W5 Dental Care Limited

W5 Dental Care Limited

Inspection Report

9-10 Station Buildings
Uxbridge Road
London
W5 3NU
Tel: 020 8993 5020
Website: www.w5dental.co.uk

Date of inspection visit: 29 June 2015
Date of publication: 10/09/2015

Overall summary

We carried out an announced comprehensive inspection on 29 June 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.

W5 Dental Care Limited is located in Ealing, London. The practice provides private dental services to adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers, crowns and bridges and oral hygiene.

The premises are arranged over the ground floor and basement and include two treatment rooms, one of which is primarily used by the dental hygienist and a dedicated decontamination room. All the areas used by patients are located on the ground floor. The practice has a reception area with seating and patient and staff toilets.

The practice is staffed by one principal dentist, (who is the owner), and four part-time associate and specialist dentists including a periodontist and an endodontist. The practice employs two practice nurses who also work on reception. The practice also contracts a part-time dental hygienist.

The practice is open Monday to Friday and offers an evening session on Tuesday until 8pm. The practice also opens one Saturday each month by appointment.

The principal dentist was 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 29 June 2015. The inspection took place over one day and was carried out by a CQC inspector and a dentist specialist advisor.

Twenty patients provided feedback about the service. Patients we spoke with, and those who completed comment cards, were all positive about the care they received from the practice. Patients frequently described the service as excellent and told us the staff were friendly and involved them in their care.

Our key findings were:

- Patients' needs were assessed and care was planned in line with best practice guidance, such as from the National Institute for Health and Care Excellence (NICE).
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, oxygen cylinder and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and patient practice team.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- The principal dentist had a clear vision for the practice and staff told us they were well supported by the management team.
- Governance arrangements and audits were effective in improving the quality and safety of the services, though improvements could be made to ensure risks were better monitored and mitigated.

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

- Review its protocols regarding receipt of Medicines and Healthcare products Regulatory Agency (MHRA) advice to ensure the practice receives relevant updates and can act upon these in a timely way.
- Develop a practice protocol for reporting drug reactions or other side effects to the British Formulary.
- Review the practice's infection control procedures and protocols giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- Review practice policies periodically to ensure these reflect current practice and guidelines.
- Include a check in its staffing and recruitment procedures to ensure that the dental nurses are covered by appropriate professional indemnity insurance.

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 systems in place to minimise the risks associated with providing dental services. The practice had policies and protocols related to the safe running of the service although some of these were undated. Staff were aware of practice procedures and were following them. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse. Equipment was well maintained and checked for effectiveness. The practice had an effective recruitment process and staff engaged in on-going training to keep their skills up to date. The practice had systems in place for the management of infection control and waste disposal, management of medical emergencies and dental radiography. Infection control was generally good although we noted some areas for improvement in relation to the siting of loose items in the dental surgery and the process for washing instruments.

Are services effective?

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

The practice could demonstrate they followed relevant guidance, for example, issued by the National Institute for Health and Care Excellence (NICE) and The Department of Health (DH). The practice monitored patients' oral health. Staff explained treatment options to ensure that patients could make informed decisions about any treatment. There were systems in place for recording written consent for treatments, such as for those involving sedation.

The practice maintained appropriate medical records and details were updated appropriately The practice worked well with other providers and followed referrals up to ensure that patients received treatment in good time. Staff engaged in continuous professional development (CPD) and were meeting the training requirements of the General Dental Council (GDC).

Are services caring?

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

We received feedback from patients through comment cards that they were treated with dignity and respect. They noted a positive and caring attitude amongst the staff. We found that patient 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.

Patients had good access to appointments, including emergency appointments, which were available on the same day. There was evidence of good communication between staff and patients. The needs of people with disabilities had been considered in terms of accessing the service. Patients were invited to provide feedback through feedback questionnaires and a suggestions box situated in the waiting area. Information about how to make a complaint was displayed on the reception desk. There had been no complaints recorded in the past year.

Are services well-led?

