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Care Dental Smile Studio

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection of Care Dental Smile Studio on 7 July 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

Care Dental Smile Studios is located in the London borough of Hounslow in West London. The practice has been under new management since November 2014.The practice provides NHS and private treatment and caters for both adults and children. The practice provides a variety of specialised care including intermediate oral surgery (IMOS), dental implants including the provision of conscious sedation for selected patients for this type of treatment, orthodontics and specialised gum treatments.

The practice provides services on the ground floor. The practice had four dental treatment rooms and a separate decontamination room for cleaning, sterilising and packing dental instruments.

The practice had six dentists and four dental nurses one of whom is the practice's lead nurse. There was a part time dental hygienist who provided preventative advice and gum treatments on prescription from the dentists working in the practice. The practice also had a practice manager and two dental receptionists. The practice is open Monday and Tuesday – 9:00am – 7:30pm

Wednesday, Thursday and Friday – 9:00am – 6:00pm and on Saturday 09:00am -4:00pm.

Our key findings were:

- Staff felt well supported and were committed to providing a quality service to their patients.
- The practice was visibly clean and well maintained.
- Infection control procedures were robust and the practice followed published guidance.
- Patients' needs were assessed and care was planned and delivered in line with current professional guidelines

Summary of findings

- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding children and adults in vulnerable circumstances.
- The practice had enough staff to deliver the service.
- The practice placed an emphasis on the promotion of good oral health and provided regular oral health instruction to patients.
- The practice took into account any comments, concerns or complaints and used these to help them improve the practice.
- The practice staff did not have access to an automated external defibrillator (AED)
- The practice did not have a risk assessment with regards to the use of safer sharps

There were areas where the provider should make improvements.

- Review availability of medicines and equipment to manage medical emergencies giving due regard to guidelines issued by the British National Formulary, the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review the practices' safe sharps policy giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Ensure that all staff receive appropriate child protection training refresher courses.

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 the practice was providing care which was safe in accordance with the relevant regulations.

The practice had arrangements for essential topics such as infection control, clinical waste control, conscious sedation and dental radiography (X-rays). We found that all the equipment used in the dental practice was well maintained. There were sufficient numbers of suitably qualified staff working at the practice and staff understood their responsibilities in terms of identifying and reporting any potential abuse.

Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. We saw examples of positive team work within the practice and evidence of good communication with other dental professionals. Staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

Are services caring?

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

We received 30 completed CQC patient comment cards. These provided a positive view of the service the practice provided. All of the patients commented that the quality of care was good. Some patients commented that treatment was explained clearly and the staff were caring and put them at ease. They also said that the reception staff were always helpful and efficient.

Are services responsive to people's needs?

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

The service was aware of the needs of the local population and took those these into account in how the practice was run. Patients could access treatment and urgent and emergency care when required. The practice had a ground floor treatment rooms and level access into the building for patients with mobility difficulties and families with prams and pushchairs.

Are services well-led?

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

The principal dentist and other staff had an open approach to their work and shared a commitment to continually improving the service they provided. Staff told us that they felt well supported and could raise any concerns with the practice manager. All the staff we met said that the practice was a good place to work.

Care Dental Smile Studio

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 7 July 2015. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a dentist specialist advisor.

Prior to the inspection we asked the practice to send us some information which we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, and the details of their staff members and proof of registration with their professional bodies.

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

During the inspection we spoke with the practice manager, principal dentist, dentists, dental hygienist, lead dental nurse, reception staff and reviewed policies, procedures and other documents. We also spoke with patients. We reviewed 30 comment cards that we had left prior to the inspection, for patients to complete, about the services provided at the practice.

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 clear guidance for staff on how to report incidents and accidents. We saw evidence that all incidents were documented, investigated and reflected upon by the dental practice. We reviewed the information within the practice's critical incidents files that were stored electronically and found the practice had responded appropriately on all incidents. Examples of recorded instances included clerical and administrative errors that had resulted in incorrect patient registrations details. To avoid future occurrences the practice ensured all records were audited.

