Aspire Dental Practice Partnership

# Mydentist - Ewell Road - Surbiton

## Inspection Report

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Date of inspection visit: 17 December 2015
Date of publication: 04/02/2016

## Overall summary

We carried out an announced comprehensive inspection on 17 December 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

**Our findings were:**

**Are services safe?**

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

**Are services effective?**

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

**Are services caring?**

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

**Are services responsive?**

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

**Are services well-led?**

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

**Background**

Mydentist – Ewell Road – Surbiton is a dental practice located in the London Borough of Kingston-upon-Thames. The premises are situated in a converted residential building with treatment rooms on the ground and first floors. There are seven treatment rooms, a dedicated decontamination room, a waiting room with reception area, a staff room, an administrative office, and three toilets.

The practice provides NHS and private services to adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers and crowns and bridges.

The staff structure of the practice consists of six dentists, a hygienist, a head dental nurse, three other dental nurses, a practice manager and three receptionists.

The practice opening hours are on Monday from 8.00am to 5.00pm, Tuesday and Wednesday from 7.00am to 5.00pm (and every other Tuesday until 7.00pm), Thursday from 7.00am to 7.30pm, Friday from 7.00am to 5.00pm and Saturday from 9.00am to 4.00pm.

The practice manager was in the process of applying to become a registered manager at the time of the

# Summary of findings

inspection. A registered manager is a person who is registered with the CQC 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 inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

Eight people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

**Our key findings were:**

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were effective systems in place to reduce and minimise the risk and spread of infection.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Staff knew how to report incidents and forms were available to keep a record of any incident which could be used by the practice used for shared learning.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- The provider 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.

# 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. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse. There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. The practice had policies and protocols, which staff were following, for the management of infection control, medical emergencies and dental radiography. We found the equipment used in the practice was well maintained and checked for effectiveness.

**Are services effective?**

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

The practice provided evidence-based care in accordance with relevant, published guidance, for example, from the General Dental Council (GDC). The practice monitored patients' oral health and gave appropriate health promotion advice. Staff explained treatment options to ensure that patients could make informed decisions about any treatment. The practice worked well with other providers and followed up on the outcomes of referrals made to other providers.

Staff had engaged in continuous professional development (CPD) and were meeting all of the training requirements of the General Dental Council (GDC). Staff had received appraisals within the past year to discuss their role and identify additional training needs.

**Are services caring?**

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

We received positive feedback from patients through comment cards and by speaking with patients on the day of the inspection. Patients felt that the staff were kind and caring; they told us that they were treated with dignity and respect at all times. We found that dental care records were stored securely and patient confidentiality was well maintained.

**Are services responsive to people's needs?**

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

The needs of people with disabilities had been considered and there was level access to the waiting area and one of the treatment rooms on the ground floor. Patients were invited to provide feedback via the practice website and through the use of the NHS 'Friends and Family Test'. Patients generally had good access to appointments, including emergency appointments, which were available on the same day.

There was a complaints policy in place and we saw that complaints received in the past year had been acted on in line with this policy. The practice manager had carried out relevant investigations and recorded the outcome of these.

**Are services well-led?**

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

The current provider had taken over the running of the practice in 2014. They had implemented clear clinical governance and risk management structures. A system of audits was used to monitor performance.

# Summary of findings

Staff described an open and transparent culture where they were comfortable raising and discussing concerns with management team. They were confident in the abilities of the management team to address any issues as they arose.

# Mydentist - Ewell Road - Surbiton

**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.

We carried out an announced, comprehensive inspection on 17 December 2015. The inspection took place over one day and was carried out by a CQC inspector and a dentist specialist advisor.

We reviewed information received from the provider prior to the inspection. During our inspection we reviewed policy documents and spoke with eight members of staff. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. The head dental nurses demonstrated how they carried out decontamination procedures of dental instruments.

Eight people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

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

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

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

# Are services safe?

## Our findings

**Reporting, learning and improvement from incidents**

There was an effective system in place for reporting and learning from incidents. There had not been any significant events related to patients in the past year. There was a written policy which described what types of events might need to be recorded and investigated. The practice manager was responsible for investigating incidents and had support from the provider's head office regarding the process of investigation. Clinical advice related to any incidents was provided by a clinical supervision manager employed by the provider to work across their London practices.

We discussed the investigation of incidents with the practice manager and the provider's area manager. They confirmed that if patients were affected by something that went wrong, they were given an apology and informed of any actions taken as a result.

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 manager was the named practice lead for child and adult safeguarding. They were able to describe the types of behaviour a child might display that would alert them to possible signs of abuse or neglect. They also had a good awareness of the issues around vulnerable elderly patients who presented with dementia.