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

Summary of findings

The practice had effective leadership and an open supportive culture. Governance arrangements were in place to guide the management of the practice. This included having appropriate policies and procedures and staff meetings, although some policies were undated and it was not always clear if they reflected current practice. Risk assessments, audits and staff meetings were generally being used to monitor and improve the quality of care. Staff meetings were held every two months and were used to share learning and best practice strategies.

W5 Dental Care Limited

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 29 June 2015. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a dentist specialist advisor.

We reviewed information received from the provider prior to the inspection. We informed the local 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 the three members of staff who were at the practice on the day, including the principal dentist. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We observed the dental nurses carrying out decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area.

We reviewed feedback from 20 patients either in the form of comment cards completed in the days preceding the inspection or obtained by interview on the day.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had an effective system in place for reporting and learning from incidents. There was a policy in place which set out the actions that staff needed to take in the event of an error, accident or 'near miss'. Staff knew how to report incidents and learning was shared in team meetings which were documented. The principal dentist told us that if patients were affected by an incident, they would be given an apology and informed of any actions taken as a result. There had been no recent incidents in the last year.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any such incidents in the past 12 months.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding adults. This included contact details for the local authority safeguarding team. This information was accessible to staff in the treatment rooms.

The principal dentist took the lead in managing safeguarding issues. Staff had completed safeguarding training to an appropriate level and were able to describe potential indicators of abuse or neglect and how they would raise concerns. The practice had not reported any safeguarding concerns to the local safeguarding team.

Staff were less familiar with the procedures for whistleblowing if they had concerns about another member of staff's performance or behaviour. However, there was an accessible whistleblowing policy on file. Staff told us they had confidence in the integrity of the principal dentist and would feel able to report any concerns to them.

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, they had carried out risk assessments of the premises and fire safety in 2015. The staff were able to explain routine risk assessments and checks they undertook and how these were recorded. The practice manager could demonstrate that they followed up any issues identified during audits as a method for minimising risks.

The practice followed national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments. (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. All staff had received training in emergency resuscitation and basic life support. This training was renewed annually. The staff we spoke with were aware of the practice protocols for responding to an emergency.

The practice had suitable emergency equipment in accordance with guidance issued by the Resuscitation Council UK. This included relevant emergency medicines (as recommended in the British National Formulary), oxygen and 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 equipment was regularly tested by staff and a record of the tests was kept. However some staff were not trained on how to use the practice's AED device which might delay their response in an emergency. A child-size bag valve mask (equipment used in resuscitation) had recently passed its expiry date and a replacement was on order.

Staff recruitment

The practice staffing consisted of a principal dentist, four part-time dentists, two dental nurses who also worked on reception and a hygienist.

.

Three staff members had joined the practice within the last 18 months and we saw that appropriate checks were carried out before they started to work in the practice and effective recruitment and selection procedures had been used. We saw that the staff files for these members of staff included the use of an application form, interview notes, review of employment history, evidence of relevant qualifications, the checking of references, a check of registration with the General Dental Council and checks with the Disclosure and Barring Service (DBS). New staff

Are services safe?

had undergone a documented structured induction process. The practice was able to demonstrate that the dental nurses were both qualified and registered with the General Dental Council.

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.

There were effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors that were associated with hazardous substances had been identified and actions were described to minimise these risks. We saw that COSHH products were securely stored. Staff training files indicated that staff had received relevant training in managing COSHH products.

The practice had a system in place to respond promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. However, the practice was not routinely receiving MHRA alerts electronically and had not received any MHRA alerts or advice in the last year. The practice could not assure us that they were aware of any recent alerts and this could potentially put patients at risk.

The practice did not have a written business continuity plan but had an arrangement in place with another practice to provide continuity of care in the event that the premises could not be used.

Infection control

There were systems in place to reduce the risk and spread of infection. There was an infection control policy which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. One of the dental nurses was the infection control lead.

Staff files we reviewed showed that staff regularly attended external training courses in

infection control. The practice had followed 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)'. In accordance with HTM01-05 guidance an instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which ensured the risk of cross infection was minimised.

