Anele De Novo Dental Practice

Anele De Novo Dental Practice - Beltinge

Inspection Report

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Date of inspection visit: 05 October 2016
Date of publication: 03/02/2017

Overall summary

We carried out an announced comprehensive inspection on 5 October 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.

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
Anele De Novo Dental Practice Beltinge provides both restorative and preventative dentistry on an NHS and private basis to approximately 7500 patients of all ages. More complex procedures such as oral surgery and implants are provided privately. The practice has three dental treatment rooms which are based on the ground floor. There is a separate decontamination room used for cleaning, sterilising and packing of instruments. The ground floor is accessible to wheelchair users, prams and patients with limited mobility via an inbuilt ramp. There is a wheelchair accessible toilet.

The practice employs three dentists, one hygienist, three registered dental nurses who also work on the reception area and one receptionist.

The practice's opening hours are Monday to Friday between 8.45 am and 5.30 pm. Access for urgent treatment outside of opening hours is by a dental advice line. Before the inspection we sent Care Quality

Summary of findings

Commission comment cards to the practice for patients to complete to tell us about their experience of the practice. We received feedback from seven patients. These provided a completely positive view of the services the practice provides. Patients commented on the very good service they received, the caring nature of all staff, the helpfulness of reception staff and the overall high quality of customer care.

Our key findings were:

- The practice appeared visibly clean, was bright and clutter free.
- Staff were polite and friendly.
- The building was maintained to a suitable standard for a dental practice and provided wheelchair access and a wheelchair accessible toilet.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- Staff had been trained to deal with medical emergencies and emergency medicines and equipment were readily available.
- Patients were able to make routine and emergency appointments when needed.
- Infection control procedures followed published guidance.
- Clinical staff had the necessary skills to carry out their duties in line with the requirements of their professional registration.
- Information from seven completed Care Quality Commission (CQC) comment cards gave a positive picture of a friendly and caring service.

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

- Review its audit protocols to document learning points that are shared with all relevant staff and ensure that the resulting improvements can be demonstrated as part of the audit process.
- Review the practice policy for infection control and update yearly to maintain compliance with national guidance.
- Review the practice policy for fire safety and consider carrying out fire drills.
- Review the way that recruitment checks are carried out for new staff at the practice to ensure that Disclosure and Barring Services (DBS) checks are carried out in a timely manner.
- Review the information that is gained from the NHS Friends and Family Test (FFT) and consider displaying this in the patient waiting area.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice operated systems for recording and reporting significant events and accidents. Staff were aware of protocols to follow. The provider acted as the safeguarding lead and all staff understood their responsibilities for reporting any suspected abuse. Medicines and equipment for use in a medical emergency were stocked and were being appropriately checked. Staff were confident in dealing with a medical emergency. Staff were suitably qualified for their roles and staff were meeting the regulations as set out by the dental professionals' regulatory body, the General Dental Council (GDC). The practice maintained a system of policies and risk assessments which included radiation, fire safety, general health and safety and those pertaining to all the equipment used in the practice. The practice employed a dedicated decontamination operative and there were effective systems to reduce the risk and spread of infection within the practice. Equipment checks were carried out in line with the manufacturer's recommendations and medicines were stored approriately. All elements necessary for the safe working of X-ray units were present.

No action ✓

Are services effective?

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

The dental care provided at the practice focused on the needs of the patients. The practice integrated current professional guidance such as that issued by the National Institute of Care Excellance (NICE). The practice monitored patients' oral health and gave appropriate preventative and health promotion advice. Staff maintained their continuing professional development (CPD) training appropriate to their roles and learning needs. Dentists referred patients onto primary and secondary services as necessary. All staff understood the principles of informed consent.

No action ✓

Are services caring?

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

We observed staff being welcoming and friendly when patients came in to the practice. We collected seven Care Quality Commission comments cards on the day. The comments were entirely positive. Patients commented that they were very happy with their treatment, that staff were reassuring and kind. Patients understood their treatment options and explained how they were made aware of any costs they may have to pay . They commented on how helpful the reception staff were and on the great service they received as a whole.

No action ✓

Are services responsive to people's needs?

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

No action ✓

Summary of findings

The practice had an efficient appointment system to respond to patients' needs. There was an effective system for dealing with patients' emergency dental needs.

There was a procedure for responding to patients' complaints and this information was clearly visible for patients attending the practice. Information on the fees for both private and NHS treatment was clearly displayed.

The practice had ground floor treatment rooms and a wheelchair accessible toilet.

Are services well-led?

