

Mrs. Heather Williams

# H Williams & Associates Dental Surgery

## Inspection Report

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### Overall summary

We carried out an announced comprehensive inspection on 25 February 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**

H Williams & Associates Dental Surgery is located in Petts Wood, Orpington in the London Borough of Bromley. The practice has three treatment rooms, waiting and reception area and patient toilet, all the facilities situated on the ground floor.

The practice provides private dental treatment to children and adults. The practice offers a range of specialist dental treatments as well as routine examinations, treatments, veneers, crowns and bridges, implants, orthodontics and oral hygiene treatments. The practice is open Monday 8am-7.30pm, Tuesday – Thursday 8.30am - 7.30pm, Friday 8 am-6pm and Saturdays 9am - 1pm

The staff structure consists of a principal dentist, seven associate dentist, six dental nurses, three hygienists/ therapists, two practice administrators and a practice manager.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. Like registered

# Summary of findings

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.

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

We received 49 CQC comment cards completed by patients and spoke with five patients during our inspection visit. Patients we spoke with, and those who completed comment cards, were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the 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.
- The practice manager had a clear vision for the practice and staff told us they were well supported by the management team.
- Governance arrangements and audits were effective in improving the quality and safety of the services.

# 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. There was an electronic system in place for updating policies and protocols, which informed staff of any requirements to review practice, audit or arrange training. This included the management of infection control, medical emergencies and dental radiography. We found the equipment used in the practice was well maintained and checked for effectiveness.

There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. There were regular meeting to provide staff with feedback from any incidents.

### **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 Faculty of General Dental Practice (FGDP), National Institute for Health and Care Excellence, (NICE) and 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 were undertaking continuous professional development (CPD) and were meeting the training requirements of the GDC.

### **Are services caring?**

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

We reviewed 49 completed CQC comments cards and spoke with five patients on the day of the inspection. Patients were positive about the care they received from the practice. Patients commented they felt fully involved in making decisions about their treatment, were made comfortable and felt, their concerns, if any would be listened to.

We noted that patients were treated with respect and dignity during interactions at the reception desk and over the telephone.

Patients were invited to provide feedback via a satisfaction survey and the feedback was positive.

### **Are services responsive to people's needs?**

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

The needs of people with disabilities had been considered. There was level access to the waiting area and treatment rooms, although the front access was narrow, staff were available to provide assistance.

Patients were invited to provide feedback via a satisfaction survey. There was a clear policy in place which was used to handle complaints as they arose. The practice had received two complaints in the past year. We saw that these had been dealt with promptly and that the complaints handling procedure had been disseminated to staff during the team meetings.

# Summary of findings

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

## **Are services well-led?**

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

The practice had suitable clinical governance and risk management structures in place. There were processes in place for dissemination of information and feedback to all staff. There were appropriate audits used to monitor and improve care.

Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the principal dentist. They were confident in the abilities of the management team to address any issues highlighted.

There was a strategy and vision in place to develop the practice and improve the practice environment. .

# H Williams & Associates Dental Surgery

## Detailed findings

### Background to this inspection

We carried out an announced, comprehensive inspection on 25 February 2016. The inspection took place over one day and was led by a CQC inspector. They were accompanied by a dental specialist advisor.

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

Forty-nine 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. There was a policy for staff to follow for the reporting of these events and staff were aware of how to access the policy if necessary. There were two reported incidents recorded for 2015. One related to a hand piece issue and we saw that additional checks had been put into place to prevent recurrence.

There was a Duty of Candour policy which directed staff to operate in an open and transparent manner in the event that something went wrong. Staff told us they understood the need for transparency and felt able to raise any concerns. [Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity].

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.

### Reliable safety systems and processes (including safeguarding)

There was a named practice lead for child protection 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 adult patients who may present with dementia. Staff described how they would assess patients and seek assistance if required from their General Practitioner.

The practice had a children and adults safeguarding policy which referred to national guidance and local authority contact details were displayed in several locations for staff to escalate concerns that might need to be investigated.

