Care Quality Commission

Patel Rattan and Rattan

One Dental Care

Inspection Report

1 Beckenham Rd
West Wickham
BR4 0QR
Tel: 020 8777 1977
Website: NA

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Overall summary

We carried out an announced comprehensive inspection on 24 September 2015 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

The One Dental Care practice is located in the London Borough of Bromley. The premises are laid out over two floors with three treatment rooms, a dedicated decontamination room, waiting room with reception area, staff room, and toilet.

The practice provides private dental services and treats both adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers, crowns and bridges, and oral hygiene.

The staff structure of the practice is comprised of a principal dentist (who is also the owner), three associate dentists, one hygienist, three dental nurses, a practice manager and a receptionist.

The practice opening hours are from Monday to Friday from 8.30am to 5.30pm and on Saturday from 8.30am to 12.30pm.

This is an established practice which changed ownership and registration with the Care Quality Commission (CQC) in January 2015. It has not been inspected since this change in ownership. The principal dentist was the registered manager at the time of the inspection. A registered manager is a person who is registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Summary of findings

The inspection took place over one day and was carried out by a CQC inspector and dentist specialist advisor.

Twelve people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

Our key findings were:

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were effective systems in place to reduce and minimise the risk and spread of infection.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- Governance arrangements and audits were effective in improving the quality and safety of the services.

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

- Review the practice's protocols for recording in the patients' dental care records, or elsewhere, the reason for taking the X-ray and quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000.
- Review the system of stock checks to ensure that out-of-date products are disposed of in a timely manner.
- Review and embed the use of staff appraisals as part of a system for identifying staff concerns and ensuring that staff remain skilled and competent in their role.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had systems in place to minimise the risks associated with providing dental services. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse. The practice had policies and protocols, which staff were following, for the management of infection control and medical emergencies. There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. We found the equipment used in the practice was well maintained and checked for effectiveness.

However, we noted two areas where safety could be improved. The recording of X-ray quality was inconsistent and there were some items of out-of-date stock in treatment room drawers.

Are services effective?

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

The practice provided evidence-based care in accordance with relevant, published guidance, for example, from the General Dental Council (GDC). The practice monitored patients' oral health and gave appropriate health promotion advice. Staff explained treatment options to ensure that patients could make informed decisions about any treatment. The practice worked well with other providers and followed up on the outcomes of referrals made to other providers.

Staff engaged in continuous professional development (CPD) and were meeting the training requirements of the GDC. However, staff had not received an appraisal within the past year to discuss their role and identify additional training needs.

Are services caring?

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

We received positive feedback from patients through comment cards and by talking to patients on the day of the inspection. Patients felt that the staff were kind and caring; they told us that they were treated with dignity and respect at all times. We found that dental care records were stored securely and patient confidentiality was well maintained.

Are services responsive to people's needs?

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

The practice had access to telephone interpreting services to support people who did not have English as their first language. The needs of people with disabilities had been considered and there was level access to the waiting area and treatment room on the ground floor. Patients were invited to provide feedback via a satisfaction survey.

Patients generally had good access to appointments, including emergency appointments, which were available on the same day.

No complaints had been received in the past year, but there was a policy in place to handle complaints as they arose.

Summary of findings

Are services well-led?

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

A new provider had taken over the running of the practice in January 2015. They had been effectively supported by the previous owner during a transition period to ensure the smooth and safe running of the practice. Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the principal dentist. However, not all staff felt that the issues they raised had been addressed. The principal dentist was aware of these concerns and had a development plan in place which included the provision of additional staff, new computer software and stronger management oversight.

The practice had good clinical governance and risk management structures in place. These were well maintained and disseminated effectively to all members of staff. A system of audits was used to monitor performance, although there was some evidence that the results of audits had not always been used successfully to drive improvements.

One Dental Care

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 24 September 2015. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a dentist specialist advisor.

We reviewed information received from the provider prior to the inspection. We also informed the NHS England area team that we were inspecting the practice; however we did not receive any information of concern from them.