The practice had a well-designed safeguarding policy which referred to national guidance. Information about the local authority contacts for safeguarding concerns was displayed in the staff room and each of the treatment rooms. There was evidence in staff files showing that staff had been trained in safeguarding adults and children to an appropriate level.

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, we asked staff about the prevention of needle stick injuries. The practice used a 'safer sharps' system to minimise needle stick injuries. Following administration of a local anaesthetic to a patient needles were not resheathed using the hands. The staff we spoke with demonstrated a clear understanding of the practice policy and protocol with respect to handling sharps and needle stick injuries. There were also written protocols on the intranet for staff to refer to, when necessary. These arrangements were in line with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

The practice followed other national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments in line with guidance from the British Endodontic Society. (A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth).

**Medical emergencies**

The practice had arrangements in place to deal with medical emergencies. The practice had an automated external defibrillator (AED), oxygen and other related items, such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm).

The practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. The emergency medicines were all in date and stored securely with emergency oxygen in a location known to all staff. Staff received annual training in using the emergency equipment. The staff we spoke with were all aware of the location of the emergency equipment.

**Staff recruitment**

The staff structure of the practice consisted of six dentists, a hygienist, a head dental nurse, three other dental nurses, a practice manager and three receptionists.

There were effective recruitment and selection procedures in place. There was a recruitment policy which the practice had been following via an intranet system which prompted the completion of relevant documents and requests for pre-employment checks.

The practice held a staff file for each person. We checked five of these files. This showed that pre-employment checks of staff had been carried out in line with the relevant regulations. This included the use of application forms, a

# Are services safe?

review of employment history, evidence of relevant qualifications, the checking of references and a check of registration with the General Dental Council (where required).

The practice manager told us that it was their policy to carry out a Disclosure and Barring Service (DBS) check for all staff members prior to employment and periodically thereafter. Information about the outcome of the DBS check was held by the practice manager.

**Monitoring health & safety and responding to risks**

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety policy in place. The practice had been assessed for risk of fire and there were documents showing that fire extinguishers had been recently serviced.

There were 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 associated with hazardous substances were identified. Actions were described to minimise identified risks. COSHH products were securely stored. Staff were aware of the COSHH file and of the strategies in place to minimise the risks associated with these products.

The practice had a system in place to respond promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. MHRA alerts, and alerts from other agencies, were received by the practice manager via email. These were disseminated to staff, where appropriate.

There was an informal arrangement to use one of the sister practices to provide continuity of care in the event that the practice's premises could not be used.

**Infection control**

There were effective systems in place to reduce the risk and spread of infection within the practice. The head dental nurse was the infection control lead. 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. The practice had carried out practice-wide infection control audits every six months and found high standards throughout the practice. We noted that the last audit had been completed in February 2015.

We observed that the premises appeared clean, tidy and clutter free. Clear zoning demarked clean from dirty areas in all of the treatment rooms. Hand-washing facilities were available, including wall-mounted liquid soap, hand gels and paper towels in each of the treatment rooms, decontamination room and toilet. Hand-washing protocols were also displayed appropriately in various areas of the practice.

We asked the head dental nurse to describe to us the end-to-end process of infection control procedures at the practice. The protocols described demonstrated that 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)'.

The dental nurse explained the decontamination of the general treatment room environment following the treatment of a patient. We saw that there was a checklist system for ensuring that the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

We checked the contents of the drawers in one of the treatment rooms. These were well stocked, clean, ordered and free from clutter. All of the instruments were pouched. It was obvious which items were for single use and these items were clearly new. Each treatment room had the appropriate personal protective equipment, such as gloves and aprons, available for staff and patient use.

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). The practice manager described the method they used which was in line with current HTM 01-05 guidelines. A Legionella risk assessment had been carried out by an external contractor in August 2014. A number of recommendations were detailed in the report; this included regular testing of the water temperatures of the taps in several rooms in the building. We saw evidence that these checks were being carried out. A record had been kept of the outcome of these checks on a monthly basis.

The practice used a decontamination room for instrument processing. In accordance with HTM 01-05 guidance, an instrument transportation system had been implemented to ensure the safe movement of instruments between

# Are services safe?

treatment rooms and the decontamination room which ensured the risk of infection spread was minimised. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

Instruments were placed in an ultrasonic cleaner and rinsed in the dirty-zone sink prior to inspection under a light magnification device. Items were then placed in an autoclave (steriliser). When instruments had been sterilized, they were pouched and stored appropriately, until required. All pouches were dated with a date of sterilisation and an expiry date.

We saw that there were systems in place to ensure that the autoclaves and ultrasonic cleaners were working effectively. These included the automatic control test and steam penetration test for the autoclave and protein and foil tests for the ultrasonic cleaner. It was observed that the data sheets used to record the essential daily validation checks of the sterilisation cycles, and weekly tests for the ultrasonic cleaner, were always complete and up to date.

