Aspire Dental Care UK Limited

East Cowes Walk In Dental Centre

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 17 May 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

East Cowes Dental Walk In Centre operates from the first floor of a commercial premises and provides NHS and private dentistry for both adults and children. The practice is situated in East Cowes.

The practice has two dental treatment rooms and two separate decontamination rooms used for cleaning, sterilising and packing dental instruments. The practice is based in a health centre which is also occupied by a GP practice and a pharmacy.

The practice employs three dentists, a hygienist, two qualified dental nurses, three trainee dental nurse/ receptionists, one receptionist and a practice manager. The practice opens seven days a week between 8.00am and 6.00pm and Wednesdays between 8.00am and 8.00pm.

There are arrangements in place to ensure patients receive urgent dental assistance when the practice is

Summary of findings

closed. This is provided by an out-of-hours service. If patients called the practice when it was closed an answerphone message gives the telephone number patients should ring depending on their symptoms.

The practice manager 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.

During our inspection we reviewed 15 CQC comment cards completed by patients and obtained the view of 17 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:

- The practice manager explained that the practice ethos was to provide patient care in a relaxed and friendly environment.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice appeared clean and well maintained.
- Infection control procedures were robust and the practice followed published guidance.
- The practice had a safeguarding lead and 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 had received training appropriate to their roles and were supported in their continued professional development (CPD).
- Staff we spoke with felt well supported by the practice manager and were committed to providing a quality service to their patients.
- Information from 15 completed Care Quality Commission (CQC) comment cards gave us a positive picture of a friendly, caring, professional and high quality service.
- The practice reviewed and dealt with complaints according to their practice policy.

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

- Consider installing a hearing loop for patients with hearing difficulties.
- Inform the Health and Safety Executive of the use of radiography in accordance with the Ionising Radiation Regulations 1999.
- Re-establish the system of the formal reporting of other incidents and near misses.
- Review the systems and processes and mitigate risks relating to fire safety and training.
- Review the storage of emergency medicines and equipment and consider re-locating this equipment away from the clean room of the decontamination unit.
- Consider the provision of an annual infection prevention control statement in accordance with The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had arrangements in place for infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found that all the equipment used in the dental practice was properly maintained. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents. Staff 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 focused on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals. The staff received professional training and development appropriate to their roles and learning needs. Staff where appropriate were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

Are services caring?

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

We collected 15 completed Care Quality Commission patient comment cards. 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 the friendliness and helpfulness of the staff and dentists were good at explaining the treatment that was proposed. We obtained the views of 17 patients on the day of our visit. These also provided a positive view of the service the practice provided.

Are services responsive to people's needs?

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

The service was aware of the needs of the local population and took those these into account in how the practice was run. Patients could access treatment and urgent and emergency care when required. The practice provided patients with written information in a 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 regulation.

The practice staff team had an open approach to their work and shared a commitment to continually improving the service they provided. The practice had essential clinical governance and risk management structures in place. Staff told us that they felt supported and could raise any concerns with the practice manager. Staff we met said that they were happy in their work and the practice was a good place to work.

East Cowes Walk In Dental Centre

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 17 May 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 records. We spoke with six members of staff. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment.

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

Patients gave positive feedback about their experience at the practice.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice manager and area manager described good awareness of RIDDOR (The reporting of injuries diseases and dangerous occurrences regulations). The practice had an accident reporting system in place for the reporting of minor injuries to patients and staff.

The area manager explained that the practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA) through the practice owner who acted as the clinical director for the group. These were then shared with staff during staff meetings and the 'daily huddle' when staff would be informed of points of note. The dentists also received them personally by electronic post from the clinical director. Previously the practice had a formal process in place for the reporting of other incidents but this system appeared to be no longer used.

Reliable safety systems and processes (including safeguarding)

We spoke to a dental nurse about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current European Union (EU) directive with respect to safer 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. A special rubber needle guard was used to prevent contaminated needle stick injuries during recapping procedures. Dentists were also responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps.

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

The practice manager was the lead for safeguarding and acted as a point of referral should members of staff encounter a child or adult safeguarding issue. A policy and protocol was in place for staff to refer to in relation to children and adults who may be the victim of abuse or neglect. Training records showed that all staff had received appropriate safeguarding training for both vulnerable adults and children. Information was available in the practice that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an automated external defibrillator, 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 dental emergencies.