During our inspection visit we reviewed policy documents and spoke with six members of staff, including the principal dentist. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We asked one of the dental nurses to demonstrate how they carried out decontamination procedures of dental instruments.

Twelve people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

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

There was an effective system in place for reporting and learning from incidents. No incidents had been recorded in the past year. However, there was a policy for staff to follow for the reporting of these events and the staff we spoke with were aware of the reporting procedures

We noted that the practice policy stated that they would offer an apology when things went wrong. There was also a Duty of Candour policy which directed staff to operate in an open and transparent manner in the event that something went wrong.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There was a book for the recording of any accidents, but none had been recorded in the past year. There were a range of risk assessments in place for the prevention of accidents and incidents. For example, the practice had a written sharps protocol and risk assessment for the handling of sharps. Our discussions with staff demonstrated that all staff were following the same sharps protocol, for example, where the re-sheathing and disposal of needles was the responsibility of the dentist.

Reliable safety systems and processes (including safeguarding)

The principal dentist was the named practice lead for child and adult safeguarding. The safeguarding lead was able to describe the types of behaviour a child might display that would alert them to possible signs of abuse or neglect. They also had a good awareness of the issues around vulnerable elderly patients who presented with dementia.

The practice had a well-designed safeguarding policy which referred to national guidance, held evidence of staff training and local authority telephone numbers for escalating concerns that might need to be investigated. This information was displayed in the waiting areas and treatment rooms.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, there was a risk assessment and associated protocol in relation to fire safety. Staff received training in fire safety and there were named fire marshals on site each day. Emergency exit routes were shown on the back of each surgery door and an appropriate assembly point outside had been established.

The practice followed national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments in line with guidance supplied by the British Endodontic Society. 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

The practice had arrangements in place to deal with medical emergencies. 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). The practice held emergency medicines in line with guidance issued by the British National Formulary 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 location known to all staff. Staff received annual training in using the emergency equipment. The staff we spoke with were all aware of the locations of the emergency equipment.

Staff recruitment

The practice staffing consisted of a principal dentist, three associates, one hygienist, three dental nurses, a practice manager and a receptionist.

All of the staff had been employed at the practice over a long period of time. A new member of staff had not been recruited for over ten years. There was a recruitment policy in place which stated that all relevant checks would be carried out to confirm that the person being recruited was suitable for the role. This included the use of an application form, interview notes, review of employment history, evidence of relevant qualifications, the checking of references and a check of registration with the General Dental Council. We checked five staff files and noted that a Disclosure and Barring Service (DBS) check had been carried out for all members of staff in 2013. However, the recruitment policy did not explicitly state that this check would be carried out prior to employment.

Are services safe?

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety policy in place. The practice had been assessed for risk of fire and there were documents showing that fire extinguishers had been recently serviced.

There were effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. Actions were described to minimise these risks. COSHH products were securely stored. Staff were aware of the COSHH file and of the strategies in place to minimise the risks associated with these products.

The practice had a system in place to respond promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. MHRA alerts, and alerts from other agencies, were received by the principal dentist and disseminated by them to the staff, where appropriate.

There was a business continuity plan in place. This had been kept up to date with key contacts in the local area. There was also an arrangement in place to use the premises of a second practice owned by the principal dentist for emergency appointments in the event that the practice's own premises became unfit for use.

Infection control

There were systems in place to reduce the risk and spread of infection. There was an infection control policy which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. One of the associate dentists was the infection control lead. Staff files showed that staff regularly attended training courses in infection control. Clinical staff were also required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients.

There were good supplies of protective equipment for patients and staff members including gloves, masks, eye protection and aprons. There were hand washing facilities in the treatment rooms and the toilets.

The practice had followed the guidance on 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)'. In accordance with HTM 01-05 guidance an instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which ensured the risk of infection spread was minimised.

