Southampton Orthodontic Centre Limited

Southampton Orthodontic Centre

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 21 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

Southampton Orthodontic Centre is a specialist dental practice that provides orthodontic treatment to children and some adults mainly on a referral basis (orthodontics is a specialist branch of dentistry concerned with the alignment of the teeth and jaws to improve the appearance of the face, the teethand their function).

Orthodontic treatment is provided under NHS regulations for children except when the problem falls below the accepted eligibility criteria for NHS treatment. Private treatment is available for these patients as well as adults who require orthodontic treatment. The practice employs one orthodontist, two orthodontic therapists, four dental nurses and two reception staff.

The practice operates from a commercial premises situated in Southampton City Centre and is based on the first floor. The practice has two dental treatment rooms of which one as an open planned area with three dental treatment chairs, and two separate decontamination rooms used for cleaning, sterilising and packing dental instruments.

Summary of findings

The practice opens Monday to Friday between 9am and 5.30pm. Extended hours are available on Monday, Wednesdays and Thursdays until 7pm and two Saturday mornings a month.

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.

Dr Rupinder Sidhu 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 11 CQC comment cards completed by patients and obtained the views of 21 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 quality orthodontic care.
- Strong and effective leadership was provided by the practice owner and an empowered practice manager.
- 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 very clean and well maintained.
- Infection control procedures were robust and the practice followed published guidance.
- The practice had effective processes in place for safeguarding adults and children living in vulnerable circumstances.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- The orthodontist and orthodontic therapists provided care in accordance with current professional guidelines.
- The practice had fully embraced the concept of skill mix to assist in the delivery of effective orthodontic care to patients.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Staff recruitment files were organised.
- Staff received training appropriate to their roles and were supported in their continued professional development (CPD) by the practice owner and practice manager.
- Staff we spoke with felt well supported by the practice owner and practice manager and were committed to providing a quality service to their patients.
- Information from 11 completed Care Quality Commission (CQC) comment cards gave us a completely positive picture of a friendly, caring, professional and high quality service.

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

- 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 safeguarding training to ensure that staff receive training at Level 2 for clinical staff and Level 1 for administrative staff.
- Review the minutes of the staff meetings to ensure that they record learning from incidents and complaints and training received.
- Consider the use of privacy screens between each of the three dental chairs in the main treatment area.

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 robust arrangements for essential areas such as 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 well 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. There were sufficient numbers of suitably qualified staff working at the practice. Staff were aware of their responsibilities regarding safeguarding children and vulnerable adults

Are services effective?

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

The orthodontic care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance in relation to orthodontics including that from the British Orthodontic Society to guide their practice. We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals. The 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 this practice was providing caring services in accordance with the relevant regulations

We collected 11 completed Care Quality Commission patient comment cards and obtained the views of a further 21 patients on the day of our visit. These provided a completely 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 the orthodontists 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 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.

Are services well-led?

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

The practice owner, practice manager and other staff had an open approach to their work and shared a commitment to continually improving the service they provided. 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 and practice manager. All the staff we met said that they were happy in their work and the practice was a good place to work.

Summary of findings

The provider could not demonstrate it had effective recruitment procedures and could not provide evidence to confirm all the checks required for new staff had been carried out.

Southampton Orthodontic Centre

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 21 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 and training records. We spoke with seven 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 practice manager described 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 was one incident during 2015 that required investigation. We found that the incident had been investigated thoroughly and the learning outcomes had been shared with the staff concerned in accordance with the practice policy. The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA). The practice owner explained that relevant alerts would be cascaded to staff when required.

Reliable safety systems and processes (including safeguarding)

We spoke to the practice manager about the prevention of sharps 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. Due to the nature of the treatment, local anaesthetic was not used in the practice.

The orthodontist and orthodontic therapists were responsible for the disposal of wires and other sharps used in orthodontic treatment. A practice protocol was in place should a sharps injury occur. The systems and processes we observed were in line with the current EU directive on the use of safer sharps.

We saw that the practice treated the risk of fire very seriously due to the nature of the building. The practice manager was responsible for fire safety and acted as the fire warden for the building. We saw detailed fire risk assessments and that these fully mitigated the risks against fire. The practice had appropriate signage and floor plans on display and the fire extinguishers and emergency lighting were maintained on a regular basis.

The practice owner was the safeguarding lead and point of referral should members of staff encounter a child or adult safeguarding issue. A policy 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 all staff had received safeguarding training for both vulnerable adults and children. Safeguarding training certificates did not indicate the level of training undertaken. The practice manager and practice owner undertook to investigate this and contact training providers to confirm the level the training referred to.

Information was displayed 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 not been any 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 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. The last training session was carried out in June 2016. 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.

We looked at three staff recruitment files and records confirmed they had been recruited in accordance with the practice's recruitment policy. Staff recruitment records

were ordered. We found that none of the three staff had satisfactory information about any physical or mental health conditions which could be relevant to their roles. We spoke to the practice manager 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 and included radiation, fire safety, general health and safety and those pertaining to all the equipment used in the practice.

The practice had in place a well-maintained 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 a robust 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 exceeded. It was observed that audit of infection control processes carried out in June 2016 confirmed compliance with HTM 01 05 guidelines.