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

Leadership at the practice was provided by the principle dentist. The practice had a range of governance arrangments such as policies and procedures and staff had awareness of these. The culture of the practice encouraged openness and staff told us that they felt comfortable in raising concerns. Staff commented that they felt listened to and that their learning needs were supported. The practice shared learning informally and were considering having regular staff meetings. The practice did not have a structured plan in place to audit quality and safety although mandatory audits were carried out. Patient feedback was sought verbally and through utilising the NHS Friends and Family Test (FFT).

No action

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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 carried out on 5 October 2016 by a CQC inspector who was supported by a specialist dental advisor.

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

During the inspection, we spoke with the two dentists one of which is the principal, dental nurses and a receptionist. We reviewed policies, procedures and other documents. We also reviewed seven comment cards that we had left prior to the inspection, for patients to complete, about the services provided at the practice. We carried out a tour of the practice observing the decontamination procedures for dental instruments.We looked at the storage of emergency medicines and equipment. We were shown the systems which supported patients' dental care records.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had a policy explaining how staff would deal with incidents relating to RIDDOR 2013 (reporting of injuries diseases and dangerous occurrences regulations). All staff we spoke with had an awareness of RIDDOR and most understood what to do in the event of a serious incidient happening at the practice. The practice had an incident reporting system for when something went wrong. This included an accident book to report minor injuries to patients and staff. The practice had recorded a single needlestick injury over the last twelve months. We saw that the incident had been dealt with appropriately by the practice. Staff told us that any incidents were discussed amongst all staff so that learning could be shared. This occurred during daily informal conversations.

The practice had recently signed up to receive national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA). The principle dentist explained that these would be discussed during staff meetings to facilitate shared learning.

Reliable safety systems and processes (including safeguarding)

We spoke with dental nurses on duty about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current EU directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne diseases. We saw from records that following a needle stick injury the inoculation injury protocol had been followed. The practice had a sharps risk assessment. There was evidence of risk reduction following completion of this assessment.

We asked both dentists how they treated the use of instruments used during root canal treatment. They explained that these instruments were single patient use only. The practice followed guidance issued by the British Endodontic Society in relation to the use of a rubber dam where practically possible. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work. We noted that the thin sheets used contained latex, we discussed this with the dentists as to what they would do for a patient who has a latex allergy or was sensitised to latex. The dentists agreed that an alternative sheet for the rubber dam would be required. Following the inspection we received information to show that the practice had ordered latex free rubber dam sheets.

The principle dentist acted as the safeguarding lead and as a point of referral should a safeguarding issue be encountered. A policy was in place for staff to refer to which contained the necessary contact details and protocol should a member of staff identify a person who may be the victim of abuse or neglect. Training records showed that staff had received appropriate safeguarding training for both vulnerable adults and children. The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities.

Medical emergencies

The practice had appropriate arrangements to deal with medical emergencies at the practice. The practice had an automated external defibrillator (AED) . An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. Staff had received training in using the equipment and performed daily checks of the device. The pads for the device had expired but a new set had been ordered and we saw the electronic order form to confirm this. The practice had access to emergency oxygen and other equipment as set out in the Resuscitation Council UK guidelines. The working conditions of the oxygen cylinder were checked as per the guidelines. All emergency medicines as set out in the British National Formulary (BNF) guidance for dealing with common medical emergencies in a dental practice were present. These were in date and stored in a location known to all staff. When asked, staff were confident in how they would deal with a medical emergency. Staff were due to attend a medical emergency training annual update in December 2016.

Staff recruitment

All of the dentists, dental hygienists and dental nurses had current registration with the General Dental Council, the dental professionals' regulatory body. The practice had a recruitment policy. The policy detailed the checks to be undertaken before a person started work. These included proof of identity, a full employment history, evidence of relevant qualifications, adequate medical indemnity cover, immunisation status and references.

Are services safe?

Many of the staff members had been working at the practice prior to the introduction of the recruitment policy. Some items were missing from the files, such as a copy of their indemnity insurance or hepatitis b status. These items were found and presented to us later on the day of the inspection.

All but one staff member had an appropriate Disclosure and Barring Services (DBS) check. These are checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. We saw evidence that the outstanding DBS check had been applied for and was being processed at the time of inspection.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice maintained a system of policies and risk assessments which included radiation, fire safety, general health and safety and those pertaining to all the equipment used in the practice.

The practice had a Control of Substances Hazardous to Health (COSHH) file. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients. The principle dentist added blood and cleaning products used at the practice to the file on the day of the inspection.

