. These included guidance about confidentiality, record keeping, managing violence and aggression, inoculation injuries and patient safety. There was a clear process in place to ensure all policies and procedures were reviewed as required to support the safe running of the service.

Leadership, openness and transparency.
The practice had a statement of purpose that described their vision, values and objectives. Staff told us that there was an open culture within the practice which encouraged candour and honesty. There were clearly defined leadership roles within the practice with the practice ethos was providing high quality dental care to their patients. The practice manager told us patients were informed when they were affected by something that goes wrong, given an apology and told about any actions taken as a result.

There were structured arrangements for sharing information across the dental team, including holding regular meetings which were documented for those staff unable to attend. These included daily informal meetings called 'huddles', monthly practice meetings for the whole team and dentists meetings. Management meetings occurred at least monthly or more often as needed. Nursing staff scheduled meetings as required

Learning and improvement.
We found that there were a number of clinical audits taking place at the practice. These included clinical record keeping and X-ray quality. We looked at a sample of them and they showed that the dentists in relation to record keeping were maintaining a consistently high standard in patient assessment, medical history updating, and cancer screening. The X-ray audit for each dentist was an on-going process; this involved grading the quality of the X-rays to ensure they had been taken correctly. We found that the audit process was effective because the standards set out in the audit template were reflected in the dental care records we observed.

Practice seeks and acts on feedback from its patients, the public and staff.
The practice had systems in place to seek and act upon feedback from patients using the service. These included inviting patients to complete a brief survey following their visit to the practice. We saw numerous patient satisfaction survey forms which showed that patients were very satisfied or satisfied with the service they received.

The practice had a continual process to encourage staff to provide feedback about working in the practice including for example, what opportunities staff had to use their initiative and for personal growth and development.