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 and protect the

airway. Rubber dams should be used when endodontic treatment is being provided. On the occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured] 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 protocols 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 appropriate assembly point outside the practice.

### Medical emergencies

The practice had suitable arrangements in place to deal with medical emergencies. 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, and an automated external defibrillator (AED) were available in line with the Resuscitation Council UK guidelines. (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 emergency medicines were all in date and stored securely with emergency oxygen in a central 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 within the premises.

### Staff recruitment

The practice staffing consisted of a principal dentist (who was also the owner), seven associate dentist, six dental nurses, three hygienists/therapists, two practice administrators and a practice manager.

There was a recruitment policy in place and we reviewed the recruitment records for six staff members. We saw that relevant checks to ensure that the person being recruited was suitable and competent for the role had been carried out. This included the use of an application form, evidence of relevant qualifications, references and a check of

# Are services safe?

registration with the General Dental Council. We noted that it was the practice's policy to carry out Disclosure and Barring Service (DBS) checks for all new members of staff. The DBS checks were carried out by an outside company.

## 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 and staff associated with hazardous substances were identified. 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. Information relating to COSHH and Health and Safety were available on the staff notice board.

The practice responded promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. MHRA alerts, and alerts from other agencies, were reviewed by the practice manager and 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.

## 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 dental nurses was the infection control lead. Staff files showed that staff regularly attended training courses in infection control.

Staff and patients were able to easily access supplies of protective equipment which included gloves, masks, eye protection and aprons. There were hand washing facilities in the treatment rooms and the toilets. Posters displaying hand washing techniques were in all treatment rooms, decontamination area and 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)'.

We checked the cleaning and decontaminating of dental instruments which was carried out in each surgery. The surgeries were well organised with a clear flow from 'dirty' to 'clean'. One of the dental nurses demonstrated the decontamination process and showed a good understanding of the correct processes. Following inspection of cleaned items, they were placed in an autoclave (steriliser) and were applicably pouched, dated and stored appropriately.

The lead dental nurse showed us that systems were in place to ensure all decontamination equipment such as the autoclaves were working effectively. These included the automatic control test for the autoclave and protein residue test for the ultrasonic bath. The data sheets used to record the essential daily validation were completed and up to date.

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 domestic waste were properly separated and stored although sharps bins were not wall mounted and this was discussed with the practice manager. The practice used a contractor to remove dental waste from the practice. Waste consignment notices were available for inspection.

The practice had carried out practice-wide infection control audits every six months; the most recent audit conducted on February 2016 had a compliance score of 98%.

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 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)'. A Legionella risk assessment had also been carried out by an appropriate contractor in 2015 and no issues were noted.

## Equipment and medicines

# Are services safe?

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 on 24 February 2016. (Portable appliance testing (PAT), is the name of a process during which electrical appliances are routinely checked for safety); had been completed in the previous year, and we saw evidence that a PAT had been arranged for later this year.

Staff told us that if necessary a private prescription was written manually and scanned into the computer. The practice did not hold FP10 prescription pads as all patients were private.

The expiry dates of medicines, oxygen and equipment were monitored using a daily and monthly check sheet which enabled the staff to replace out-of-date drugs and equipment promptly. There was a system in place to ensure that all medication such as antibiotics held by the practice were accounted for and recorded in the patients' notes. We were provided with the antibiotic audit undertaken on 17 February 2016 which showed 100% accuracy in recording and dispensing the medication. The audit was due to be repeated in May 2016 to ensure standards are maintained.

## **Radiography (X-rays)**

The practice had a Radiation Protection Adviser in place and a nominated Radiation Protection Supervisor in accordance with the Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). A radiation protection file and local rules were displayed within the surgeries. Included in the file were the critical examination pack for the X-ray set, which included dose assessment reports, the maintenance log and appropriate notification to the Health and Safety Executive. The maintenance log was within the current recommended

interval of three years and was last carried out on 12 February 2016. We saw evidence that staff had completed radiation protection training.

