Petrie Tucker and Partners Limited

Mydentist - Abbey Parade - Wimbledon

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 4 August 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Mydentist-Abbey Parade-Wimbledon is located in the London Borough of Merton. The premises consist of five treatment rooms and two dedicated decontamination rooms. There are also toilet facilities, waiting areas, a reception area, an administrative office and a staff room.

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

The practice staffing consisted of seven associate dentists, four trainee dental nurses, five qualified dental nurses, one hygienist, four receptionists, one practice support manager and one practice manager.

The practice was open; Monday and Tuesday from 8:00am to 8:00pm, Wednesday, Thursday and Friday from 9.00am to 5.30pm, Saturday 8:30am to 12:30pm.

The practice manager is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'.

Summary of findings

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.

We carried out an announced, comprehensive inspection on 4 August 2015. The inspection took place over one day and was carried out by a CQC inspector, a dentist specialist advisor and a practice manager specialist advisor.

We received 17 CQC comment cards completed by patients and spoke to three families with children and four adult patients that were attending appointments during our inspection visit. Patients we spoke with, and those who completed comment cards, had commented positively about the staff and their experience of being treated at the practice.

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 effective systems and processes in place to ensure all care and treatment was carried out safely. Significant events, complaints and accidents were recorded appropriately, investigated and analysed and improvement measures implemented.

There was a safeguarding lead and staff understood their responsibilities for identifying and reporting any potential abuse. There were suitable recruitment procedures in place and staff were trained and skilled to meet patient's needs.

The practice had robust infection control procedures and staff had received training in infection prevention and control. Radiation equipment was suitably maintained and only used by trained staff. Local rules were displayed clearly where X-rays were carried out.

There were systems for identifying, investigating and learning from incidents relating to the safety of patients and staff members. We found the equipment used in the practice was maintained and checked for effectiveness.

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 National Institute for Health and Care Excellence. The practice monitored patients' oral health and gave appropriate health promotion advice. Patients were referred to other services in a timely manner if needed.

Staff explained treatment options to ensure that patients could make informed decisions about any treatment. The practice worked with other providers when required and followed up on the outcomes of referrals made to other providers. Staff were registered with the General Dental Council (where applicable) and were engaged in continuous professional development to meet the training requirements of their registration.

Are services caring?

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

We received feedback from patients through CQC comment cards and in speaking with them on the day of the inspection. We found that they were treated with dignity and respect. We noted a caring attitude amongst the staff towards the patients. We found that dental care records were stored securely and patient confidentiality was well maintained.

Are services responsive to people's needs?

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

The practice was accessible to patients with restricted mobility, with level access and ground floor surgeries if needed.

Patients were able to access treatment quickly in an emergency, and there were arrangements in place for patients to receive alternative emergency treatment when the practice was closed.

The practice had a complaints procedure that explained to patients the process to follow, the timescales involved for investigation and the person responsible for handling the issue. The practice was following this policy and procedure.

Summary of findings

Are services well-led?

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

The practice had arrangements in place for monitoring and improving the services provided for patients. Regular checks and audits were completed to ensure the practice was safe and patient's needs were being met.

The practice had a full range of policies and procedures to ensure the practice was safe and met patient's needs. Responses to patients' concerns or complaints had been recorded, and showed an open no blame approach.

Mydentist - Abbey Parade - Wimbledon

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 4 August 2015. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a dentist specialist advisor and a practice manager specialist advisor.

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

During our inspection visit, we reviewed policy documents and dental care records. We spoke with 12 members of staff, including the management team. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We observed dental nurses carrying out decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area.

We reviewed 17 Care Quality Commission (CQC) comment cards completed by patients and spoke with three families with children and four adult patients that were attending appointments on the day we visited. They had commented positively about the staff and their experience of being treated 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

There was an effective system in place for reporting and learning from incidents. One, minor incident had been recorded last year. There was a policy for staff to follow for the reporting of these events and we saw that this had been followed in these cases.