We examined the facilities for cleaning and decontaminating dental instruments. There was a

dedicated decontamination room with a clear flow from 'dirty' to 'clean.' One of the dental nurses demonstrated how they used the room and displayed a good understanding of the correct processes. However, the nurses were using a shallow bowl for washing instruments which was unnecessary as the decontamination room was equipped with a double sink unit. We also noted that instruments were sometimes allowed to dry out between end of use and washing. We discussed these findings with the principal dentist who told us the decontamination procedure would be amended to ensure that instruments were kept moist and washed directly in the sink. The decontamination room was located in the basement and did not have an air extraction system. The practice were already aware of this but had limited options to address the issue as they did not own the building and the room had no external walls.

Dental nurses wore appropriate protective equipment, such as heavy duty gloves, aprons and eye protection. The staff were clear about the practice uniform policy and we saw that they always changed before leaving the premises, for example, for their lunch break.

An illuminated magnifier was used to check for any debris during the cleaning stages. Items were placed in an autoclave (steriliser) after cleaning. Instruments were placed in pouches after sterilisation and a date stamp indicated how long they could be stored for before the sterilisation became ineffective. The practice kept daily logs to monitor the effectiveness of the sterilisation process. It also carried out weekly protein residue tests to check the performance of the ultrasonic cleaner.

All of the staff were required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. Staff also had a wider check of their immunisation history including rubella, tetanus, polio and tuberculosis.

Are services safe?

There had been regular, six-monthly infection control audits with the last one having been completed in April 2015. This was comprehensive and had not identified any issues.

The practice had an on-going contract with a clinical waste contractor. Waste was being appropriately stored and segregated. This included clinical waste and safe disposal of sharps. Sharps bins were well-sited and not over-full but they had not been signed and dated when installed. Staff demonstrated they understood how to dispose of single-use items appropriately.

Records showed that a Legionella risk assessment had been carried out by an external company in February 2015. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). The assessment had not identified any risks requiring action. Dental water lines were routinely flushed in accordance with current guidance in order to prevent the growth of Legionella.

The premises appeared clean and tidy although there was further scope to declutter some working surfaces for example by reducing the number of cleaning agents stored in the decontamination room. There was a good supply of cleaning equipment which was stored safely. The practice had a cleaning schedule that covered all areas of the premises and detailed what and where equipment should be used. This took into account national guidance on colour coding equipment to prevent the risk of infection spread. However, the practice stored a range of items, such as syringes and syringe tips in drawers in treatment rooms. We noted that there was a risk of environmental contamination as they were located within the splatter zone when patients were being treated.

There were good supplies of personal protective equipment for patients and staff members including gloves, masks, eye protection and aprons. There were hand washing facilities in the treatment rooms, the decontamination room and the toilets.

Equipment and medicines

The practice was equipped with appropriate specialist equipment for the range of treatments it provided. 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. However, not all electrical equipment had been marked as having undergone portable appliance testing (PAT) in line with good practice guidance. (PAT is the name of a process during which electrical appliances are routinely checked for safety).

Batch numbers and expiry dates for local anaesthetics were recorded in the clinical notes. These medicines were stored safely and could not be accessed inappropriately by patients. The emergency medicines were also stored securely.

The practice did not have a written protocol for reporting drug reactions or other side effects either via yellow cards or online to the British National Formulary.

Radiography (X-rays)

The practice kept a radiation protection file in relation to the use and maintenance of X–ray equipment. There were suitable arrangements in place to ensure the safety of this equipment. The local rules relating to the equipment were held in the file and available for view. The procedures and equipment had been assessed by an external radiation protection adviser (RPA) within the recommended timescales. The principal dentist was the radiation protection supervisor for the practice. All clinical staff had completed radiation training. The practice carried out six-monthly radiography audits, the last one in December 2014 which was comprehensive.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We reviewed dental care records kept by each dentist and discussed patient care with the principal dentist and dental nurses. We found that the dentists regularly assessed patients' gum health and soft tissues (including lips, tongue and palate) using the basic periodontal examination (BPE) screening tool. (The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums.) BPE scores of 3 or 4 old triggered a fuller examination in consultation with the in- house periodontal specialist who visited the practice every two weeks.

