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Bridgeways Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 18 January 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

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

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

Are services caring?
We found that this practice was providing caring services in accordance with the relevant. Regulations.

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

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

Background
Bridgeways Dental Practice is a private practice providing treatment for both adults and children. The practice is situated in a converted domestic property. The practice has two dental treatment rooms and a separate decontamination room for cleaning, sterilising and packing dental instruments. Dental care is provided on two floors with a reception and waiting area on the ground floor.

The practice is open between 8.00am and 5.30pm on Monday and Tuesday and between 8:30am and 7.30pm on Thursday. The practice is closed Wednesday and Friday. Saturday appointments are available by appointment only. The practice has one dentist who is supported by two dental nurses of whom one is also the practice manager, a dental hygienist and a receptionist.

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

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to

Summary of findings

tell us about their experience of the practice. We received feedback from 24 patients. These provided a positive view of the services the practice provides. Patients commented on the high quality of care, the caring nature of all staff, the cleanliness of the practice and the overall high quality of customer care.

Our key findings were:

- The practice ethos was to provide high quality patient centred care at all times
- Staff had been trained to handle emergencies; appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice was clean and well maintained.
- Infection control procedures were robust and the practice followed published guidance.
- The practice had a dedicated safeguarding lead professional and effective safeguarding processes in place for safeguarding adults and children living in vulnerable circumstances.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- The dentist and dental hygienist provided dental care in accordance with current professional 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, urgent and emergency care when required.
- The practice had a dentist who could provide a range of more specialised services including dental implants and orthodontics and there were enough supporting staff to deliver the services on offer.
- Staff had received training appropriate to their roles and was supported in their continuing professional development.
- Staff we spoke with felt well supported by the practice owner who was committed to providing a quality service to their patients.
- Information from 24 completed CQC comment cards gave us a positive picture of a friendly, caring, professional and high quality service.

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

- Provide the hygienist with the chair side support of a dental nurse.
- Secure the decontamination room to prevent unauthorised access.
- Introduce a system to manage national patient safety alerts received by the practice.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

The practice had robust arrangements for essential topics such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found all the equipment used in the dental practice was well maintained. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents. There were sufficient numbers of suitably qualified staff working at the practice. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance which included guidance from the National Institute for Health and Care Excellence to guide their practice. We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals. Staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council 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 24 completed CQC patient comment cards and obtained the views of a further six patients on the day of our visit. These provided a positive view of the service the practice provided. All of the patients commented the quality of care was very good. Patients commented about the friendliness and helpfulness of the staff and told us all dentists were good at explaining the treatment or tests they proposed. All patients spoken with would recommend the practice to someone new to the area.

Are services responsive to people's needs?
We found that this practice was providing responsive care in accordance with the relevant regulations.

The service was aware of the needs of the local population and took these into account in how the practice was run. We asked six patients for their views which aligned with the CQC comment card feedback of a caring and effective practice. Patients commented the quality of care was very good. Patients could access treatment; urgent and emergency care when required. The practice had a portable ramp to access the building for patients with mobility difficulties and families with prams and pushchairs.

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

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

Bridgeways Dental Practice

Detailed findings

Background to this inspection

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

The inspection took place on 18 January 2016 and was conducted by a lead CQC inspector and a specialist dental adviser.

Prior to the inspection, we asked the practice to send us some information which we reviewed. This included their latest statement of purpose, and the details of their staff members together with proof of professional registration with their professional bodies.

During the inspection, we spoke with the practice manager, dentists, lead dental nurse, reception staff and reviewed policies, procedures and other documents. We also obtained the views of six patients on the day of our visit. We reviewed 24 comment cards we had left with the practice prior to the inspection, for patients to complete, about the services provided at the practice.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had in place a 'near misses' book for staff to complete when something went wrong. We saw examples of four such incidents that occurred during 2015. We found for example the incident involving a sharps injury was discussed in a follow-up monthly staff meeting to ensure the whole practice learned from the incident.

The practice did not have in place a system for receiving national patient safety alerts such as those issued by the medicines and healthcare regulatory authority (MHRA). However when we pointed this out to the lead nurse she noted this and undertook to introduce a system for receiving safety alerts as soon as practically possible.

Reliable safety systems and processes (including safeguarding)

We spoke with the lead dental nurse about the prevention of needle stick injuries. They explained the treatment of sharps and sharps waste was in accordance with the current EU Directive with respect to safe sharp guidelines, thus protecting staff against blood borne viruses. The practice used a system whereby needles were not resheathed using the hands following administration of a local anaesthetic to a patient. The dentist was responsible for ensuring safe recapping using a specialised device. The lead dental nurse was also able to explain the practice protocol in detail should a needle stick injury occur, a protocol was on display. The systems and processes we observed were in line with the current European Union Directive about the use of safer sharps. There had been one needle stick injury to a member of staff during 2015. We observed this had been reported through the practice incident reporting system and managed in accordance with practice policy.