Incidents had been appropriately recorded and investigated. Actions taken at the time and any lessons that could be learnt to prevent a recurrence were noted and discussed with staff. Where necessary a staff meeting had also been convened to discuss learning points which would improve the quality of care. For example, an incident had been recorded in October 2014 and a meeting had been held following the incident. A discussion was held at the meeting about strategies for adhering to the protocol in order to prevent injuries.

We noted that it was the practice policy to offer an apology when things went wrong. We saw examples of written apologies that had been offered following patient's complaints.

Most staff understood the process for accident and incident reporting including the Reporting of Injuries,Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). One dentist explained to us the processes for reporting incidents within the practice.. They told us they would inform the practice manager of any incidents and take direction from them. The practice manager confirmed there had been no accidents that had required notification under the RIDDOR guidance.

Reliable safety systems and processes (including safeguarding)

One of the principal dentists was the named practice lead for child and adult safeguarding. The safeguarding lead was able to describe the types of behaviour a child might display that would alert them to possible signs of abuse or neglect.

The practice had a safeguarding policy which referred to national guidance. We saw information was displayed in the reception area and staff room and all staff understood where to find the contact details if required. All staff had completed safeguarding training and the staff we spoke with were able to describe what might be signs of abuse or neglect and how they would raise concerns with the safeguarding lead. There had been no safeguarding issues reported by the practice to the local safeguarding team.

Staff were aware of the procedures for whistleblowing if they had concerns about another member of staff's performance. They told us they were confident about raising such issues with the practice manager in the first instance.

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, a practice-wide risk assessment had been carried which covered topics such as fire safety, the safe use of X-ray equipment, disposal of waste, and the safe use of sharps (needles and sharp instruments). The practice manager could demonstrate that they followed up any issues identified during audits as a method for minimising risks.

We asked how the practice treated the use of instruments which were used during root canal treatment. A dentist we spoke with explained that these instruments were single use only. They explained that root canal treatment and other treatment, where appropriate, was carried out using a rubber dam which was in line with guidance from the British Endodontic Society. (A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth).

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an automated external defibrillator (AED). (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm). The practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. Oxygen and other related items, such as manual breathing aids and portable suction, were available in line with the Resuscitation Council UK guidelines. The emergency medicines were all in date. However, the storage of the medicines were not secure and could be accessed by patients including young children. These were stored in the waiting area with the emergency oxygen. The practice manager was made aware of this and agreed to review this.

Are services safe?

Staff received annual training in using the emergency equipment. The most recent training had taken place in January 2015. We noted that the training also included responding to different scenarios, such as epileptic seizures and anaphylaxis, using dummies and role-playing drills.

Staff recruitment

The practice staffing consisted of seven associate dentists, four trainee dental nurses, five qualified dental nurses, one hygienist, four receptionists, one practice support manager and one practice manager. The staff worked a mixture of full-time hours and part-time hours and covered two days a week from 8:00am to 8:00pm. The practice had a low turnover of new staff. For example the practice manager had been with the practice for 33 years, one dentist had been with the practice for 15 years and another for 17 years.

There was a recruitment policy in place and we reviewed the recruitment files for five staff members and saw that the practice carried out some relevant checks to ensure that the person being recruited was suitable and competent for the role. This included the checking of qualifications, proof of identity, registration with the General Dental Council (where relevant) and checks with the Disclosure and Barring Service (DBS). However, we noted that the practice had not kept copies of references for all members of staff. The practice manager explained that some staff had been with the practice for a long time and transferred from the previous business. They agreed to ensure this was done before any new person was recruited.

We noted that it was the practice's policy to carry out DBS checks for all members of staff and details related to these checks were kept on file.

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 system in place to record all COSHH products where risks to patients, staff and visitors associated with hazardous substances were identified. Actions were described to minimise any risks. Staff were aware of the COSHH records and the strategies in place to minimise the risks associated with these products. During our observations around the practice we saw COSHH products were securely stored.