Dentists took X-rays at appropriate intervals, as informed by guidance issued by the Faculty of General Dental Practice (FGDP). They also recorded the justification, findings and quality assurance of X-ray images taken.

The practice kept up to date with current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to the appropriate management and extraction of impacted wisdom teeth.

The practice had a robust protocol for obtaining and updating patients' medical history. This was obtained in writing when a patient first registered and updated verbally at every visit. Patients then reviewed and signed to indicate their medical history was accurately recorded before every course of treatment.

Health promotion & prevention

We were told that the standard of oral health of established practice patients tended to be good but was much more variable among new patients, some of whom were visiting a dentist for the first time in a number of years. 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. Patients could book to see the hygienist directly without having to be referred. Dentists also carried out examinations to check for the early signs of oral cancer.

We observed that there were limited health promotion materials and information displayed in the waiting area and available for staff to give to patients. The dental nurses said they sometimes used physical aids for example a model of the teeth, to demonstrate how to clean teeth effectively and they were keen to develop their skills in this area. One of the dental nurses had recently attended a training course on good oral health but had not yet had many opportunities to put this into practice.

Staffing

Staff told us they received appropriate professional development and training. We reviewed the 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 and infection control. Staff told us they had opportunities to keep up to date with their clinical practice and to develop particular clinical interests.

There was a structured induction programme for new staff to follow to ensure that they understood the protocols and systems in place at the practice. This included checklists to be completed on the first day and at three months. Staff also signed to indicate that they had read key practice policies.

Staff received an annual appraisal which included consideration of individual development needs and reflection on performance and strengths.

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. Dentists used a system of onward referral to other providers, for example, for oral surgery, orthodontics or advanced conservation. Referrals were followed up and the outcomes were appropriately recorded in patient's notes. Dentists within the practice also referred work on to each other, depending on the particular skills and specialisms required for any given treatment. Patients were not routinely given copies of referral letters which were typically sent electronically directly to the relevant specialist, however the practice had provided copies of letters to patients on request.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. Staff discussed treatment options,

Are services effective?

(for example, treatment is effective)

including risks and benefits, as well as costs, with each patient. Notes of these discussions were recorded in the clinical records. Signed consent was obtained before any course of treatment.

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

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The feedback we received from patients was very positive. Twenty patients provided feedback about the service and many made comments about the friendly and caring manner in which they were treated at the practice. We also observed that staff were welcoming and helpful when patients arrived and over the telephone. The members of staff we spoke with consistently told us that the practice ethos was to provide a patient-centred service. They were able to provide examples of how they supported more anxious patients.

The practice obtained regular feedback from patients through feedback questionnaires. The data were analysed every six months. We reviewed the most recent analysis of 20 questionnaires received between January and June 2015. This feedback was also positive with 18 respondents indicating that they would recommend the practice.

The staff were careful to protect patient privacy. Confidential information was kept out of sight in public areas and doors were always closed when patients were in the treatment rooms. The receptionists offered to talk to patients away from the reception area if they preferred to discuss something privately.

Involvement in decisions about care and treatment

Patient feedback indicated that patients felt well informed about their treatment and involved about decisions. Several patients commented specifically about how good their dentist was at communicating and explaining different options. There was corroborating evidence in patient records that patients' preferences and wishes had been noted and acted upon. Staff told us that they had sufficient time to explain the treatment options available and to answer patients' questions.

There was however a limited range of information in the waiting area which described some of the dental treatments available. The practice website contained more information about this. The practice displayed information in the waiting area and on its website giving details of the practice's private dental fees for treatment and an alternative dental payment scheme. The practice gave patients a copy of their treatment plan which included the cost. The practice's most recent analysis of 20 patient feedback questionnaires found that all the respondents reported having enough information and 19 said their dentist was good at listening to them.

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. The principal dentist and nurses gave a clear description about which types of treatment or reviews would require longer appointments.

