WJNJS Limited

Forestside Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 14 June 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 regulation.

Background

Forestside Dental Practice operates from commercial premises and provides private dentistry for both adults and children. The practice is situated in Dibden Purlieu, a village on the east side of the New Forest in Hampshire.

The practice is based on the ground and first floor. The ground floor is accessible to wheelchair users, prams and patients with limited mobility. The practice has three dental treatment rooms, one of which is based on the ground floor. The practice has a separate decontamination room used for cleaning, sterilising and packing dental instruments.

The practice employs three dentists, one hygienist, six dental nurses and three reception staff.The practice opens Monday to Friday between 9am and 5pm. Extended hours are available on alternate Wednesdays and Thursdays until 7pm.

There are arrangements in place to ensure patients receive urgent dental assistance when the practice is closed. This is provided by an out-of-hours service. If patients call the practice when it is closed, an answerphone message gives the telephone number patients should ring depending on their symptoms.

Summary of findings

The practice owner is registered as an individual and is legally responsible for making sure that the practice meets the requirements relating to safety and quality of care, as specified in the regulations associated with the Health and Social Care Act 2008.

During our inspection we reviewed 32 CQC comment cards completed by patients and obtained the views of seven patients on the day of our inspection.

The inspection was carried out by a lead inspector and a dental specialist adviser.

Our key findings were:

- We found that the practice ethos was to provide patient centred dental care in a relaxed and friendly environment.
- Effective clinical leadership was provided by the principle dentist who was also the practice owner.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice appeared clean and well maintained.
- Infection control procedures were robust and the practice followed published guidance.
- The practice had a safeguarding lead with effective processes in place for safeguarding adults and children living in vulnerable circumstances.
- There was a policy and procedure in place for recording adverse incidents and accidents.
- Dentists provided dental care in accordance with current professional and National Institute for Care Excellence (NICE) guidelines.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Patients could access treatment and urgent and emergency care when required.
- Staff we spoke with felt well supported by the practice owner and were committed to providing a quality service to their patients.
- Information from 32 completed Care Quality Commission (CQC) comment cards gave us a positive picture of a friendly, caring, professional and high quality service.
- The practice reviewed and dealt with complaints according to its practice policy.

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

- Consider installing a hearing loop for patients with hearing difficulties.
- Amend the annual infection control statement to include details of staff training in relation to infection prevention control.
- Undertake a Legionella risk assessment giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.'
- Amend the practice's recruitment policy so that procedures are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, specifically by undertaking health assessment checks in respect of persons prior to employment at the practice.
- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as Public Health England (PHE).
- Review the practice's safeguarding training; ensuring all staff receive Level 2 verifiable continuing professional development in child safeguarding matters.

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 arrangements in place for infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found that all the equipment used in the dental practice was properly maintained. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents. Staff were aware of their responsibilities regarding safeguarding children and vulnerable adults and received training but this was not verifiable for their registration. We raised this with the provider who undertook to remedy this as soon as practically possible.

Are services effective?

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

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

Are services caring?

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

We collected 32 completed Care Quality Commission patient comment cards and obtained the views of a further seven patients on the day of our visit. These provided a positive view of the service the practice provided. All of the patients commented that the quality of care was very good. Patients commented on friendliness and helpfulness of the staff and dentists were good at explaining the treatment that was proposed.

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 provided patients with written information in language they could understand and had access to telephone interpreter services when required. The practice had a ground floor treatment room and level access into the building for patients with mobility difficulties and families with prams and pushchairs.

Are services well-led?

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

Strong and effective leadership was provided by the practice owner and an empowered lead dental nurse. Staff had an open approach to their work and shared a commitment to continually improving the service they provided. There was a no blame culture in the practice. The practice had robust clinical governance and risk management structures in place. Staff told us that they felt well supported and could raise any concerns with the practice owner. All the staff we met said that they were happy in their work and the practice was a good place to work.

Forestside Dental Practice

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 14 June 2016. The inspection was carried out by a CQC inspector and a dental specialist adviser.

During our inspection visit, we reviewed policy documents and staff recruitment records. We spoke with six members of staff. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment.

We were shown the decontamination procedures for dental instruments and the computer system that supported the patient dental care records. We reviewed CQC comment cards completed by patients and obtained the views of patients on the day of our inspection.