The practice responded promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. MHRA alerts, and alerts from other agencies, were received by the head office and cascaded to branch practices and disseminated through the software systems to the staff, where appropriate. For example, we were told of an alert which had been received about recalling a local anaesthetic. Staff were sent an electronic memo to inform them about the alert and the practice had stopped using the brand and replaced all the stock held at the practice.

There was a business continuity plan in place. This had been kept up to date with a list of the key contacts required. The practice manager told us they had arrangements in place to use a company owned local practice's premises for emergency appointments in the event that the practice's own premises became unfit for use.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. It was demonstrated through direct observation of the cleaning process and a review of protocols that the practice was overall following 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)'. There was a recent audit of infection control processes which confirmed that the practice was following the HTM 01-05 guidelines.

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

One of the dental nurses was the infection control lead and they described 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 a good system for decontaminating the working surfaces, dental unit and dental chair.

The practice had two separate decontamination rooms for instrument processing. One room was located on the ground level and another on the first level. Both rooms appeared organised. Protocols were displayed on the wall to remind staff about the correct processes to follow at each stage of the decontamination process. Staff demonstrated the process to us; 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 system designed to minimise the risks of infection.

The practice used a system of ultra-sonic cleaning bath, manual scrubbing (utilising the double sink method) and a washer disinfector as part of the initial cleaning process. The instruments were then placed in an autoclave (steriliser). 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 dental nurse showed us that systems were in place to ensure that the autoclaves, ultra-sonic bath and washer disinfector were working effectively. These included the automatic control test and steam penetration tests for the autoclave, foil tests for the ultrasonic cleaning bath, and protein residue test for the washer disinfector. It was observed that the data sheets used to record the essential daily validation were always complete and up to date.

The drawers and cupboards of some treatment rooms were inspected. All of the instruments were placed in pouches and it was obvious which items were for single use as they were clearly labelled. Each treatment room had the appropriate routine personal protective equipment such as gloves, aprons and eye protection available for staff and patient use.

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 by the dental nurses was in line with current HTM 01-05 guidelines. A Legionella risk assessment had been carried out by an appropriate contractor to determine if there were any further risks associated with the plumbing at the premises. These measures ensured that patients and staff were protected from the risk of infection associated with Legionella.

The practice employed a domestic staff to carry out more general cleaning of the premises. There was a cleaning schedule to follow and one the principal dentists reviewed their work to ensure schedules were being effectively followed.

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 generall waste were properly stored. The practice used a contractor to remove dental waste from the practice. Waste consignment notices were available for inspection.

Equipment and medicines

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

The expiry dates of medicines, oxygen and equipment were monitored daily and monthly and a check sheet was signed by staff; this enabled the staff to replace out-of-date drugs and equipment promptly.

We noted prescription pads were kept out of site and stored securely so they were not open to abuse.

Radiography (X-rays)

The practice had in place a Radiation Protection Adviser (RPA) and a Radiation Protection Supervisor (RPS) in accordance with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). A radiation protection file, in line with these regulations, was present. This file included the critical examination pack for the X-ray set, the three-yearly maintenance log and a copy of the local rules. We noted there was no certificate of notification to the Health and Safety Executive. The procedures and equipment had been

Are services safe?

assessed by an external RPA. The maintenance log was within the current recommended interval of three years with the next service due in 2016. The local rules were displayed next to the X-ray equipment.

A copy of the most recent radiological audit was available for inspection. This demonstrated that radiographs were graded and quality assured. The practice manager told us they were due to meet with dentists individually to discuss the X-ray audits and improve outcomes.

We saw evidence in some files that training in IR(ME)R 2000 had been completed. However, although staff we spoke with told us they had completed this training it was not clearly documented on file.

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. 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. 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. Following an examination of a patient's teeth, gums and soft tissues the diagnosis was then discussed with the patient and treatment options explained in detail.