The practice responded to national patient safety and medicines alerts that affected the dental profession. The practice manager told us they reviewed all alerts and took all the necessary actions including alerting staff. The principal dentist and the practice manager understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR) and provided guidance to staff within the practice's health and safety policy. The practice had no recorded RIDDOR incidents in the last 12 months.

Reliable safety systems and processes (including safeguarding)

The practice had child protection and vulnerable adult policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff and local contact details for safeguarding teams were easily available to all staff. All staff at the practice were due to have updated training in child protection as the previous training had expired. We discussed with staff about the different types of abuse that could affect patients and how and who to report their concerns. All staff were able to describe in detail the types of behaviour a child would display that would alert them if there were possible signs of abuse or neglect. All staff had awareness of the issues around vulnerable elderly patients who presented with dementia that required dental care and treatment.

One of the dentists at the practice carried out intra-venous sedation at the practice for some patients who were undergoing the provision of dental implants. The dentist provided this service for one or two patients each month. We found that patients were appropriately assessed for sedation. The clinical records demonstrated that all patients undergoing sedation had important checks made prior to sedation; this included a medical history and blood pressure. We saw an example of a dental care record that demonstrated that during the sedation procedure important checks were recorded at regular intervals which included pulse, blood pressure and the oxygen saturation of the blood. This was carried out using a specialised piece of equipment known as a pulse oximeter which measured not only the patient's heart rate, oxygen saturation of the blood but also blood pressure. These checks were in line with current good practice guidelines demonstrating that sedation was carried out in a safe and effective way.

We spoke with the lead dental nurse about the use of safer sharps. 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 protecting staff against blood borne viruses. The practice used a system whereby needles were not resheathed using the hands following administration of a local anaesthetic to a patient. Dentists used the 'scoop' method to re-sheath a needle following the delivery of a local anaesthetic. It was also practice policy that the discarding of the used needle was the dentist's responsibility. A protocol was on display describing the process that should be following in the event of a contaminated needle stick injury. Although the practice had safe systems and processes in place, they did not have in place a written risk assessment explaining why needles were re-sheathed following the delivery of a local anaesthetic. Current guidance provided by the Health and Safety Executive required a risk assessment with appropriate measures put in place to prevent needle stick injuries to satisfy the current EU Directive on safer sharps use.

We asked how the practice treated the use of instruments which were used during root canal treatment. The lead dental nurse we spoke with explained that these instruments were single use only. One of the dentists we spoke with explained that root canal treatment was carried out using a rubber dam. 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. The practice followed appropriate guidance by the British Endodontic Society in relation to the use of the rubber dam.

Are services safe?

Patient medical histories were taken when they first joined the practice. This included details of current medication, known allergies and existing conditions. We were shown copies of patients' medical histories and saw they were updated appropriately.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The responsibility for infection control procedures had been delegated to the practices' lead dental nurse. It was demonstrated through direct observation of the cleaning process and a review of practice protocols that the practice was following guidance as set out in the 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05) (national guidance for infection prevention control in dental practices'). We noted that a current audit of infection control processes confirmed compliance with HTM 01 05 guidelines.

It was noted that the four dental treatment rooms, waiting area, reception and toilet were clean, tidy and clutter free. Clear zoning demarcation of clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available including liquid soap and paper towels in each of the treatment rooms and toilets. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

The lead nurse who was responsible for infection control described the end to end process of infection control procedures at the practice. The dental nurse explained the decontamination of the general treatment room environment following the treatment of a patient. They demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

The drawers of a treatment room was inspected in the presence of the dental nurse. These were well stocked, clean, well ordered and free from clutter. All of the instruments were pouched and it was obvious which items were single use and these items were clearly new. Each treatment room had the appropriate routine personal protective equipment such as masks, protective eyewear, and face shields were available for staff use.

