

Task B Limited

Dental Perfection Branston

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 28 January 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Dental Perfection Branston is a mixed dental practice providing NHS and private treatment for both adults and children. The practice is situated in a converted commercial property. The practice had three dental treatment rooms and a separate decontamination room for cleaning, sterilising and packing dental instruments. Dental care was provided on two floors and had a reception and waiting area on the ground floor.

The practice has four dentists who are supported by eight dental nurses, three dental therapists a dental hygienist and a practice manager.

The principal dentist and owner of the practice is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run. The registered manager was supported in their role by the practice manager.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice. We received feedback from 19 patients. These provided a positive view of the services the practice provides. Patients commented on the high quality of care, the caring nature of all staff, the cleanliness of the practice and the overall high quality of customer care.

Summary of findings

Our key findings were:

- The practice ethos was to provide high quality preventative centred care at all times
- Strong and effective clinical leadership was provided by the practice owner.
- The practice also benefitted from a stable staff base 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 safeguarding leads with 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.
- 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 recruitment files were organised and complete.
- Staff had 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 to felt well supported by the practice owner and practice manager and were committed to providing a quality service to their patients.
- Information from 19 completed Care Quality Commission (CQC) comment cards gave us a positive picture of a friendly, caring, professional and high quality service.
- The practice received no written complaints during 2015.

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 had received safeguarding training and 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 dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. We saw examples of positive 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 19 completed Care Quality Commission patient comment cards and obtained the views of a further five 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 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 two ground floor treatment rooms and level access into the building for patients with mobility difficulties and families with prams and pushchairs.

Are services well-led?

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

The practice owner and 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.

Dental Perfection Branston

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 28 January 2016 was led by a dentally qualified CQC inspector and supported by a dental specialist advisor. Prior to the inspection, we asked the practice to send us some information that we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, and the details of their staff members including proof of registration with their professional bodies.

We informed NHS England area team that we were inspecting the practice; however, we did not receive any information of concern from them.

During the inspection, we spoke with the practice manager, dentists, lead dental nurse, reception staff and reviewed policies, procedures and other documents. We also obtained the views of five patients on the day of our visit. We reviewed 19 comment cards that we had left prior to the inspection, for patients to complete, about the services provided at the practice.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice 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 along with forms for staff to complete when something went wrong, this system also included the reporting of minor injuries to patients and staff. The only significant event of note was a burglary suffered by the practice; this burglary did not impact upon patient care. The incident was reported to the Care Quality Commission (CQC) as part of the national requirement to notify the CQC of such events. The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA) via email. We observed that the alerts were kept in a well maintained file and the practice acted upon any of the alerts that were specific for dental practice. Relevant alerts were discussed during staff meetings to facilitate shared learning, these meetings occurred on the first Wednesday of each month.

Reliable safety systems and processes (including safeguarding)

We spoke to the dental nurse responsible for decontamination procedures and practice owner 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 resheathed using the hands following administration of a local anaesthetic to a patient. The dentists were responsible for ensuring safe recapping using a needle protection device. Staff were also able to explain the practice protocol in detail 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. There had been no needle stick injuries since the practice opened four years ago. We observed that this had been reported through the practice incident reporting system and managed in accordance with practice policy.

We asked how the practice owner how they treated the use of instruments used during root canal treatment. They explained that these instruments were single 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). This was also confirmed when we spoke to other dentists. Patients can be assured that the practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam.

A practice owner and practice manager acted as the safeguarding leads. They acted as a 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 appropriate safeguarding training for both vulnerable adults and children. 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 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. Emergency medicines in this practice were supplied by the pharmacy team of the local primary health trust. Although the expiry dates of medicines and equipment were monitored by the practice using a monthly check sheet, the pharmacy team replaced medication that was close to its use by date. 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 twice yearly

Are services safe?

using an outside provider for the whole team so that they could maintain their competence in dealing with medical emergencies. In addition the practice internally carried out update training in dealing with medical emergencies four times per year.