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. However these were kept in the clean room of the decontamination area which was locked. We spoke with the practice manager about this who undertook to move the medicines to a more suitable place. The practice held training sessions yearly for the whole team so that they could maintain their competence in dealing with medical emergencies. Staff we spoke with demonstrated they knew how to respond if a person suddenly became unwell.

Staff recruitment

All the dentists and dental nurses who worked at the practice had current registrations with the General Dental Council. We looked at recruitment files for five staff

Are services safe?

employed since the provider registered with CQC and found the registered provider had undertaken all the required checks to comply with Schedule 3 of the Health and Social Care Act 2008 (amended 2014). Checks required included proof of identity, a full employment history, evidence of relevant qualifications and employment checks, including references.

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 system of policies and risk assessments which included radiation, Legionella (legionella is a term for particular bacteria which can contaminate water systems in buildings) and general health and safety in the practice.

Although there was a fire policy in place there were areas where the practice could improve their systems and processes in relation to fire safety. The practice had a business continuity plan to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service. We also saw that the practice had in place a Control of Substances Hazardous to Health (COSHH) file. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The practice had in place 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 May 2016 confirmed compliance with HTM 01 05 guidelines.

An annual statement in relation to infection prevention control required under The Health and Social Care Act 2008 Code of Practice about the prevention and control of infections and related guidance had not been prepared.

We saw that the two dental treatment rooms, waiting area, reception and toilets 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 a treatment room were inspected and these were clean, ordered and free from clutter. Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

The practice carried out the placement of dental implants. We noted that the practice used a single use surgical drape pack system for patients requiring these complex oral surgery procedures. These packs consisted of single use surgical drapes to cover all non- essential areas of the treatment room and for the patient, surgeon and nurse gowns, head covers for both staff and patients. We also saw that there were ample stocks of surgical gloves and single use surgical irrigant packs used during the placement of dental implants. The dental nurse we spoke with explained that the single use items that formed part of each dental implant system were for single patient use only and came in pre-sterilised packs.

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

The dental unit water lines were maintained to prevent the growth and spread of Legionella bacteria, 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 in March 2016. The recommended procedures contained in the report were carried out and logged appropriately.

The practice had two separate decontamination rooms for instrument processing, one was designated the dirty room where the initial pre-cleaning of instruments was undertaken and the other room, the clean room, where sterilisation and packing of the processed instruments took place. The dental nurse demonstrated the process from

Are services safe?

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 ultrasonic 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 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 two autoclaves used in the decontamination process were working effectively. It was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were always complete and up to date. We also noted that validation tests for the ultrasonic cleaning bath were also complete and up to date.

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

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the practice steriliser had been serviced and calibrated in March 2016. The practice's X-ray machines had been serviced and calibrated as specified under current national regulations in May 2016. Portable appliance testing (PAT) had been carried out in May 2016.

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. The practice stored prescription pads in a safe overnight to prevent loss due to theft. The practice also had a prescription logging system to account for the prescriptions issued to prevent inappropriate prescribing or loss of prescriptions. We observed that the practice had equipment to deal with minor first aid problems such as eye problems, body fluid and mercury spillage.

Radiography (X-rays)

We were shown a 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 maintenance files and a copy of the local rules. The maintenance logs were within the current recommended interval of three years. The only piece of missing documentation was the notification to the Health and Safety Executive that radiation was being used at the practice.

A copy of the radiological audit for each dentist carried out between February and April 2016 was available for inspection. 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 the practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. We saw training records that showed all staff where appropriate had received training for core radiological knowledge under IRMER 2000.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Dentists carried out consultations, assessments and treatment in line with recognised general professional guidelines. The dentists described to us how they carried out their assessment of patients for routine care. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained in detail.

Preventative dental information was given in order to improve the outcome for the patient where relevant. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

We saw dental care records that were completed by all of the dentists working at the practice. We saw that the findings of the assessment and details of the treatment carried out were recorded appropriately by each dentist. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums. These were carried out where appropriate during a dental health assessment.

Health promotion & prevention

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

Staffing

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

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

Working with other services

The 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 and orthodontic providers. We noted the practice used a referral tracking system to monitor referrals from the practice. This ensured that patients were seen by the right person at the right time.

Consent to care and treatment

The dentists we spoke to explained how they implemented the principles of informed consent; they had a clear understanding of consent issues. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an

Are services effective?