We saw that the 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. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

The drawers of the treatment rooms 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.

The dental nurse we spoke with 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 (legionella is a term for particular bacteria which can contaminate water systems in buildings). Staff described the method they used which was in line with current HTM 01 05 guidelines. We saw that a Legionella risk assessment had been carried out at the practice by a competent person in July 2015. The recommended procedures contained in the report were carried out and logged appropriately.

The practice had two separate rooms for instrument processing, a pre cleaning room and a clean room where sterilisation and packaging of processed instruments took place. 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 an ultra-sonic cleaning bath 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 autoclave used in the decontamination process was working effectively. It was observed that the log book used to record the essential daily and weekly validation checks of the sterilisation cycles were always complete and up to date. All recommended tests as part of the validation of the ultra-sonic cleaning bath were carried out in accordance with current guidelines, the results of which were recorded in an appropriate log book.

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. Waste

consignment notices were available for inspection. Environment cleaning was carried out by the dental nursing staff according to cleaning plans developed by the practice.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclave had been serviced and calibrated in October 2015. The practice's X-ray machine had been serviced and calibrated as specified under current national regulations in February 2015.

Portable appliance testing (PAT) had been carried out in December 2015. We observed that the practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid spillage.

Radiography (X-rays)

We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). This file contained 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. Included in the file were the maintenance log and a copy of the local rules. The maintenance log was within the current recommended interval of three years.

We also saw a copy of the most recent X-ray audit. 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.

Training records seen confirmed 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 practice used two orthodontic therapists to improve the outcomes for patients (orthodontic therapists are registered dental professionals who carry out certain parts of orthodontic treatment under prescription from a dentist). They worked within their scope of practice to prescriptions provided by the orthodontist.

One orthodontic therapist explained that the orthodontist carried out consultations, assessments and treatment in line with recognised general professional guidelines and the guidance provided by the British Orthodontic Society. The orthodontic therapist described to us how the service carried out their assessment of patients for a course of orthodontic treatment. 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 of the patient's jaw and tooth relationships and the factors that affected these relationships. Following the clinical assessment, the diagnosis was then discussed with the patient, their parents, guardians or carers and treatment options explained in detail.

Where relevant, preventative dental information was given in order to improve the outcome of orthodontic treatment for the patient. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products specifically designed for orthodontic patients. 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 if private orthodontic treatment had been proposed. Patients were monitored through follow-up appointments and these typically lasted between eighteen months to two years for a course of orthodontic treatment.

We saw several examples of detailed treatment plans provided by the orthodontist which the therapist followed to complete each patient's treatment plan. Dental care records that were shown to us by the orthodontic therapist demonstrated that the findings of the assessment and details of the treatment carried out were recorded appropriately. The records were comprehensive, detailed and well maintained.

To monitor the quality of the orthodontic treatment provided the practice used a system known as peer assessment rating or PAR scoring. The PAR index is a fast, simple and robust way of assessing the standard of orthodontic treatment that an individual provider is achieving. The orthodontic therapist explained that the practice was achieving a high level of improved outcomes for patients when judged by the scoring assessor.

Health promotion and prevention

The practice was very focused on the prevention of dental disease and the maintenance of good oral health during the patients' course of orthodontic treatment. To facilitate this aim the practice used a number of strategies. For example, the waiting room at the practice contained literature in leaflet form that explained about how to reduce the risk of poor dental health.

Following the first treatment session the orthodontic therapist or an extended duty dental nurse would provide intensive oral hygiene instruction and details on how to look after the orthodontic braces to prevent problems during the course of orthodontic treatment. Patients would then be given a list of dental hygiene products suitable for maintaining their orthodontic braces; these were available for sale in reception.

This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. Underpinning this was a range of leaflets explaining how patients could maintain good oral health during their orthodontic treatment.

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 an orthodontist, two orthodontic therapists, of which one was the practice manager, four dental nurses and two reception staff.

Are services effective?

(for example, treatment is effective)

Records seen confirmed that the dental nurses received an annual appraisal and had personal development plans. These appraisals were carried out by the practice manager. There was effective use of skill mix in the practice. This enabled the orthodontist to concentrate on providing care to patients whose needs were more complex. We saw the use of two orthodontic therapists in the provision of orthodontics.

The practice encouraged the development of the extended duty dental nurse role (EDDN). We found that dental nurses had received additional training in the taking of dental X-rays, dental photography, the making of orthodontic retainers, preparing orthodontic study models and oral health education.

The practice manager showed us their system for recording training that staff had completed. These contained details of continuing professional development (CPD), confirmation of current General Dental Council (GDC) registration, and current professional indemnity cover where applicable. There was a structured induction programme in place for new members of staff.

Working with other services

The practice was a specialist referral practice for orthodontics for practices across the Southampton area. Referring practices were required to complete a bespoke referral form to access services through a centralised referral system.

The orthodontic therapist explained how they would work with other services if patients required other specialist input such as that from consultant restorative and maxillo-facial services as part of the patients' orthodontic treatment.