The dental care record was updated with the proposed treatment after discussing options with the patient. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Although the dentists we spoke with were able to explain clinical pathways and reasons for recommended treatments there were some areas for improvement for referring to the National Institute for Health and Care Excellence (NICE) guidelines such as for wisdom teeth removal.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. Staff told us they discussed oral health with their patients, for example, effective tooth brushing or dietary advice, though they were not aware of the Delivering Better Oral Health Toolkit when considering care and advice for patients. (This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting). Dentists identified patients' smoking status and recorded this in their notes. This prompted them to provide advice or consider how smoking status might be impacting on their oral health. Dentists also carried out examinations to check for the early signs of oral cancer.

We observed that there were a range of health promotion materials displayed in the waiting area. These could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition. There was information in the waiting area which described the local availability of stop smoking services.

Staffing

Staff told us they received appropriate professional development and training. We reviewed staff files and saw that this was the case. The training covered all of the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, safeguarding and infection control.

There was an induction programme for new staff to follow. Every new member of staff was provided with a staff handbook that included the protocols and systems in place at the practice. One of the trainee dental nurses confirmed they had received the handbook and referred to it if they needed to. There was an appraisal at the end of the induction period.

The practice held regular supervision and review meetings with 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. The practice manager told us that appraisals were due to be completed by the end of August 2015 for all staff.

Working with other services

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients. The dentist used a system of onward referral to other providers, for example, for oral surgery. The practice kept a file with referral forms for local secondary providers. The practice manager and the receptionist ensured that referral letters were sent out on the same day that the dentist made the recommendation.

We reviewed a referral letter and saw it included all the necessary details from the patients' record including medical history. All letters were filed into patient's notes kept on the computer. When the patient had received their treatment they were discharged back to the practice for further follow-up and monitoring.

Consent to care and treatment

Are services effective?

(for example, treatment is effective)

The practice ensured valid consent was obtained for all care and treatment. Staff discussed treatment options, including risks and benefits, as well as costs, with each patient. Patients confirmed that treatment options, and their risks and benefits were discussed with them. However, our review of the dental care records found that these discussions were not consistently recorded.

Formal written consent was obtained using standard treatment plan forms. Patients were asked to read and sign these before starting a course of treatment.

Dentists and dental nurses were aware of the Mental Capacity Act (2005). They could 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.

We noted that some dentists were not completely aware of Gillick competence. This is a term used to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We received 17 CQC comment cards. All but one described a positive view of the service the practice provided. Patients commented that the team were caring, polite and efficient. They were happy with the quality of treatment provided.

During the inspection we observed staff in the reception area. They were polite and helpful towards patients and the general atmosphere was welcoming and friendly. All the staff we spoke with were mindful about treating patients in a respectful and caring way. They were aware of the importance of protecting patients' privacy and dignity. However, we noted that some clinical treatment rooms had a glass window in the door where patients were clearly visible while they were receiving treatment. The practice manager told us they will review this and arrange for this to be corrected.

We spoke to three families with children and four adult patients that were attending appointments on the day we visited. They all spoke positively about the staff and their experience of being treated at the practice.

There were systems in place to ensure that patients' confidential information was protected. Dental care records were stored electronically. Any paper correspondence was scanned and added to the electronic record prior to disposal. Electronic records were password protected and regularly backed up. Staff understood the importance of data protection and confidentiality and had received training in information governance. Reception staff told us that people could request to have confidential discussions in an empty treatment room, if necessary.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area which gave details of NHS and private dental charges or fees. On the day of our inspection we observed the receptionist took time to explain NHS charges to patients in detail.

Staff told us that they took time to explain the treatment options available. They spent time answering patients' questions and gave patients a copy of their treatment plan. There was a range of information leaflets in the waiting area which described the different types of dental treatments available.

The patient feedback we received via discussions and comment cards confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff. They told us that treatment options were well explained; the dentist listened and understood their concerns, and respected their choices regarding treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. Each dentist could decide on the length of time needed for their patient's consultation and treatment. The reception staff were provided with a colour-coded system on the practice computer to indicate the length of time each dentist generally preferred to have with a patient for any given treatment. The dentists we spoke with told us they scheduled additional time for patients depending on their knowledge of the patient's needs, including scheduling additional time for patients who were known to be anxious or nervous.