The segregation and storage of dental 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. The practice used a contractor to remove dental waste from the practice. Waste was stored in a separate, locked location within the practice prior to collection by the contractor. Waste consignment notices were available for inspection. Environmental cleaning was carried out in accordance with the national colour coding scheme

Staff files showed that staff regularly attended training courses in infection control. Clinical staff were also 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. (People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections.)

**Equipment and medicines**

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

Prescription pads were kept to the minimum necessary for the effective running of the practice. They were individually numbered and stored securely in the administrative office.

**Radiography (X-rays)**

There was 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 as well as 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. We also saw evidence that staff had completed radiation training. Audits on X-ray quality were undertaken at regular intervals.

# Are services effective?

(for example, treatment is effective)

## Our findings

**Monitoring and improving outcomes for patients**

The staff working in the practice carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. Two of the associate dentists described to us how they carried out their assessment. The assessment began with the patient completing a medical history questionnaire covering 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 made aware of the condition of their oral health and whether it had changed since the last appointment.

The patient's 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 details of the costs involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

We checked a sample of dental care records to confirm the findings. These 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 were noted using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). These were carried out where appropriate during a dental health assessment.

**Health promotion & prevention**

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. Staff told us they discussed oral health with their patients, for example, effective tooth brushing or dietary advice. The dentists were aware of the need to discuss a general preventive agenda with their patients. The dentists referred to the advice supplied in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. (This is an evidence-based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting). They were aware of the need to hold discussions around smoking cessation, sensible alcohol use and providing dietary advice. The dentists also carried out examinations to check for the early signs of oral cancer.

There was a hygienist working at the practice three days a week. The dentists could refer patients to the hygienist to further address patients' oral hygiene concerns.

We observed that there were health promotion materials displayed in the waiting area; including information aimed at engaging children in good dental hygiene practices. These could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition.

**Staffing**

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

There was an induction programme for new staff to follow to ensure that they understood the protocols and systems in place at the practice.

Staff told us they had recently been engaged in an appraisal process which reviewed their performance and identified their training and development needs. We reviewed some of the notes kept from these meetings and saw that each member of staff had the opportunity to put a development plan in place.

**Working with other services**

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients.

The practice manager, associate dentists and reception staff explained how they worked with other services, when required. Dentists were able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. For example, the practice made referrals to other specialists for implants and more complicated extractions.

# Are services effective?

## (for example, treatment is effective)

We reviewed the systems for referring patients to specialist consultants in secondary care. A referral letter was prepared and sent to the hospital with full details of the dentist's findings and a copy was stored on the practices' records system. The practice kept a written log of all referrals made which they used to check each patient's progress. When the patient had received their treatment they were discharged back to the practice. Their treatment was then monitored after being referred back to the practice to ensure patients had received a satisfactory outcome and all necessary post-procedure care. A copy of the referral letter was always available to the patient if they wanted this for their records.

**Consent to care and treatment**

The practice ensured valid consent was obtained for all care and treatment. We spoke to the associate dentists about their understanding of consent issues. They explained that 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. Patients were asked to sign formal written consent forms for specific treatments.

The dentists were aware of the Mental Capacity Act 2005. (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). The dentists could describe scenarios for how they would manage a patient who lacked the capacity to consent to dental treatment. They noted that they would involve the patient's family, along with social workers and other professionals involved in the care of the patient, to ensure that the best interests of the patient were met.

# Are services caring?

## Our findings

**Respect, dignity, compassion & empathy**

The comments cards we received, and the patients we spoke with, all commented positively on staff's caring and helpful attitude. Patients indicated that they felt comfortable and relaxed with their dentists and that they were made to feel at ease during consultations and treatments. We observed staff were welcoming and helpful when patients arrived for their appointment.

Staff were aware of the importance of protecting patients' privacy and dignity. Treatment rooms were situated away from the main waiting area and we saw that doors were closed at all times when patients were having treatment. Conversations between patients and dentists could not be heard from outside the rooms which protected patient's privacy.

Staff understood the importance of data protection and confidentiality and had received training in information governance. Patients' dental care records were stored electronically and in a paper format. Computers were password protected and regularly backed up to secure storage; screens at reception were not overlooked which ensured patients' confidential information could not be viewed. Paper records were stored securely in locked cabinets in the staff room.

**Involvement in decisions about care and treatment**

The practice displayed information in the waiting area and on its website which gave details of the private and NHS dental charges or fees. There were a range of information leaflets in the waiting area which described the different types of dental treatments available.

We spoke with two of the associate dentists and the hygienist on the day of our visit. All of the staff told us they worked towards providing clear explanations about treatment and prevention strategies. We saw evidence in the records that the dentists and hygienist recorded the information they had provided to patients about their treatment and the options open to them.