Consent to care and treatment

The practice manager who acted as an orthodontic therapist explained about how the practice implemented the principles of informed consent; they had a very clear understanding of consent issues. They explained how individual treatment options, risks, benefits and costs where appropriate 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 their treatment options. This included the extensive use of dental photography which was used as part of the initial patient assessment and throughout the course of the orthodontic treatment to provide a record of the progression of the treatment through to the final treatment outcome.

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. The practice manager 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 was in accordance with (the provisions of) the Mental Capacity Act 2005.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

One treatment room was situated away from the main waiting area and we saw that the door was closed at all times when patients were with clinical staff. Conversations between patients and clinical staff could not be heard from outside this treatment room which protected patient's privacy.

We noted that the one large open plan treatment area contained three dental chairs, these were not divided into three discrete areas separating one from another. We pointed out to the provider that the arrangements could not always preserve the dignity of patients during treatment. They explained that patients were offered the use of the closed treatment room if patients and or their parents, guardians or carers were not happy with the open plan arrangements.

We asked the provider to consider the use of some form of separation between each unit such as ceiling suspended curtains to preserve each patient's dignity during treatment.

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 a lockable records storage cabinet behind the reception area. 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.

Before the inspection, we sent Care Quality Commission (CQC) comment cards so patients could tell us about their experience of the practice. We collected 11 completed CQC patient comment cards and obtained the views of 21 patients on the day of our visit.

These provided a completely positive view of the service the practice provided. All of the patients commented that the quality of care was very good. 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 reception area. We observed that they were polite and helpful towards patients and that the general atmosphere was welcoming and friendly.

Involvement in decisions about care and treatment

Although the vast majority of orthodontic treatment that is provided to young people under the age of 18 is free of charge under NHS regulations, the practice provided details of the costs of private orthodontic treatment to adults or children under 18 years of age who were not eligible for NHS treatment. These details were available in the waiting room and on the practice website.

The practice manager explained that the orthodontist paid particular attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the orthodontist recorded the information they had provided to patients about their treatment and the options open to them. This included information recorded on the standard orthodontic NHS treatment planning forms where applicable.

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 variety of information including the practice patient information leaflet. This explained opening hours, emergency 'out of hours' contact details and arrangements, staff details and how to make a complaint.

The practice website also contained useful information to patients such as how to book appointments on-line and how to provide feedback on the services provided. We observed that the appointment diaries were not overbooked and the orthodontists 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 and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to prevent inequity for disadvantaged groups in society.

The practice had access to a translation service, which they arranged if it was clear that a patient had difficulty in understanding information about their treatment. The practice did not have a hearing loop in place for patients who may be hearing aid wearers. We spoke with the practice manager about this who undertook to order one as soon as practically possible. We have since been advised a hearing loop has been purchased and installed.

Although the practice was situated on the first floor of the building, patients with mobility difficulties were sign-posted to nearby dental services with ground floor access.

Access to the service

Southampton Orthodontic Centre offered NHS and private specialist orthodontic dental care services for adults and children Monday to Friday between 9am and 5.30pm. Extended hours are available on Monday, Wednesdays and Thursdays until 7pm and two Saturday mornings a month.

We asked 21 patients if they were satisfied with the practice's opening hours and 19 said they were whilst one said they were not sure when the practice was open and another did not have an opinion either way.

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 and 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 the timeframe agreed at an initial meeting. The practice listed one complaint 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 patient website, patient leaflet and on display in the practice waiting room. We asked 21 patients if they knew how to make a complaint if they had an issue and 17 said yes, three were not 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 practice manager who were responsible for the day to day running of the practice.

The practice maintained a comprehensive system of policies and procedures. All of the staff we spoke with were aware of the policies and how to access them. We noted management policies and procedures were comprehensive and kept under review by the practice manager on a regular basis.

Leadership, openness and transparency

The practice ethos focused on providing patient centred quality orthodontic 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 raising concerns with the practice manager or the practice owner. 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 and practice manager were 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 and receptionists received an annual appraisal; these appraisals were carried out by the practice manager. We found there were a number of clinical audits taking place at the practice. These included reasons for discharge from the service, infection control, clinical record keeping and X-ray quality. The audits demonstrated a comprehensive process where the practice had analysed the results to discuss and identify where improvement actions may be needed.

Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. The practice manager told us that the practice ethos was that all staff should receive appropriate training and development.

The practice used a variety of ways to ensure staff development including internal training and staff meetings as well as attendance at external courses and conferences. The practice provided a rolling programme of professional development. This included training in cardio pulmonary resuscitation (CPR), infection control, child protection and adult safeguarding and dental radiography (X-rays).

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

The practice gathered feedback from patients through compliments and complaints and an ongoing patient satisfaction survey system. March 2016's survey analysis showed that 94% of patients, who responded, said they would recommend the practice to a friend. As a result of patient feedback the practice introduced improvements which included the availability of more children's books in the waiting area.

Staff told us that the practice manager and principal dentist were 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 month. Changes made included extended hours and longer appointment slots.

We found that meeting minutes did not follow a recognised format which would evidence that areas such as incident reporting, complaints and training were discussed. We spoke with the practice manager about this who undertook to review the format of future meetings.