The dental water lines were maintained suitably to prevent the growth and spread of Legionella bacteria (Legionella is a term for particular bacteria which can contaminate water systems in buildings) The dental nurse described the method they used which was in line with current HTM 01-05 guidelines. A Legionella risk assessment had been carried out by an appropriate contractor and documentary evidence was available for inspection. These measures ensured that patients and staff were protected from the risk of infection due to Legionella.

The practice utilised a separate decontamination room for instrument processing. This room was well organised and was clean, tidy and clutter free. Protocols were displayed on the wall to remind staff of the processes to be followed at each stage of the decontamination process. Dedicated hand washing facilities were available in this room. The dental nurse demonstrated to us the decontamination process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a system of manual scrubbing utilising the double sink method and the use of a washer disinfector as part of the initial cleaning process. Following inspection they were placed in an autoclave (a machine used to sterilise instruments). When instruments had been sterilized they were pouched and stored appropriately until required. All pouches were dated with an expiry date in accordance with current guidelines. The nurse also demonstrated that systems were in place to ensure that the autoclaves used in the decontamination process were working effectively. These included the automatic control test and steam penetration tests for the autoclaves and a protein residue test for the washer disinfector. It was observed that the data sheets used to record the essential daily validation checks of the sterilisation cycles and weekly tests for the autoclaves and the washer disinfectors were always complete and up to date.

The segregation and storage of dental 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 dental waste

Are services safe?

from the practice and waste was stored in a separate locked location adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection.

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 well maintained radiation protection file in line with these regulations was observed. This file was well maintained and complete. The critical examination packs for each X-ray set along with the three yearly maintenance logs and a copy of the local rules were Included in the file. The maintenance logs were within the current recommended interval of 3 years. It also contained the Local Rules; X-ray set inventory and notification to the Health and Safety Executive.

A sample of dental care records where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured every time. The X-rays we observed were of a high quality. These findings showed that practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

Equipment and medicines

Records we viewed reflected that equipment in use at the practice was regularly maintained and serviced in line with manufacturers guidelines. All electrical equipment had been PAT tested by an appropriately qualified person. PAT stands for 'portable appliance testing'. We observed the maintenance schedules ensuring that the autoclaves were maintained to the standards set out in the Pressure Systems Safety Regulations 2000, the most recent service being carried out in June 2015. The washer disinfector was serviced in May 2015. X-ray machines were the subject of regular visible checks and records had been kept. A specialist company attended at regular intervals to calibrate and review all X-ray equipment to ensure they were operating safely. The maintenance schedules were within the current recommended time interval of 3 years which was in accordance with the Ionising Radiation Regulations 1999. A maintenance contract was in place for the replacement of the emergency oxygen ensuring that the contents and the metal oxygen cylinder did not deteriorate over time.

We noted that the practice used a single use surgical drape pack system for patients requiring complex oral surgery procedures such as the placement of dental implants. We saw that single use surgical irrigant packs were used in the placement of dental implants along with a dedicated surgical drill unit for complex oral surgical procedures including the placement of dental implants. The equipment used for the provision of conscious sedation was in line with current guidelines; this included a combined pulse oximeter and blood pressure machine, cannulas, tourniquet and syringes.

The practice had a recording system for the prescribing and recording of medicines including those used for conscious sedation. The records we saw were complete and provided an account of medicines patients had been prescribed. The batch numbers and expiry dates for sedative drugs and local anaesthetics were always recorded in the clinical notes. The practice held appropriate stock of the reversal agent for the sedative drug midazolam.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had in place the emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. Oxygen and other related items such as manual breathing aids and portable suction were available in line with the Resuscitation Council UK guidelines. The emergency medicines were all in date and stored securely with emergency oxygen in a central location known to all staff. The expiry dates of medicines and equipment were monitored using a daily and monthly check sheet which enabled the staff to replace out of date drugs and equipment promptly. The practice held training sessions for the whole team to maintain their competence in dealing with medical emergencies on an annual basis. However the practice did not have access to an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a

Are services safe?

normal heart rhythm. Although as part of their annual training staff were instructed on how to use such a device. The principal dentist advised that they had considered purchasing AED and were awaiting quotations.