Staff told us they had enough time to treat patients and that patients could generally book an appointment in good time to see the dentist of their choice. The feedback we received from patients confirmed that they could 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.

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.

Some of the clinical staff spoke additional languages and one of the principal dentists told us they had access to a telephone translation service, although they had not had to use this so far. There was written information for people who were hard of hearing and as well as large print documents for patients with some visual impairment.

The practice had made significant adjustments to the structure of the premises to ensure that it was wheelchair accessible. For example, the corridors were wide enough to allow for wheelchair access and there was a disabled toilet.

Access to the service

The practice was open; Monday and Tuesday from 8:00am to 8:00pm, Wednesday, Thursday and Friday from 9.00am to 5.30pm, Saturday 8:30am to 12:30pm. The practice displayed its opening hours on their premises. New patients were also given a practice information sheet which included the practice contact details and opening hours.

Patients told us that they could get an appointment in good time and did not have any concerns about accessing the dentist. They told us they could book an appointment online for a general check-up. The practice manager and receptionist told us that the dentists planned some gaps in their schedule on any given day which meant that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, could be accommodated.

We asked the receptionist about access to the service in an emergency or outside of normal opening hours. They told us the answer phone message and the practice leaflet gave details on how to access out of hours emergency treatment. They also displayed the information about local emergency dental services on the wall in the waiting area.

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 and on the practice website.

There had been seven complaints recorded in the last 12 months. These complaints had been responded to in line with the practice policy. The managers had carried out investigations and discussed learning points with relevant members of staff. Patients had received a written response, including an apology, when anything 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.

The practice also collected feedback through the use of the 'Friends and Family Test'. The survey results for this test were displayed in the waiting area. The majority of the feedback collected during the past year indicated a high level of satisfaction.

Are services well-led?

Our findings

Governance arrangements

The practice had good governance arrangements with an effective management structure. New providers had taken over the running of the practice in January 2013. They had implemented, with the support of the practice manager, 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 these policies and procedures and acted in line with them. There were weekly informal practice meetings, as well as more formal staff meetings, where necessary, to discuss key governance issues. For example, we saw minutes from meetings where issues such as infection control and information governance had been discussed. This facilitated an environment where improvement and continuous learning were supported.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said told us they were comfortable about raising concerns with the management staff. They felt they were listened to and responded to when they did so. They were aware that they could escalate concerns to external agencies, such as the Care Quality Commission (CQC), if necessary.

We spoke with one of the principal dentists who told us they aimed to provide high-quality care in a sometimes challenging environment where, due to the relatively high level of population movement in the area, continuity of care could sometimes be difficult to achieve. They were committed to both maintaining and continuously improving the quality of the care provided.

The staff we spoke with all told us they enjoyed their work and were well-supported by the management team. There was a system of staff appraisals to support staff in carrying out their roles to meet the standards.

Learning and improvement

All staff were supported to pursue development opportunities. 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 General Dental Council (GDC).

The practice had a programme of clinical audit in place. These included audits for infection control, clinical record keeping and X-ray quality. The audits showed a good standard of work, but identified some areas for improvement. For example, the X-ray audit for the dentists showed that they could improve their recording for justification of when an X-ray is required and discussed with, patients. The audits had all been initiated within the past 12 months and were due to be repeated after a year to determine if any changes implemented had led to an improvement in performance.

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

The practice gathered feedback from patients through the use of a patient satisfaction survey. The survey covered topics such as the quality of staff explanations, cleanliness of the premises, and general satisfaction with care. The responses had indicated a high level of satisfaction with the care provided.

Staff described an open culture where feedback between staff was encouraged in order to improve the quality of the care. This was supported by the activities of one of the principal dentists who carried out regular observation and feedback sessions with each member of staff.