(for example, treatment is effective)

understanding of their treatment options. They went on to say that patients should be given time to think about the treatment options presented to them. This made it clear that a patient could withdraw consent at any time and that they had received a detailed explanation of the type of treatment required, including the risks, benefits and options.

We also asked them about how they would obtain consent from a patient who suffered with any mental health impairment that may mean that they might be unable to fully understand the implications of their treatment. 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 patients' privacy. Patients' paper records were stored in lockable records storage cabinets. Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff were aware of the importance of providing patients with privacy and maintaining confidentiality.

All the 17 patients asked told us the dentists were good at treating them with care and concern. Before the inspection, we sent Care Quality Commission (CQC) comment cards so patients could tell us about their experience of the practice. We collected 15 completed CQC patient comment cards. 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 and 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

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. A poster detailing NHS fees was displayed in the waiting area. Information was available in the waiting area and on the practice website that detailed the costs of both NHS and private treatment. 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

The practice waiting area displayed a variety of information on the patient notice board. Information included; opening hours, emergency 'out of hours' contact details and arrangements and how to make a complaint. On the day of our visit, we observed that the appointment diary for the dentist was not unduly overbooked. This provided capacity each day for patients with dental pain to be seen by the dentist with patients invited to come and sit and wait. 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 was based on the ground floor of a purpose built building. Each treatment room was spacious which made it fully accessible to wheelchair users, prams and patients with limited mobility.

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 did not have a hearing loop in place for patients who may be hearing aid wearers.

Access to the service

East Cowes Walk In Centre offered NHS and private dental care services for adults and children seven days a week between8.00am and 6.00pm and Wednesdays between 8.00am and 8.00pm. All the 17 patients asked told us they were satisfied with the practices' opening hours.

East Cowes offered appointments to registered patients and a sit and wait service for those not registered. These patients could be from another practice or those visiting the Isle of Wight for business or holiday reasons.

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

Concerns & complaints

The practice had a complaints policy and a procedure that set out how complaints would be addressed, who by, and the timeframes for responding. For example, a complaint would be acknowledged within three days and a full response would be provided to the patient within ten days. The practice listed nine written complaints received over the previous year which records confirmed eight had been concluded satisfactorily and one was on-going.

Information for patients about how to make a complaint was seen on the practice website, patient leaflet and on display in the practice waiting room. We asked 17 patients if they knew how to make a complaint if they had an issue and 14 said yes but three were not sure.

Are services well-led?

Our findings

Governance arrangements

The governance arrangements for this location were overseen by the practice manager who was responsible for the day to day running of the practice. The provider had in place a system of managers who provided support and leadership to the practice manager. The practice maintained a comprehensive system of policies and procedures. which were kept under review by the practice management on a regular basis.

Staff recruitment arrangements included the recording of necessary checks required to meet Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Leadership, openness and transparency

The practice ethos focussed on providing patient care in a relaxed and friendly environment. The comment cards we saw reflected this approach. The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said they felt comfortable about raising concerns with the practice manager. 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. 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 found there were a number of audits taking place at the practice. These included infection control, radiography (X-rays) and clinical record keeping. 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. The radiography audits demonstrated that the practice had analysed the results to discuss and identify where improvement actions may be needed.

Staff were supported to maintain their continuing professional development as required by the General Dental Council. The practice provided a rolling programme of professional development. This included training in cardio pulmonary resuscitation (CPR), infection control, child protection and adult safeguarding, dental radiography. Training was completed through a variety of resources including the attendance at face to face and online courses. Staff were given time to undertake training which would increase their knowledge of their role.

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

The practice had gathered feedback from patients through the NHS Friends and Family test (FFT), compliments and complaints. We saw that there was a robust complaints procedure in place, with details available for patients in the waiting area.

Results of the FFT carried out in April 2016 indicated that 96% of patients, who responded, were happy with the quality of care provided by the practice and were highly likely to recommend the practice to family and friends.

March 2016's survey showed that 100% of patients, who responded, said they would recommend the practice to a friend. As a result of patient feedback the practice had introduced improvements suggested by patients which included the addition of a new dentist.

Staff told us that the practice manager and dentists 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. Staff described the meetings as good, with the opportunity to discuss successes, changes and improvements. Staff we spoke with said they felt listened to.