A fire risk assessment had recently been completed and fire marshall checks had been completed daily and logged. The practice did not carry out formal fire drills but staff we spoke with explained the protocol to follow.

Infection control

There were effective systems to reduce the risk and spread of infection within the practice. The practice had an infection control policy in line with HTM 01 05 (national guidance for infection prevention control in dental practices). Essential Quality Requirements for infection control were being exceeded. We noted that this policy was dated 2015. We pointed this out to the principle dentist who told us that the policy would be reviewed and updated at the earliest opportunity. An audit of infection control processes was carried out in July 2016. This confirmed compliance with HTM 01 05 guidelines.

We found that all treatment rooms, waiting areas, reception and toilets were visibly clean, tidy and clutter free. Dirty to clean zones were clearly defined in all treatment rooms. Each treatment room had the appropriate personal protective equipment available for staff to use. This included protective gloves, masks, aprons and eye protection.

The practice had a separate decontamination room with an obvious dirty to clean flow. This allows complete separation of dirty and processed instruments and equipment. The member of staff responsible for decontatmination described to us the end-to-end process of infection control procedures at the practice. Dirty instruments and equipment arrived in the dirty box. The instruments were collected from each surgery. These were stored awaiting processing in the dedicated cupboard marked 'Contaminated Instruments'. Instruments were then scrubbed manually using an enzymatic detergent. The temperature was monitored to ensure the water was below 40 degrees centigrade as per the manufacturers instructions. Instruments were rinsed and inspected under an illuminated inspection device. Instruments were then placed in the washer disinfector and the dental drills in the handpiece steriliser. Items were then pouched, dated and signed prior to being placed in the vacuum autoclave (a device for sterilising dental and medical instruments). Following this they were stored in clean transport boxes to be taken back to the relevant surgeries.

We were shown the systems to ensure that the autoclaves used in the decontamination process were working effectively. It was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were always complete and up to date.

We saw that a Legionella risk assessment had been carried out at the practice by a competent person in 2012. Water temperature had been recorded on a weekly basis as per the recommended procedures outlined in the report; and digitally logged. These measures ensured that patients and staff were protected from the risk of infection due to Legionella. Legionella is a term for particular bacteria which can contaminate water systems in buildings.

Staff were responsible and carried out the environmental cleaning of the premises and environmental cleaning schedules reflected this. The cleaning schedule of the

decontamination room demonstrated daily, weekly and monthly tasks which had been completed. A company is contracted to carry out a deep cleaning of the premises on a quarterly basis.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained and was in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice.

Only the dentists handled sharps in the surgery and they were disposed of in the sharps bins at the point of use.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclaves had been service and calibrated in October 2016. The practice's X-ray machines had been service and calibrated as specified under current national regulations. Portable appliance testing (PAT) had been carried out in 2016. The suction pumps, compressor and handpieces were serviced by an approved contractor.

The practice had emergency medicines in line with the Resuscitation Council UK guidelines. These were all in date and stored in a location known to all staff. We saw that the batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. We found that some local anaesthetic cartridges had been removed from their blister packs. We brought this to the attention of the principal dentist who discarded them immediately. Prescription pads were locked away securely at night to prevent loss due to theft although there was no prescription logging system in place to account for prescriptions issued.

We saw that the practice had suitable equipment to deal with minor first aid problems and body fluids and mercury spillage safely.

Radiography (X-rays)

We were shown a radiation protection file in line with the Ionising Radiation Regulations 1999 (IRR 1999) and Ionising Radiation Medical Exposure Regulations 2000 (IRMER 200).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary records relating to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for each X-ray set along with the maintenance logs, Health and Safety Executive (HSE) notification and a copy of the local rules. The local rules describe the operating procedures for the area where x-rays are taken and the amount of radiation required to achieve a good image. Each practice must compile their own local rules for each x-ray set on the premises. The local rules set out the dimensions of the controlled area around the dental chair/patient; and state the lowest X-ray dose possible to use. Applying the local rules to each x-ray taken means that x-rays are carried out safely. The X-ray units are contracted for safety and performance checks with an approved company who is also the Radiation Protection Advisor.

We saw training records that showed that all staff where appropriate had received necessary radiography training to maintain their knowledge under IRMER 2000 and IRR 1999 regulations. A radiography audit had been carried out in August 2016. This demonstrated that staff were justifying, reporting on and quality assuring their X-rays as well as documenting the outcome for the patient.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We spoke with two dentists on the day of our inspection. They told us that their consultations, assessments and treatments were carried out were in line with recognised general professional guidance. We saw evidence of this in patients' records.