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 or hygienist 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. Staff spoke four different languages and also could arrange an interpreter although this was rarely required. The practice was sensitive to cultural needs, for example, understanding the need to flexibly schedule appointments for patients who were fasting during Ramadan. The reception and treatment rooms were wheelchair accessible and the practice had an induction loop installed for patients with hearing difficulties.

Access to the service

The practice was open Monday to Friday with variable opening hours. It offered an evening session on Tuesday until 8pm. The practice also opened one Saturday each month by appointment.

The practice displayed its opening hours on their premises and on the practice website. New patients were also given a practice information leaflet which included the practice contact details and opening times. When the practice was closed, a contact number was displayed on the door for patients to use in an emergency and also on an answerphone message. The principal dentist was available on-call when not attending the practice and the staff told us the principal dentist always responded to their telephone questions and queries.

The practice allowed space in the daily appointment schedule for urgent and emergency appointments such as, patients attending with dental pain. On the day of the inspection, the practice had been able to accommodate a new patient with an urgent problem and this had not affected the timing of other patients' appointments.

Concerns & complaints

Information about how to make a complaint was displayed on the reception desk. Information on the website was more limited but indicated there was a complaints procedure that patients could use. There had been no complaints recorded in the past year. The staff told us they tried to respond to and resolve any issues, for example, delayed appointments as they arose.

The practice also had a suggestions box and gave patients feedback questionnaires to complete. These were displayed in the waiting area.

The patient questionnaires had been analysed and the results shared with the staff. The most recent results were generally very positive but practice had decided to lengthen appointments to reduce the risk of overrunning and delaying patients.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements and a clear management structure. There were relevant policies and procedures in place. Staff were aware of the practice policies and procedures and acted in line with them. Records, including those related to patient care and treatment were kept accurately. Some policy documents, such as the safeguarding children and vulnerable adults policies were clearly tailored to the practice, reviewed and updated. Others however, such as the significant events policy, were undated and it was unclear when they had last been reviewed.

The practice had robust recruitment and training procedures. Staff were being supported to meet their professional standards and complete continuing professional development standards set by the General Dental Council. However, the practice had not checked that the dental nurses were covered by appropriate professional indemnity insurance.

There were arrangements for identifying, recording and managing risks through the use of scheduled risk assessments and audits. The practice had not carried out a risk assessment in relation to the hygienist working alone but the dental nurses told us they were able to support the hygienist if this was requested on an ad hoc basis.

The practice was generally well-organised but some of the governance procedures could be improved. The practice had not received safety advice from the Medicines and Healthcare products Regulatory Agency (MHRA) for over a year and had not investigated and addressed this. The practice also did not have a system for reporting negative drug side effects to the British National Formulary (BNF).

Practice meetings were scheduled to take place every two months and minutes were kept. We saw that a range of governance issues had been discussed. The meetings were held on different days of the week to enable as many of the team to attend in person as possible.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said that they felt comfortable about raising concerns with the principal dentist. They felt they were listened to and responded to when they did so. Staff told us they enjoyed their work and were well supported by the management team.

We spoke with the principal dentist who outlined the practice's ethos for providing good care for patients. Staff shared the overall ethos. The practice was able to demonstrate that it was providing good, patient-centred care in line with its ethos.

A system of staff appraisals was in place. The principal dentist was aware of which members of staff were interested in taking additional training courses and supported this as a way of improving the mix of skills available at the practice. For example, one of the dental nurses had recently completed training on oral health promotion and was keen .

Management lead through learning and improvement

All clinical staff were up to date with their continuing professional development (CPD). 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).

Appropriate audits were carried out for example, routine audits of radiographs and infection control. However, the infection control audits had not successfully identified a number of issues around infection control which were noted by the inspection team during our site visit. We noted that the quality of clinical record keeping was being routinely audited, the last one was carried out in March 2015.

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 and a suggestions box. The feedback received through the patient survey was reviewed every six months. The majority of feedback had been positive. The practice had acted on patient feedback to improve the service.