A copy of the most recent radiological audit carried out in January 2016 was available for inspection. Staff told us that quality assurance checks were carried out and all the dentists were audited every six months to ensure the quality was maintained and reasons for any retakes were documented. We checked a sample of dental care records to confirm the findings which showed dental X-rays were justified and required as part of the patient care plan.



# 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 professional and General Dental Council (GDC) guidelines. One of the dentists we spoke with described how they carried out patient assessments using a typical patient journey scenario. The practice used a pathway approach to the assessment of the patient which was supported and prompted by the use of computer software. The assessment began with a review of the patient's medical history. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues of the mouth. Patients were 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 discussed with the patient and treatment options were fully explained. The dental care record was updated with the new treatment plan after discussing the options with the patient. The care given to patients was monitored at their follow-up appointments in line with their individual requirements.

During the course of our inspection we checked dental care records to confirm the findings. These 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 such as type of anaesthetic, site of administration, batch number and expiry date were also 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 such as tooth brushing and dietary advice and where applicable smoking cessation and alcohol consumption with their patients. The dentist also carried out examinations to check for the early signs of oral cancer.

The waiting area had health promotion material available as well as samples of toothpaste and interdental brushes to support patients with their oral hygiene. Health promotion material included information on how to prevent gum disease and how to maintain healthy teeth and gums.

### Staffing

Staff told us they received appropriate professional development and training. We reviewed staff files and saw that this included responding to emergencies, safeguarding and X-ray training.

There was an induction programme for new staff to ensure that they understood the protocols and systems in place at the practice. There was a training programme in place for trainee dental surgery assistants with three of the staffing currently undertaking the programme. Staff we spoke with told us the practice was supportive with helping them achieve their training goals.

The practice carried out annual appraisals for each member of staff. This provided staff with an opportunity to discuss their current performance as well as their career aspirations. Notes from these meetings were kept in each staff member's file.

### Working with other services

The principal dentist and the practice manager 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 in the patient's dental care records. A log was kept for all patients referred into the practice as well as to other care providers.

The dentists did internal written referrals to the hygienists which were held in the patients' records and we were shown examples which confirmed this practice.

### Consent to care and treatment

Consent was obtained for all care and treatment patients' received. Staff discussed treatment options, including risks and benefits, as well as costs, with each patient. Notes of these discussions were recorded in the dental care records. Patients were asked to sign to indicate they had understood their treatment plans and formal written consent forms were completed.

# Are services effective?

(for example, treatment is effective)

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 comment cards from 49 patients and spoke with five patients. They were complimentary of the care, treatment and professionalism of the staff and gave a positive view of the service. Patients commented that the team were courteous, friendly and kind. Some patients' told us the care was excellent and they were very happy with the care. During the inspection we observed staff in the reception area. They were polite, courteous welcoming and friendly towards patients at all times.

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 added to the patient records. Electronic records were password protected and staff files were stored securely. Staff understood the importance of data protection and confidentiality and had received training in information governance. Staff told us that people could request to have confidential discussions in one of the offices or treatment room, if necessary. There was a treatment coordinator in place should patients wish to have further information about any procedures.

The practice obtained regular feedback from patients via a satisfaction survey. We noted from their report in November 2015 that the majority of feedback about staff was positive and corroborated our own findings regarding

staff's caring attitude. The feedback was specific about individual dentist and results were fed back. People completing the feedback stated they would be likely to recommend the practice to other people.

### **Involvement in decisions about care and treatment**

The practice displayed information in the waiting area regarding the 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 information about their proposed treatments, and associated costs. We checked dental care records to confirm the findings 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 the principal dentist, associate dentists, lead for infection control, lead for safeguarding, the dental nurses, reception staff and practice manager on the day of our visit. All of the staff told us they worked towards providing clear explanations about treatment plans. They emphasised that patients were given time to think about the treatment options presented to them and that it was up to the patient to decide whether they wanted to go ahead with the treatment.