The dentists started the patient assessment by reviewing and updating the patient's medical history. This included noting any medical conditions suffered, medicines being taken and any allergies the patient had. They then examined the patient's teeth, gums and soft tissues and signs of mouth cancer were checked. The dentists used screening tools such as the Basic Periodontal Examination (BPE) and carried out a caries risk assessment. These are widely used tools to assess the risk of dental decay and conditions of the gums. These tools help the dentists to systematically check and monitor any changes in the patients soft and hard tssues. This information would then be used to determine at what intervals patients would need to attend for further checks and screenings. We saw in the patients' dental care records that these findings, together with the findings of any X-rays taken, where applicable; were used to create a treatment plan. There was evidence in the records that this was discussed in detail with patients.

Where relevant, preventative dental information such as general oral hygiene instructions and brushing technique advice was given. Dentists referred patients to the hygienist as appropriate. We saw that at the end of the appointment patients were encouraged to book their next examination as determined by the dentist.

Health promotion & prevention

The practice was focussed on the prevention of dental disease and the maintenance of good oral health in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. The practice appointed a dental hygienist to work alongside the dentists. The principle dentist told us that children at high risk of tooth decay were offered fluoride applications to keep their teeth healthy. They placed fissure sealants (special plastic coatings on the biting surfaces of permanent back teeth in children) on the teeth of children particularly vulnerable to tooth decay. They prescribed high concentration fluoride toothpaste where appropriate to adults where a high risk of dental decay had been identified. We saw evidence in dental care records that the dentists and hygienist had given oral health advice to patients.

Staffing

The practice employed two dentists, one hygienist and three registered dental nurses who also perfomed a dual role working on the reception. The practice also had a decontamination operative. Other staff included a receptionist. Some staff members had been at the practice for many years. We asked staff if they felt that there were enough staff working at the practice. All staff said that the practice is very busy and that they work well together as a team. Some staff said they felt that another dental nurse would be beneficial.

Staff told us that they felt management listened to them, for example, making improvements as required. They were not afraid to communicate any problems to management. Staff said that they felt their learning needs were supported. The principle dentist told us that the most important aspect of running the practice was communication. We observed a friendly atmosphere at the practice.

There was an induction programme for new staff members. Staff were encouraged to maintain their own records of continuing professional development (CPD), confirmation of General Dental Council (GDC) registration and current professional indemnity cover where applicable. The records for some staff were missing on the day of the inspection, but were later located for us to review. The principle dentist noted this to review how the practice maintains its records of staff. We saw in staff records that appraisals were due to be carried in October and November 2016. The Care Quality Commission comments cards we received reflected that patients had confidence and trust in the dentists.

Working with other services

The dentists explained to us how they would work with other services. Dentists were able to refer patients to a range of specialists in primary and secondary services as necessary. We were told that some patients request the referral themselves as they do not wish to have treatment under local anaesthetic. We saw evidence that the referrals

Are services effective?

(for example, treatment is effective)

were tracked and recall time frames followed those set out in National Institute for Health and Care Excellance (NICE) guidelines. Most referrals were electronic with the exception of those for orthodontic treatment.

Consent to care and treatment

The dentists we spoke with explained to us the processes they used within the practice to ensure that the principles of informed consent were implemented at each point of dental care delivery. We reviewed dental care records and saw evidence that dentists explained individual treatment options, risks, benefits and costs.

Staff demonstrated an understanding of the principles of the Mental Capacity Act (MCA) 2005. We saw evidence in the staff records of attendance at MCA training. Staff told us how its guidelines would inform their work with patients who may suffer from any mental impairment that may mean they might be unable to fully understand the implications of treatment.

Staff were familiar with the concept of Gillick competency with regards gaining consent from children under the age of 16. The Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

During the inspection we observed staff in the reception area. Staff were polite, friendly and provided a welcoming and relaxed greeting. Staff ensured patients confidentiality and did not use patients names whilst on the phone or recite personal information. Computers were password protected and regularly backed up. The screens were not visible to patients. Paper records were stored in lockable cupboards away from the main reception area. Treatment rooms were situated away from the main waiting area and doors remained closed at all times when patients were present. Conversations between patients and dentists could not be overheard.

We collected seven completed CQC patient comment cards. These provided a positive view of the service. Patients commented that staff were friendly, reassuring and kind. They also commented on the helpfulness of reception staff.