The patient feedback we received via comments cards, and through speaking with patients on the day of the inspection, confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

# 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' dental needs. Each dentist could decide on the length of time needed for their patient's consultation and treatment. Staff told us it was a busy practice with a large NHS contract. However, they told us they had enough time available to prepare for each patient, and could flexibly schedule additional time for patients they knew required additional support. The feedback we received from patients indicated that they felt they had enough time with clinicians and were not rushed.

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 opening hours, emergency 'out of hours' contact details and practice policy documents. The practice had a website which reinforced this information. New patients were given a practice brochure which included advice about payment, appointments, and complaints; although this was in the process of being reviewed and rebranded at the time of the inspection.

**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. Reception staff showed us they had access to a translation service could provide written information for people who were hard of hearing and use large print documents for patients with some visual impairment.

The practice had wheelchair access. There was a car park at the back of the building with a wheelchair ramp at the rear entrance. There was also a disabled toilet. One of the treatment rooms was situated on the ground floor and was accessible via wheelchair.

**Access to the service**

The practice was open from Monday from 8.00am to 5.00pm, Tuesday and Wednesday from 7.00am to 5.00pm (and every other Tuesday until 7.00pm), Thursday from 7.00am to 7.30pm, Friday from 7.00am to 5.00pm and Saturday from 9.00am to 4.00pm. The practice displayed its opening hours on their premises and on the practice website. New patients were also given a practice information sheet which included the practice contact details and opening hours.

We asked the practice manager about access to the service in an emergency or outside of normal opening hours. They told us the answer phone message gave details on how to access out-of-hours emergency treatment.

The practice manager and reception staff told us that patients who needed to be seen urgently, for example, because they were experiencing dental pain, were seen on the same day that they alerted the practice to their concerns. Patients needing to see a dentist urgently were asked to wait for the next available dentist to become free and reception staff notified the dentists via an internal messaging system that an emergency case was waiting to be seen.

**Concerns & complaints**

Information about how to make a complaint was displayed in the reception area and on the practice website. There was a formal complaints policy describing how the practice handled formal and informal complaints from patients. There had been three complaints recorded in the past year. These complaints had been responded to in line with the practice policy. The practice manager had carried out investigations and discussed learning points with relevant members of staff. The practice manager also received advice from the provider's head office on how to respond to complaints. Patients had received a written response, including an apology, when anything had not been managed appropriately.

We noted that complaints handling and patient feedback, for example, through reports on the 'NHS Choices' website, was part of a set agenda for discussion at monthly staff meetings. However, the minutes from these meetings did not clearly show how these reports had been reviewed with a view to sharing learning and improving service provision.

# Are services well-led?

## Our findings

**Governance arrangements**

The practice had governance arrangements with an effective management structure. There were relevant policies and procedures in place on a staff intranet. These were all frequently reviewed and updated. Staff were aware of the policies and procedures and acted in line with them.

There were monthly staff meetings to discuss key governance issues. A new structure, with a set agenda, for these meetings had recently been implemented. We reviewed minutes from a meeting held in October 2015. We saw that topics such as infection control, results from the NHS 'Friends and Family Test', and updates to the safeguarding policy were discussed.

**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 practice manager, area manager, or clinical supervision manager. They felt they were listened to and responded to when they did so.

We found staff to be hard working, caring towards the patients and committed to the work they did. The practice manager and head nurse were well-supported by the area manager and clinical supervision manager. The systems for accessing key information on the staff intranet were robust and well known to staff.

Staff told us they enjoyed their work and were supported by the practice manager, area manager and clinical supervision manager. They received regular appraisals which commented on their own performance and elicited their goals for the future.

**Learning and improvement**

The provider had a clear vision for the practice and had refurbished the premises, including the treatment rooms, during the past year. They were supporting a new practice manager to take the lead in all administrative and governance issues through the provision of additional training and support from other staff.

All staff were supported to pursue development opportunities. We saw evidence that staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the General Dental Council (GDC).

The practice had a programme of clinical audit that was used as part of the process for learning and improvement. These included audits for infection control, clinical record keeping, and X-ray quality. The audits showed a generally high standard of work, and did not identify any action points for improvement.

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

The practice gathered feedback from patients through the 'Friends and Family Test' and by monitoring the 'NHS choices' website where patients can post information about the quality of their care. The majority of feedback was positive about the quality of care received. We noted that the practice kept a record of these, but they had not yet used the systems in place for sharing these with members of the staff team with a view to identifying areas for improvement. However, the practice manager was able to cite examples of action taken in response to ad hoc feedback received from patients who had made suggestions through discussions with reception staff during the course of their visit to the practice.

Staff told us that the practice manager, area manager and clinical supervision manager were open to feedback regarding the quality of the care. The appraisal system and staff meetings also provided appropriate forums for staff to give their feedback.