Staff recruitment

All of the dentists, dental therapists, dental hygienist and dental nurses, except the two trainee dental nurses had current registration with the General Dental Council, the dental professionals' regulatory body. The practice had a recruitment policy that 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, adequate medical indemnity cover, immunisation status and references. The systems and processes we saw were in line with the information required by Regulation 18, Schedule 3 of Health & Social Care Act 2008 (Regulated Activities) Regulations 2015. Staff recruitment records were stored securely in a locked cabinet to protect the confidentiality of staff personal information. We saw that all staff had received appropriate checks from the Disclosure and Barring Service (DBS). These are checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

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 carried out a number of risk assessments including a well-maintained Control of Substances Hazardous to Health (COSHH) file. Other assessments included radiation, fire safety, health and safety and water quality risk assessments. The practice had a detailed disaster plan to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The practice had a robust infection control policy that was regularly reviewed and the practice had employed a dedicated decontamination dental nurse to carry out the infection control procedures in the decontamination room. 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 audits of infection control processes carried out in 2015 confirmed compliance with HTM 01 05 guidelines.

We saw that the three 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 treatment rooms were inspected and these were clean, well ordered and free from clutter. Appropriate single use items including suction and three in one tips were evident. Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

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

The dental 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 a Legionella risk assessment had been carried out at the practice by a competent person. The recommended procedures contained in the report were carried out and logged appropriately. This included regular testing of the water temperatures of various taps in the building. These measures ensured that patients' and staff were protected from the risk of infection due to Legionella.

The practice had a separate decontamination room for instrument processing.

The decontamination dental nurse demonstrated the process from taking the dirty instruments through to clean

Are services safe?

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 they were placed in an autoclave (a device for sterilising dental and medical instruments). When instruments had been sterilized, 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. The weekly protein residue test as part of the validation of the ultra-sonic cleaning bath was carried out 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. The practice used an appropriate contractor to remove clinical waste from the practice. This was stored in a separate locked location adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection. Patients' could be assured that they were protected from the risk of infection from contaminated dental waste.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclaves had been serviced and calibrated in January 2016. The practices' X-ray machines had been serviced and calibrated as specified under current national regulations. Portable appliance testing (PAT) had been carried out in April 2015 and a gas safety test in February 2015. The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored securely for the protection of patients. We found that the practice stored prescription pads in a secure cabinet to prevent loss due to theft.

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 critical examination packs for each X-ray set along with the three yearly maintenance logs and a copy of the local rules. The maintenance logs were within the current recommended interval of three years.

A copy of the radiological audits for each dentist carried out in 2015. 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 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.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists we spoke with carried out consultations, assessments and treatment in line with recognised general professional guidelines. The registered manager, a dentist, 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 dental hygiene procedures 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 we saw showed 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 dentists were very focussed on the preventative aspects of their practice, to facilitate this aim the practice appointed three dental therapists and a dental hygienist to work alongside of the dentists to deliver preventive dental care. The practice used a computer software system that

had dental health education videos incorporated within it to assist the dentists, therapists and hygienist to help patients reduce the risk of poor dental health. Screens in the waiting area were also used for this purpose. Adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. Tooth brushing techniques were 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 waiting room and reception area contained leaflets that explained the services offered at the practice. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area.

Staffing

The practice employed four dentists who were supported by eight dental nurses, three dental therapists a dental hygienist and a practice manager. All of the patients we asked on the day of our visit said they had confidence and trust in the dentists. This was also reflected in the Care Quality Commission comment cards and the compliment cards that were displayed in the practice.

We observed a friendly atmosphere at the practice. Staff we spoke with told us the staffing levels were suitable for the size of the service. The staff appeared to be a very effective and cohesive team, they 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. For example, a trainee nurse told us they were being put forward to complete a customer services course on completion of their dental nurse training another nurse was going to begin a course on sedation in dentistry.

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 or special care dentistry. This ensured that patients were seen by the right person at the right time.

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

We spoke with three 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 their treatment options. The dentists described how they used an intra-oral camera to take photographs of the teeth prior, during and at the end of dental treatment to facilitate the consent process. This included the condition of teeth requiring treatment, the appearance of the gums and of the soft tissues. These provided a means of patient education as well as preventing medico-legal problems in cases where patients could dispute the dentist's findings and treatment outcomes.