The patients we spoke with 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.. Staff told us they scheduled additional time for patients receiving complex treatments, 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 were able to have enough time in between each patient to document care and prepare equipment 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 or website translation service, if needed.

The surgeries were on the ground floor and there was adequate parking and level access to the practice. The provider had assessed disability access at the practice in 2015. Due to space limitations the toilet facilities were small and unable to accommodate a wheelchair.

### Access to the service

The practice displayed its opening hours and fees at their premises. There was a practice information folder available in the waiting area. New patients were also given a practice information leaflet which included the practice contact details and opening hours. Information leaflets gave details of each dentist and hygienist at the practice.

The principal dentist told us that all of the dentists planned some gaps in their schedule on any given day to ensure that patients, who needed to be seen urgently, for example, if they were experiencing dental pain, could be accommodated. We reviewed the electronic appointments system and saw that this was the case and confirmed this with one of the associate dentist.

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. Staff told us there were generally appointments available within a reasonable time frame. The feedback we received from patients confirmed that they could usually get an appointment within a reasonable time frame and that they had adequate time scheduled with the dentist to assess their needs and receive treatment.

### 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 two written complaints recorded since January 2015. These complaints had been responded to in line with the practice policy. Complaints were investigated and learning points were discussed with all staff at the practice meetings. The complaints log showed that patients had received a written response outlining the investigation that had taken place and the findings. Staff told us that this would include an apology when something had not been managed appropriately. There was evidence in notes from meetings with clinical staff to show that individual cases were reviewed to understand whether they could learn or change their practice following complaints made.

# Are services well-led?

## Our findings

### **Governance arrangements**

The practice had good governance arrangements with an effective management structure.

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 accessible for all staff.

The principal dentist organised staff meetings on a monthly basis, to discuss key governance issues and staff training sessions. For example, we saw minutes from a meeting in April 2015 where discussions relating to safeguarding and MCA 2005 had taken place.

### **Leadership, openness and transparency**

The staff we spoke with described an open and transparent culture which encouraged honesty. Staff said that they felt comfortable about raising concerns with the principal dentist or practice manager. They felt they were listened to and responded to when they did so. Staff were aware of their responsibilities relating to the Duty of Candour.

We spoke with the principal dentist about their ethos and future plans for the practice. They had developed a coherent development plan which was available for all staff. The plan covered business development and planning providing strategic management of the practice. The business plan covered 11 points for example recruitment, patient demographics, personal goal development and improving the patient experience. The business plan highlighted the strengths, weaknesses, opportunities and threats to the practice and formed the basis for the future vision and development. For example there was an awareness of long waits for implant treatments being a threat and the plan covered the recruitment of a specialist to reduce the wait.

The practice had recently been awarded a gold standard accreditation for Investors in People in January 2016.

We found staff to be hard working, caring and a cohesive team committed to providing a high standard of care. There was a system of yearly staff appraisals to support staff in carrying out their roles to a high standard.

### **Learning and improvement**

The practice had a rolling programme of clinical audit in place. These included 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. We looked at a few audits which generally revealed a high level of compliance against agreed standards. For example, the dental care record keeping audit ensured that dentists were recording essential clinical data such as medical history, condition of the gums and soft tissues of the mouth. The audit showed 88% compliance and we were provided with the action plan to make improvements relating to some information recorded. The practice also had a programme of risk assessments in place that were being successfully used to minimise the identified risks.

Staff were 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. Each member of staff had been allocated specific responsibilities such as infection control, medication management and training. The practice manager had a training matrix which showed all the training that had been undertaken from 2014-2016.

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

The practice gathered feedback from patients through the use of a yearly 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.

Staff commented that the principal dentist was open to feedback regarding the quality of the care. The appraisal system and staff meetings also provided appropriate forums to give their feedback. Staff also had regular meetings with the practice manager to discuss day to day issues.