Patients gave positive feedback about their experience 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 lead dental nurse demonstrated a good awareness of RIDDOR (the reporting of injuries diseases and dangerous occurrences regulations). The practice had an incident reporting system in place when something went wrong; this system also included the reporting of minor injuries to patients and staff. The practice reported that there had been no serious incidents that required formal reporting during 2016 or that required investigation. The lead dental nurse explained that incidents would be discussed during staff meetings to facilitate shared learning.

We saw that a medical emergency incident that occurred in 2015 was discussed at the next staff meeting following the incident. We noted that the practice did not have a system in place to receive national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA). We pointed this out to the lead dental nurse and the practice owner who undertook to implement a system as soon as practically possible

Reliable safety systems and processes (including safeguarding)

We spoke to a dental nurse about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current EU directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne diseases. The practice used a system whereby needles were not manually re-sheathed using the hands following administration of a local anaesthetic to a patient. A rubber protective device was used by the dentist to cover the contaminated needle following administration of a local anaesthetic. Dentists were responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur. The systems and processes we observed were in line with the current EU directive on the use of safer sharps.

We also asked the dental nurse how they treated the use of instruments used during root canal treatment. They explained that these instruments were single patient use only. They also explained that root canal treatment was carried out where practically possible using a rubber dam. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work. The practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam.

The practice owner acted as the safeguarding lead and acted as a point of referral should members of staff encounter a child or adult safeguarding issue. A policy and protocol was in place for staff to refer to in relation to children and adults who may be the victim of abuse or neglect. Training records showed that most staff had received verifiable continuing professional development in child safeguarding whilst others had only received non-verifiable training. We pointed this out to the practice owner who undertook to arrange verifiable training for all staff as soon as practically possible. Information was available in the practice that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Staff had received training in how to use this equipment. The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had access to oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines and oxygen we saw were all in date and stored in a central location known to all staff. The practice held training sessions each year for the whole team so that they could maintain their competence in dealing with medical emergencies. Staff we spoke with demonstrated they knew how to respond if a person suddenly became unwell.

Staff recruitment

All the dentists and dental nurses who worked at the practice had current registrations with the General Dental Council. The practice had a recruitment policy which

detailed the checks required to be undertaken before a person started work. For example, proof of identity, a full employment history, evidence of relevant qualifications and employment checks including references.

We looked at two staff recruitment files and records confirmed they had been recruited in accordance with the practice's recruitment policy. Staff recruitment records were ordered and stored securely. We found that neither of the two staff had satisfactory information about any physical or mental health conditions which could be relevant to their roles. We spoke to the provider about this who undertook to implement a health monitoring system as soon as practically possible.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice maintained a comprehensive system of policies and risk assessments which included radiation, fire safety, general health and safety and those pertaining to all the equipment used in the practice. The practice had a business continuity plan to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service. The practice had in place a Control of Substances Hazardous to Health (COSHH) file. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The practice had in place an infection control policy that was regularly reviewed. It was demonstrated through direct observation of the cleaning process and a review of practice protocols that HTM 01 05 (national guidance for infection prevention control in dental practices) Essential Quality Requirements for infection control were being met. It was observed that audit of infection control processes carried out in May 2016 confirmed compliance with HTM 01 05 guidelines.

We saw that the four dental treatment rooms, waiting area, reception and toilet were clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available including liquid soap and paper towel dispensers in each of the treatment rooms and toilet and bare below the elbow working was observed.

The drawers of a treatment room were inspected and these were clean, ordered and free from clutter. Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

A dental nurse described to us the end-to-end process of infection control procedures at the practice. They 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 unit water lines.

The dental unit water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings). They described the method they used which was in line with current HTM 01 05 guidelines. We saw that general measures were in place to manage the water systems safely in the building. However, a Legionella risk assessment by a competent body such as that provided by the Legionella Control Association had not been carried out. We pointed this out to the practice owner who undertook to arrange a risk assessment as soon as practically possible.

The practice had a separate decontamination room for instrument processing. The dental nurse we spoke with demonstrated the 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 and ultrasonic baths for the initial cleaning process, following inspection with an illuminated magnifier the instruments were placed in an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilised, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines. We were shown the systems in place to ensure that the autoclaves used in the decontamination process were working effectively. It was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were always complete and up to date. We also noted that the essential validation checks for the ultrasonic baths were carried out and the results recorded.