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. Two 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. The assessment begins with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. The assessment also included details of their dental and social history. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained in detail.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included smoking cessation advice, alcohol consumption guidance and general dental hygiene procedures such as brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

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

Both dentists we spoke with on the day of our visit were aware of various best practice guidelines. For example they explained the way wisdom teeth problems should be managed in accordance with National Institute for Health and Care Excellence (NICE) guidelines. They explained to us that they used a risk based assessment when setting patients' dental recall intervals using NICE recall guidance. Both dentists explained that they assessed patients' risks in relation to dental decay, gum disease and motivation and set the recall interval accordingly. We looked at a sample of clinical records that showed this had taken place in discussion with patients.

The dentists were aware of various guidelines issued by the Faculty of General Dental Practice. This included guidelines in relation to selection criteria for dental X-rays and clinical examination and record keeping.

Health promotion & prevention

The waiting room and reception area at the practice contained literature in leaflet form that explained the services offered at the practice. This included information about effective dental hygiene and how to reduce the risk of poor dental health.

Adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. One dentist showed us how they used a picture book to reinforce preventative messages and explain various dental diseases and how they progressed. A dental hygienist was available to provide a range of advice and treatments in the prevention of dental disease under the prescription from the dentists. We were told that tooth brushing techniques were explained to patients in a way they understood and where applicable dietary, smoking and alcohol advice was also given to them. The sample of dental care records we reviewed all demonstrated that dentists had given tooth brushing instructions and dietary advice to patients.

Working with other services

Are services effective?

(for example, treatment is effective)

The dentists were always willing to refer patients to other practices or specialists if the treatment required was not provided by the practice. One of the dentists we spoke with explained that where a referral was necessary, the care and treatment required was explained to the patient and they were given a choice of other dentists or providers who were experienced in undertaking the type of treatment required. The practice held a contract to provide intermediate oral surgery services. Although the practice acted as a referral practice for local dental surgeries with respect of minor oral surgical procedures, the practice could also use this service when necessary. The practice also had dentists working in the practice who provided other specialized services such as orthodontics and the provision of advanced gum treatments. This enabled regular patients within the practice to receive specialised care without the inconvenience of traveling long distances to receive such care.

Consent to care and treatment

The Mental Capacity Act 2005 provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The dentists we spoke with gave specific examples of how they had taken mental capacity issues into account when providing dental treatment. They were aware of the Mental Capacity Act and explained how they would manage a patient who lacked the capacity to consent to dental treatment. They explained how they would involve the patient's family along with social workers and other professionals involved in the care of the patient to ensure that the best interests of the patient were met. They were therefore able to demonstrate a clear understanding of requirements of the Act.

The dentists explained how they obtained valid informed consent. They explained how they explained their findings to patients and kept detailed clinical records showing that they had discussed the available options and the costs of dental treatment with them. They also explained that they used consent forms in areas such as dental implants and conscious sedation to assist in the process. A sample of records showed that these forms were complete and there were no deficiencies. These were scanned into the computerised record system and became a permanent part of the patients dental care record.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to use to tell us about their experience of the practice. We collected 30 completed CQC patient comment cards. These provided a positive view of the service the practice provided. All of the patients commented that the quality of care was very good. Some patients commented that treatment was explained clearly and the staff were caring and put them at ease. They also said that the reception staff were always helpful and efficient. During the inspection we observed staff in the busy reception area. We observed that they were polite and helpful towards patients and that the general atmosphere was welcoming and friendly. All the staff we spoke with described treating patients in a respectful and caring way and were aware of the importance of protecting patients' privacy and dignity.

Involvement in decisions about care and treatment

Both dentists we spoke with had a clear understanding of consent issues. They stressed the importance of communication skills when explaining care and treatment to patients. They explained that they would not normally provide treatment to patients on the first appointment unless they were in pain or their presenting condition dictated otherwise. The dentists felt that patients should be given time to think about the treatment options presented to them. This made it clear that a patient could withdraw consent at any time and that they had received a detailed explanation of the type of treatment required, including the risks, benefits and options. Costs were made clear in the treatment plan.