We examined the facilities for cleaning and decontaminating dental instruments. There was one decontamination room. It was well organised with a clear flow from 'dirty' to 'clean'. One of the dental nurses demonstrated how they used the room. They showed a good understanding of the correct processes. The nurse wore appropriate protective equipment, such as heavy duty gloves and eye protection. An ultrasonic cleaner was available, but only used occasionally. A washer disinfector was mainly used instead. An illuminated magnifier was used to check for any debris following the cleaning stages. Items were then placed in an autoclave (steriliser). Instruments were pouched after sterilisation and a date stamp indicated how long they could be stored for before the sterilisation became ineffective.

The dental nurse showed us that systems were in place to ensure that the autoclaves, ultra-sonic bath and washer disinfector were working effectively. An automatic data logger recorded any faults in the sterilisation process when items were put through the autoclave. The practice used a system of daily log books to monitor the effectiveness of the sterilisation process. Two autoclaves were in constant use. There was also an additional vacuum autoclave available in case one of the others failed.

The practice had engaged an external company to supply domestic staff to carry out more general cleaning of the premises. The practice had a cleaning schedule that covered all areas of the premises and detailed what and where equipment should be used. This took into account national guidance on colour coding equipment to prevent the risk of infection spread.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. For example, we observed that sharps containers, clinical waste bags and municipal waste were properly maintained and stored. The practice used a contractor to collect dental waste from the practice. Waste consignment notices were available for inspection.

Are services safe?

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). The method described was in line with current HTM 01-05 guidelines. A Legionella risk assessment had also been carried out by an appropriate contractor in September 2015. The contractor had been engaged to carry out continuous and regular monitoring of the water systems.

The practice had carried out practice-wide infection control audits every six months, with the most recent one having been completed in September 2015. No issues were identified as needing attention subsequent to this audit. However, the principal dentist told us that when problems were identified these were discussed at a practice meeting.

Equipment and medicines

We found that the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor, fire equipment and X-ray equipment had all been inspected and serviced in 2015. Portable appliance testing (PAT) had been completed in accordance with good practice guidance in August 2015. PAT is the name of a process during which electrical appliances are routinely checked for safety.

Prescription pads were kept to the minimum necessary for the effective running of the practice. They were individually numbered and stored securely.

Stock, including medicines and equipment, was ordered weekly, meaning that generally small supplies of medicines were stored at the practice. This usually meant that supplies were used up before they went out of date.

However, we found some items of out-of-date stock in two of the three treatment rooms. These were low-risk items which had remained unopened and unused, or, where items were open, we also found that an in-date item of the same type was also open and clearly in use. This suggested that the out-of-date stock was not being used. We discussed this issue with the principal dentist who disposed of the items promptly and assured us that a stock-checking system would be implemented immediately.

Radiography (X-rays)

The practice had in place a 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 present. This file was well maintained and complete. Included in the file were the critical examination pack for the X-ray set, the three-yearly maintenance log, a copy of the local rules and appropriate notification to the Health and Safety Executive. The maintenance log was within the current recommended interval of three years with the next service due in 2018. We saw evidence that staff had completed radiation training.

A copy of the most recent radiological audit was available for inspection. This demonstrated that a high percentage of radiographs were of grade one or two (the higher) standards. We checked a sample of individual dental care records to confirm the findings. However, we found that these records showed that not all of the dental X-rays had been graded, in line with the quality assurance process recommended in the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. We spoke with two associate dentists about how they carried out patient assessments and checked a random sample of their records to confirm their descriptions. All patients had their medical history reviewed prior to an examination of the condition of the patient's teeth, gums and soft tissues. Patients were all made aware of the condition of their oral health and any changes since the last appointment were discussed. Treatment options were explained and the dental care record updated with details of these discussions. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Our check of dental care records showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw notes containing details about 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 used by dentists to indicate the level of treatment need in relation to a patient's gums). These were carried out at each dental health assessment. Details of the treatments carried out were also documented; local anaesthetic details including type, site of administration, batch number and expiry date were recorded.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. Staff told us they discussed oral health with their patients, for example, effective tooth brushing or dietary advice. The dentist was aware of the need to discuss a general preventive agenda with their patients. This included discussions around smoking cessation, sensible alcohol use and weight management. The dentist also carried out examinations to check for the early signs of oral cancer.