Are services safe?

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained and was in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. Clinical waste was stored in a locked facility adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection.

We also saw that general environmental cleaning was carried out according to a cleaning plan developed by the practice. Cleaning materials and equipment were stored in accordance with current national guidelines.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the three autoclaves had been serviced and calibrated in June 2016. The practices' X-ray machines had been serviced and calibrated as specified under current national regulations in November 2014 and were due to be serviced and calibrated again in November 2017. Portable appliance testing (PAT) had been carried out in May 2015. The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. We observed that the practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid and mercury spillage. Prescription pads were stored in a safe overnight to prevent theft or misuse by staff or unauthorised persons.

Radiography (X-rays)

We were shown a radiation protection file that contained documentation in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). Included in this file were the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. We also saw a copy of the local rules and notification to the Health and Safety Executive that X-rays were being used at the practice.

We saw that a radiological audit had been carried out in February 2016. Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured. These findings showed that the practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. We saw training records that showed all staff where appropriate had received training for core radiological knowledge under IRMER 2000 Regulations.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The two dentists we spoke with carried out consultations, assessments and treatment in line with recognised general professional guidelines. The dentists described to us how they carried out their assessment of patients for routine care. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. 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 dietary advice and general oral hygiene instruction such as tooth 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.

Dental care records that were shown demonstrated that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE tool 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 where appropriate during a dental health assessment.

Health promotion & prevention

The practice was very focussed on the prevention of dental disease and the maintenance of good oral health. To facilitate this aim the practice appointed a dental hygienist to work alongside of the dentists in delivering preventative dental care. Both dentists we spoke with explained that children at high risk of tooth decay were identified and were offered fluoride varnish applications or the prescription of high concentrated fluoride tooth paste to keep their teeth in a healthy condition. They also placed fissure sealants (special plastic coatings on the biting surfaces of permanent back teeth) in children who were particularly vulnerable to dental decay. Other preventative advice included tooth brushing techniques explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. Dental care records we observed demonstrated that dentists had given oral health advice to patients. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area.

Staffing

We observed a friendly atmosphere at the practice. All of the patients we asked told us they felt there was enough staff working at the practice. Staff we spoke with told us the staffing levels were suitable for the size of the service. All the staff we spoke with told us they felt supported by the practice manager and owner. They told us they felt they had acquired the necessary skills to carry out their role and were encouraged to progress.

The practice employed three dentists, one hygienist, six qualified dental nurses and three receptionists. All clinical staff had current registration with their professional body, the General Dental Council. There was a structured induction programme in place for new members of staff.

Working with other services

Dentists were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as oral surgery, special care dentistry and orthodontic providers.

Consent to care and treatment

We spoke with two dentists about how they implemented the principles of informed consent; all of the dentists had a very clear understanding of consent issues. They explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of

Are services effective?

(for example, treatment is effective)

their treatment options. They went on to say that patients should be given time to think about the treatment options presented to them, the practice owner explained that in certain situations patients would be brought back to the practice to discuss complex treatment options. This process made it clear that a patient could withdraw consent at any time.

The dentists went onto explain how they would obtain consent from a patient who suffered with any mental impairment that may mean that they might be unable to fully understand the implications of their treatment. If there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed. They went on to say they would involve relatives and carers if appropriate 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. Staff were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting areas and we saw that doors were closed at all times when patients were with dentists. Conversations between patients and dentists could not be heard from outside the treatment rooms which protected patients' privacy. Patients' clinical records were stored electronically and in paper form. Computers were password protected and regularly backed up to secure storage, with paper records stored in lockable records storage cabinets at various points in the practice. Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality. The practice had implemented a 'safe haven' area in the practice should patients wish to discuss subjects of a more sensitive nature to protect the patients dignity.