Involvement in decisions about care and treatment

We saw evidence in the dental care records we looked at that dentists discussed the findings of their examinations and corresponding treatment plans with patients. All treatment options available were discussed before the treatment started. We saw that clear information was given to patients on any fees applicable. Posters and patient information leaflets in the waiting area provided clear information on the costs of both NHS and private treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice waiting area clearly displayed information on the fees for private and NHS treatment and the practice complaints policy and procedure. Patient information leaflets were readily available and included topics such as oral health and treatment options. Details of out of hours contacts were clearly visible internally and externally. Fire procedures were clearly signposted. The Friends and Family Test questionnaire cards were accessible on the reception desk although previous results were not displayed.

We examined the appointment diaries. We saw that the practice was very busy but patients are not overbooked. This allowed for dedicated daily emergency slots for patients with dental pain. The dentists decided how long a patient's appointment needed to be and took into account any special circumstances such as whether a patient was very nervous, had a disability or the level of complexity of treatment.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to help patients with limited mobility or other issues that would hamper them, access the practice services. All treatment rooms were situated on the ground floor accessed via a small inbuilt ramp. A wheelchair accessible toilet was available. This ensured that patients with disabilities or infirmity as well as parents and carers using prams and pushchairs could access the treatment rooms and toilet facilities.

All staff had completed Equality and Diversity Training. Staff told us that they have not required the use of a translation service for patients whose first languge is not English; but they could if required.

Access to the service

The practice was open from 8.45am – 5.30pm Monday to Friday. The out of hours service was provided by a dental advice line. This information was readily available on the the answering machine when the practice was closed; as well as on a poster in the waiting area.

Concerns & complaints

The practice had a complaints policy and procedure. This set out how complaints would be addressed, who by and the time frames for responding. Information for patients about how to make a complaint was seen on a poster in the waiting area. We saw that the practice had received three complaints although these were all over a year old. One was still under investigation and did not concern the dentists clinical work. We saw that the complaints had been managed according to the practices' policy.

Are services well-led?

Our findings

Governance arrangements

The principle dentist was responsible for the day to day running of the practice. The practice does not have a practice manager. The practice had a range of policies and procedures and staff were aware of the location of these. We noted that several policies needed updating and the principle dentist assured us that these would be dealt with at the earliest opportunity. We found evidence in the patient records and through discussions with staff of the integration of NICE guidelines in the clinical system.

Leadership, openness and transparency

Leadership was provided by the prinicipal dentist. The culture of the practice encouraged candour. Staff we spoke with said that they felt comfortable and confident to raise any concerns they may have. They added that any concerns were listened to and acted on appropriately.

Staff regularly share information through informal daily conversations rather than formal documented team meetings. Some staff reported that they felt formal team meetings would be helpful. The principle dentist noted this and explained that these would resume and would be documented as a means of sharing learning.

Learning and improvement

Staff we spoke with told us that they felt their learning needs were supported in the practice. New staff received a practice induction and there was some evidence in the staff records that continuing professional development training was maintained in line with the General Dental Council regulations. We reviewed staff records and found that appraisals for staff had lapsed but had been booked for October/November 2016.

The practice did not have a structured plan in place to audit quality and safety although mandatory audits such as infection control and radiography had been carried out in 2016. We saw evidence that audit information had been collated and actions noted but there was no evidence of whether these actions had been addressed or were completed. We brought this to the attention of the provider and were assured that a structured audit plan to ensure completed audit cylcles will be established.

An environmental cleaning audit carried out in August 2016 identified some gaps in the cleaning logs and that a bin held in reception was not always emptied. It was apparent this this had not been addressed, we brought this to the attention of the provider who noted this and stated they will revisit the cleaning schedule and frequency of the bin emptying.

A patient medical history audit completed in July 2016 identified missing information for three patients. An action to improve this via updating addresses and obtaining patients' signatures on forms was noted, but there was no evidence that this had been completed.

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

Staff we spoke with reported feeling happy and confident to provide feedback to the dentists. They told us that this was acted on quickly. Staff told us that they regularly share information during informal conversations but that the taking of meeting minutes would help to ensure that this learning was shared and followed up. The provider noted this for review following the inspection.

The practice undertook the NHS Friends and Family Test (FFT). This is a feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience. We saw that the practice did not display the results of the FFT. The provider noted this and told us that he would display the results in the waiting area. The provider also explained that whilst the practice does not carry out patient satisfaction surveys at present, they do seek verbal patient feedback. The practice employed a hygienist as a direct result of this feedback. The provider will consider conducting patient satisfaction surveys in future.