We observed that there were some health promotion materials displayed in the waiting area; including information aimed at engaging children in good dental hygiene practices. These could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition.

Staffing

Staff told us they received appropriate professional development and training. We reviewed staff files and saw that this was the case. The training covered all of the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, safeguarding and X-ray training. There was an induction programme for new staff to follow to ensure that they understood the protocols and systems in place at the practice.

The practice had held some appraisals with each member of staff. However, the staff files we reviewed showed that appraisals had been held infrequently, and some staff had had no appraisal since 2012 or 2013. We discussed this with the principal dentist. They were aware of this issue. They told us that their priority for the practice since taking over in April 2015 was to ensure that staffing levels increased, including additional reception, dental nursing and practice management staff. They assured us that they would turn their attention to staff development and appraisal after this recruitment drive was complete.

Working with other services

The principal dentist explained how they worked with other services, when required. Dentists were able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. A referral letter was prepared and sent to the hospital with full details of the dentist's findings and a copy was stored on the practices' records system. When the patient had received their treatment they were discharged back to the practice. Their treatment was then monitored after being referred back to the practice to ensure patients had received a satisfactory outcome and all necessary post-procedure care. A copy of the referral letter was always available to the patient if they wanted this for their records.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. Staff discussed treatment options, including risks and benefits, as well as costs, with each patient. Notes of these discussions were recorded in the

Are services effective?

(for example, treatment is effective)

dental care records. Patients were asked to sign to indicate they had understood their treatment plans and formal written consent forms were completed for specific treatments, such as tooth extraction.

Staff were aware of the Mental Capacity Act 2005. They could accurately explain the meaning of the term mental capacity and described to us their responsibilities to act in patients' best interests, if patients lacked some decision-making abilities. The Mental Capacity Act 2005 (MCA) 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.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We collected feedback from 12 patients. They described a positive view of the service. Patients commented that the team were courteous, friendly and kind. Patients were happy with the quality of treatment provided. During the inspection we observed staff in the reception area. They were polite and helpful towards patients and the general atmosphere was welcoming and friendly.

All the staff we spoke with were mindful about treating patients in a respectful and caring way. They were aware of the importance of protecting patients' privacy and dignity. There were systems in place to ensure that patients' confidential information was protected. Dental care records were stored electronically. Any paper correspondence was scanned and added to the electronic record. Electronic records were password protected and regularly backed up; paper records were stored securely and were locked up. Staff understood the importance of data protection and confidentiality and had received training in information governance. Reception staff told us that people could request to have confidential discussions in an empty treatment room, if necessary

The practice had recently started to obtain feedback from patients via a satisfaction survey and through the use of the 'Friends and Family Test'. The practice had received 12 responses to their satisfaction survey in the past month, and one response to the 'Friends and Family Test'. The feedback indicated that people were largely satisfied with the care they received. The principal dentists told us they would systematically analyse the results to identify areas for improvement. They were committed to carrying out the survey periodically, and at least once a year.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area which gave details of the NHS and private dental charges and fees. There were a range of information leaflets in the waiting area which described the different types of dental treatments available. Patients were routinely given copies of their treatment plans which included useful information about the proposed treatments, any risks involved, and associated costs. We checked a sample of dental care records and saw examples where notes had been kept of discussions with patients around treatment options, as well as the risks and benefits of the proposed treatments.

We spoke with two of the associate dentists and one of the dental nurses on the day of our visit. All of the staff told us they worked towards providing clear explanations about treatment and prevention strategies. The patient feedback we received via discussions and comments cards, together with the data gathered by the practice's own survey, confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. Each dentist could decide on the length of time needed for their patient's consultation and treatment. The dentists we spoke with told us they scheduled additional time for patients depending on their knowledge of the patient's needs, including scheduling additional time for patients who were known to be anxious or nervous. Staff told us they did not feel under pressure to complete procedures and always had enough time available to prepare for each patient.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. The practice had access to a telephone translation service, although they had not had to use this so far. There was written information for people who were hard of hearing as well as a hearing loop in the reception area. Large print documents for patients with some visual impairment were also available. The ground floor was wheelchair accessible with level access to a treatment room. There was also a disabled toilet on the ground floor.