The registered manager went on to 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. They 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 patient's 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 cabinet. 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 to the practice for patients to use to tell us about their experience of the practice. We collected 19 completed CQC patient comment cards and obtained the views of five 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 that treatment was explained clearly and the staff were caring and put them at ease. They also said that the reception staff were always helpful and efficient. During the inspection, we observed staff in the busy reception area. We observed that they were polite and helpful towards patients and that the general atmosphere was welcoming and friendly.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. A poster detailing NHS and private treatment costs was displayed in the waiting area. The practice website also gave details of the cost of treatment and entitlements under NHS regulations. 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. This included information recorded on the standard NHS treatment planning forms for dentistry 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 people. 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 and how to make a complaint. The practice web site 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 that this provided capacity each day for patients with dental pain to be fitted into urgent slots for each dentist. Patients were also invited to come and sit and wait if these slots had already been allocated. The dentists decided how long a patient's appointments 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 prevent inequity for disadvantaged groups in society. The practice used a translation service, which they arranged if it was clear that a patient had difficulty in understanding information about their treatment. The practice owner explained they would also help patients on an individual

basis if they were partially sighted or hard of hearing to complete NHS and other forms. There was level access into the building that included two of the three treatment rooms.

Access to the service

The practice was open 8.40am – 7.00pm Monday and Tuesday, 9.00am – 5.00pm Wednesday and Thursday, and 8.40am – 2.00pm Friday. The practice used the NHS 111 service to give advice in case of a dental emergency when the practice was closed. This information was publicised in the practice information leaflet, practice website and on the telephone answering machine when the practice was closed.

Concerns & complaints

The practice had a complaint policy and a procedure that set out how complaints would be addressed, who by, and the timeframes for responding. Information for patients about how to make a complaint was seen in the patient leaflet, poster in the waiting area and patient website.

We asked five patients if they knew how to complain if they had an issue with the practice. Four patients said they definitely did; only one were not sure. The practice had no written complaints during 2015. The low level of complaints reflected the caring and compassionate ethos of the whole practice. The practice owner explained that in the event of a complaint they adopted a very proactive response to any patient concern or complaint. Patients were spoken to by telephone or invited to a face-to-face meeting in an attempt to resolve the complaint or concern as soon as was practically possible. Patients would receive an immediate apology when things had not gone well.

Are services well-led?

Our findings

Governance arrangements

The governance arrangements for this location consisted of the registered manager and the practice manager who was responsible for the day to day running of the practice. We saw a number of policies and procedures in place to govern the practice and we saw these covered a wide range of topics. For example, control of infection and health and safety. We noted management policies and procedures were kept under review by the practice manager and practice owner. Staff were aware of where policies and procedures were held and we saw these were easily accessible.

Leadership, openness and transparency

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 manager or owner of the practice. They felt they were listened to and responded to when they did raise a concern. Staff told us they enjoyed their work and were well supported by the owner and dentists.

It was apparent through our discussions with the dentists and nurses the patient was at the heart of the practice with the staff adopting a holistic approach to patient care with an emphasis on the prevention of dental problems. 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, 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 received an annual appraisal; these appraisals were carried out by the practice manager. The dentists also received performance reviews with the

practice owner; we saw an example of one such review. The appraisal document was meticulously completed and appeared to be an effective way of determining the dentists learning and development needs.

We found there were a number of clinical and non-clinical audits taking place at the practice. These included infection control, referrals to other services, clinical record keeping and X-ray quality. There was evidence of repeat audits at appropriate intervals and these reflected standards and improvements were being maintained. For example infection control audits were undertaken every six months and X-ray audits were carried out in accordance with current guidelines. Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. Training was completed through a variety of resources and media provision. Staff were given time to undertake training which would increase their knowledge of their role. We found that the practice undertook 'lunch and learns' where new techniques and dental materials were discussed. The practice owner organised a local study circle for neighbouring dentists which met at a nearby conference facility. At these meetings dentists discussed a variety of subjects such as oral cancer, dental radiography, medical emergencies in dental practice and dental implants. These meetings were supported by a range of guest speakers in these subjects.

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

The practice gathered feedback from patients through patient surveys, feedback cards in waiting areas, compliments and complaints. Changes made as a result of this feedback included improving waiting times for patients and improving the ceiling décor in one treatment room when a patient had noted that the roof had been leaking. All of the staff told us they felt included in the running of the practice and how the practice owner and practice manager listened to their opinions and respected their knowledge and input at meetings. Staff told us they felt valued and were proud to be part of the team. Results of the NHS Family and Friends Test we saw indicated that 100% were happy with the quality of care provided by the practice and where either highly likely or likely to recommend the service to family and friends.