Before the inspection, we sent Care Quality Commission (CQC) comment cards so patients could tell us about their experience of the practice. We collected 32 completed CQC patient comment cards and obtained the views of seven patients on the day of our visit. These provided a positive view of the service the practice provided. All of the patients commented that the quality of care was very good. Patients also commented that treatment was explained clearly and the staff were caring and put them at ease. During the inspection, we observed staff in the reception area. We observed that they were polite and helpful towards patients and the general atmosphere was welcoming and friendly.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options with indicative costs where necessary. A group of patients receiving care at the practice were part of a scheme for dental care that involved paying a monthly fee for their dental care. A poster detailing private treatment costs was displayed in the waiting area. The dentists we spoke with paid particular attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we looked at examples of information available to patients. We saw that the practice waiting area displayed a wide variety of information including leaflets about the services the practice offered, how to make a complaint and information about maintaining good oral health. The practice website also contained useful information to patients such as leaflets about different types of treatments which patients could download and how to provide feedback on the services provided. We observed that the appointment diaries were not overbooked and that this provided capacity each day for patients with dental pain to be fitted into urgent slots for each dentist. The dentists decided how long a patient's appointment needed to be and took into account any special circumstances such as whether a patient was very nervous, had a disability and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to help prevent inequity for patients that experienced limited mobility or other issues that hamper them from accessing services. The practice used a translation service, which they arranged if it was clear that a patient had difficulty in understanding information about their treatment. To improve access the practice had level access and treatment rooms on the ground floor for those patients with a range of disabilities and infirmity as well as parents and carers using prams and pushchairs.

Access to the service

Forestside Dental Practice offered NHS and private dental care services for adults and children Monday to Friday between9am and 5pm and alternate Wednesdays and Thursdays until 7pm.

We asked seven patients if they were satisfied with the practices' opening hours.All but one said they were whilst one said they were not.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an out-of-hours service. If patients called the practice when it was closed an answerphone message gave the telephone number patients should ring depending on their symptoms.

Concerns & complaints

The practice had a complaints policy and a procedure that set out how complaints would be addressed, who by, and the timeframes for responding. For example, a complaint would be acknowledged within three days and a full response would be provided to the patient within ten days. The practice listed five complaints received over the previous 12 months which records confirmed had been concluded satisfactorily.

Information for patients about how to make a complaint was seen on the practice website, patient leaflet and on display in the practice waiting room. We asked seven patients if they knew how to make a complaint if they had an issue and five said yes, one wasn't sure and one patient did not.

Are services well-led?

Our findings

Governance arrangements

The governance arrangements of the practice were developed through a process of continual learning and improvement. The governance arrangements for this location consisted of the practice owner and the lead dental nurse who were responsible for the day to day running of the practice. The practice maintained a comprehensive system of policies and procedures using a commercially available dental clinical governance system. All of the staff we spoke with were aware of the policies and how to access them. We noted management policies and procedures were kept under review by the lead dental nurse on a regular basis. They explained that the company who provided the governance system notified the practice via email when policies and protocols required updating which prevented systems and process from lapsing.

Leadership, openness and transparency

Effective leadership was provided by the practice owner and an empowered lead dental nurse. The practice ethos focussed on providing patient centred dental care in a relaxed and friendly environment. The comment cards we saw reflected this approach. The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said they felt comfortable about raising concerns with the practice owner. There was a no blame culture within the practice. They felt they were listened to and responded to when they did raise a concern. We found staff to be hard working, caring and committed to the work they did. All of the staff we spoke with demonstrated a firm understanding of the principles of clinical governance in dentistry and were happy with the practice facilities. Staff reported that the practice owner was proactive and resolved problems very quickly. As a result, staff were motivated and enjoyed working at the practice and were proud of the service they provided to patients.

Learning and improvement

We saw evidence of systems to identify staff learning needs which were underpinned by an appraisal system and a programme of clinical audit. For example, we observed that the dental nurses received an annual appraisal.

We found there was a rolling programme of clinical and non-clinical audits taking place at the practice. These included infection control, X-ray quality and the quality of clinical record keeping. The audits demonstrated a process where the practice had analysed the results to discuss and identify where improvement actions may be needed.

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

The practice gathered feedback from patients through surveys, compliments and complaints. We saw that there was a robust complaints procedure in place, with details available for patients in the waiting area.

Results of the practice survey carried out over the previous year indicated that 100% of patients, who responded, said the dentist explained treatment options and prices before offering treatment and the practice provided fair value for money.

As a result of patient feedback the practice had introduced improvements suggested by patients which included more prominent positioning of the practice complaints procedure.

Staff told us that the principal dentist was very approachable and they felt they could give their views about how things were done at the practice. Staff confirmed that they had practice meetings every quarter. Staff described the meetings as good with the opportunity to discuss successes, changes and improvements. Staff we spoke with said they felt listened to.