Access to the service

The practice was open from Monday to Friday from 8.30am to 5.30pm and on Saturday from 8.30am to 12.30pm. The practice displayed its opening hours at their premises. New patients were also given a practice information leaflet which included the practice contact details and opening hours.

The dentists we spoke with told us that they planned some gaps in their schedule on any given day. This ensured that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, could be accommodated. We reviewed the electronic appointments system and saw that this was the case.

Staff told us they had enough time to treat patients and that patients could generally book an appointment in good time to see the dentist of their choice. Reception staff told us that there were generally appointments available within a reasonable time frame. They stressed that emergency appointments for those with urgent need were available every day and that there were enough of these to meet demand. The feedback we received from patients confirmed that they could generally get an appointment when they needed one and that they had adequate time scheduled with the dentist.

Concerns & complaints

There was a complaints policy which described how the practice handled formal and informal complaints from patients. Information about how to make a complaint was displayed in the reception area. There had been no complaints received in the past year. There was a complaints file holding details of complaints received over the past five years. The practice had received, on average, one complaint per year. These were dealt with in line with the written policy. We noted that the practice offered patients an apology when they identified that something had not been managed appropriately.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements with an effective management structure. The practice had experienced a change in ownership in January 2015 with a view to securing the long-term future of the practice. The previous provider was still available to provide clinical and managerial support to the new provider.

The principal dentist had implemented suitable arrangements for identifying, recording and managing risks through the use of scheduled risk assessments and audits. There were relevant policies and procedures in place. These were all frequently reviewed and updated. Staff were aware of the policies and procedures and acted in line with them. Records, including those related to patient care and treatments, as well as staff employment, were kept accurately.

The principal dentist had organised staff meetings, where necessary, to discuss key governance issues and there were plans in place to establish these meetings on a monthly basis. For example, we saw minutes of meetings held in June, July and August 2015 where discussions about staffing levels, equipment maintenance and infection control procedures had been held.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. The majority of staff said that they felt comfortable about raising concerns with the principal dentist and that they were listened to and responded to when they did so. However, we received some feedback from staff who said that their concerns had not always been consistently addressed. We found staff to be hard working, caring and committed. However, staff appraisals had not occurred at regular intervals and there were no formal supervisory arrangements to support staff development or identify career aspirations. We discussed these concerns with the principal dentist who was aware of the need to work with the team on a range of issues, including levels of staffing and management oversight at the practice.

We also asked the principal dentist about their ethos and future plans for the practice. They had developed a coherent development plan. This covered changes to the clinical and administrative staffing levels and the installation of new computer software to support the safe and effective recording of patient information.

Learning and improvement

The practice had a rolling programme of clinical audit and risk assessments in place. Risk assessments were being successfully used to minimise the identified risks. For example, we saw evidence of actions taken following a recent Legionella risk assessment. There were audits for infection control, clinical record keeping and X-ray quality. Audits were repeated at appropriate intervals to evaluate whether or not quality had been maintained or if improvements had been made. For example, the X-ray quality audit carried out in July 2015 had identified some issues around recording of X-rays in the dental care records, although the overall quality of X-rays was good. The relevant dentists had had these issues discussed with them, although improvements had yet to be made, as revealed by our sampling of the dental care records.

Staff were also being supported to meet their professional standards and complete continuing professional development (CPD) standards set by the General Dental Council (GDC). We saw evidence that staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the GDC.

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

The practice had started to gather feedback from patients through the use of a patient satisfaction survey. The survey covered topics such as the quality of staff explanations, cleanliness of the premises, and general satisfaction with care. The majority of responses indicated a high level of satisfaction. We noted that the practice acted on feedback from patients where they could. For example, they survey results indicated that wider reading material in the waiting area was required and the principal dentist was in the process of acting on this.

Staff commented that the principal dentist was open to feedback regarding the quality of the care and that the transition to new ownership had been relatively smooth. The staff meetings also provided an appropriate forum in which to give their feedback.