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice leaflet and website explained the range of services offered to patients. This included regular check-ups (including x-rays and teeth cleaning), fillings, extractions, root canal, dentures, bridges and crowns. The practice undertook NHS and private treatments and costs were clearly explained. The practice provided continuity of care to their patients by ensuring, as far as was possible; they saw the same dentist each time they attended.

All new patients to the practice were required to complete a patient questionnaire so that the practice could conduct an initial assessment and respond to their needs. This included a medical history form.

The practice undertook a patient survey annually and the results of it were analysed for improvement areas. We found that the practice was responsive to the needs of patients and where relevant changes made to the services provided to improve patient care and experience.

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. Staff spoke different languages meaning that the need for interpreting services was greatly reduced. They provided written information for people who were hard of hearing.

Access to the service

The practice displayed its opening hours in their premises and on the practice website. Opening hours were Monday and Tuesday – 9:00am – 7:30pm, Wednesday, Thursday and Friday – 9:00am – 6:00pm and on Saturday 09:00am -4:00pm.

The practice had clear instructions in the practice and via the practice's answer machine for patients requiring urgent dental care when the practice was closed. Staff told us patients were seen as soon as possible for emergency care and this was usually within 24 hours. CQC comment cards reflected patients felt they had good access to routine and urgent dental care.

The practice had treatment rooms on the ground. The practice had made reasonable adjustments to accommodate patients with a disability or lack of mobility, including installing gentle ramps into and within the practice and having a low level reception desk. There were disabled toilet facilities in the practice.

Concerns & complaints

The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint and it included contacts of other external organisations patients could complain to. Staff told us they raised any formal or informal comments or concerns with the principal dentist to ensure responses were made in a timely manner.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients. We found there was an effective system in place which helped ensure a timely response. Information for patients about how to raise a concern or offer suggestions was available in the waiting room and on the practice website. The practice had received one complaint in the last 12 months which had been acknowledged appropriately and was still being investigated.

Are services well-led?

Our findings

Governance arrangements

The practice had good governance arrangements with a clear management structure. There were 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 reviewed on an annual basis and updated. Staff were aware of these policies and procedures and acted in line with them. All policies were accessible to staff via the practice intranet. The practice held monthly practice meetings, which included all staff members, where governance issues were discussed to ensure an environment where improvement and continuous learning were supported.

Leadership, openness and transparency

It was apparent through our discussions with the dentists and the dental hygienist that the patients were at the heart of the practice with the dentists adopting a holistic approach to patient care. We found staff to be hard working, caring and committed to the work they did and there was very much a sense of 'togetherness' between the whole of the practice team. Many of the staff had been at the practice for many years. One of the dentists we spoke with explained how one of the long standing dentists had provided a mentorship role. She explained that he was always on hand to give clinical and professional advice at any time which she found very beneficial as this had improved her confidence over the years. All of the staff we spoke with spoke highly of the principal dentist and felt supported by him and the practice manager.

Management lead through learning and improvement

There was a programme of audits to ensure that the practice was effectively monitoring the quality of the care and treatment they provided. For example, the practice carried out regular audits every three to four months on patient records to ensure the quality of clinical records was consistent and fit for purpose. The dentists' continuing professional development five year cycle ran from 2014 and was due for completion in 2019.We found that they were all working towards completing the required number of CPD hours to maintain their registrations in line with the General Dental Council (GDC)

The practice held regular staff meetings, and staff also told us that there were many opportunities throughout the day for unscheduled discussions between staff. Staff told us these were useful opportunities to discuss their clinical practice and the smooth running of the service. They felt there concerns were listened to and acted upon.

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

The comment cards and the patients we spoke with on the day of inspection rated the practice very highly in these key areas. Staff told us that the practice manager was very approachable and they felt they could give their views about how things were done at the practice. Staff confirmed that they had monthly meetings and described the meetings as good with the opportunity to discuss successes, changes and improvements. Staff we spoke with said they felt listened to.

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