We asked how the practice treated the use of instruments that were used during root canal treatment. Staff explained these instruments were single use only. They explained root canal treatment was carried out where practically possible using a rubber dam. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). Patients can be assured the practice followed appropriate guidance from the British Endodontic Society in relation to the use of the rubber dam.

The practice owner acted as a point of referral should members of staff encounter a child or adult safeguarding issue. A policy was in place for staff to refer to in relation to children and adults who may be the victim of abuse or neglect. Training records showed all staff had received appropriate safeguarding training for both vulnerable adults and children. Information was available 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 there had been no safeguarding incidents that required further investigation by appropriate authorities.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Staff had received training in how to use this equipment. The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had access to an oxygen cylinder 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 were stored in a central location known to all staff. They were all in date except one medicine, glucagon. This had been stored outside of a refrigerator and although the expiry date was 2017, the practice had not adjusted the expiry date to take into account the recent guidelines on the storage of glucagon. These guidelines state the expiry date should be reduced by half if stored outside of a refrigerator.

The expiry dates of medicines and equipment were monitored using a monthly check sheet that enabled the staff to replace out of date drugs and equipment promptly. We observed the practice had equipment to deal with minor first aid problems such as minor eye problems and

Are services safe?

body fluid and mercury spillage. The practice held training sessions for the whole team to maintain their competence in dealing with medical emergencies on an annual basis. We found all staff had received update training in 2015.

Staff recruitment

The dentists and dental nurses who worked at the practice had current registrations with the General Dental Council and staff recruitment records were stored securely. The practice had a recruitment policy which detailed the checks required to be undertaken before a person started work. For example, proof of identity, a full employment history, evidence of relevant qualifications/professional registration and employment checks including references.

We looked at staff files for three staff employed and the records examined showed the registered provider had undertaken all the required checks to comply with schedule three of the Health and Social Care Act 2008 (amended 2014).

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice carried out a number of risk assessments including a well-maintained Control of Substances Hazardous to Health (COSHH) file. Other assessments included radiation, fire safety, health and safety and water quality risk assessments. The practice had a dedicated decontamination room where instruments were appropriately treated. This room was not secure which meant it was accessible to unauthorised people.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The practice had a robust infection control policy that was regularly reviewed. 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') Best Practice Requirements for infection control were being met. It was observed audits of infection control processes carried out in 2015 confirmed compliance with HTM 01-05 guidelines.

It was noted that the two dental treatment rooms, waiting area, reception and toilet areas were clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in both treatment rooms. Hand washing facilities were available including wall mounted liquid soap, hand gel and paper towel dispensers in each of the treatment rooms and toilet. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

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

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

The dental unit water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a term for particular bacteria which can contaminate water systems in buildings) they described the method they used which was in line with current HTM 01-05 guidelines. A Legionella risk assessment had been carried out at the practice by a competent person in February 2015. The recommended procedures contained in the report were carried out and logged appropriately. This included regular testing of the water temperatures of various taps in the building. These measures ensured patients and staff were protected from the risk of infection due to Legionella.

The practice had a separate decontamination room for instrument processing. This room was well organised and was clean, tidy and clutter free. The lead dental nurse demonstrated the process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a system of manual scrubbing where appropriate and the use of an automated washer disinfector for the initial cleaning process, following inspection with an illuminated magnifier they were placed in a vacuum autoclave (a device for sterilising medical and dental instruments). When instruments had been sterilized, they were pouched were appropriately stored in a non-clinical room or treatment room until required. All

pouches were dated with an expiry date in accordance with current guidelines. We were shown the systems in place to ensure that the autoclave used in the decontamination process was working effectively. It was observed the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles and steam penetration tests and the tests for the automated washer disinfector 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 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 dental waste from the practice and was stored in a separate locked location adjacent to the practice prior to collection by the waste contractor. Waste consignment notices and pre-acceptance audits were available for inspection. Patients could be assured they were protected from the risk of infection from contaminated dental waste.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclave had been serviced and calibrated in April 2015 and was due again in April 2016. The automated washer disinfector had been serviced in July 2015.

The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored securely for the protection of patients. We also found the practice dispensed medicines such as antibiotics. We observed a protocol was in place to describe the process, this included appropriate labelling, stock control and secure storage of medicines in a wall mounted lockable cabinet.

Radiography (X-rays)

The practice's X-ray machine had been serviced and calibrated in June 2014 with the next service due in 2017. We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination pack for the X-ray set along with the three yearly maintenance logs, HSE notification and a copy of the local rules. The maintenance log was within the current recommended interval of three years.

A copy of the radiological audits over a period of years was available; we saw the most recent had been carried out between July 2015 and January 2016. Dental care records we saw where X-rays had been taken showed dental X-rays were justified, reported upon 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

The dentist working at the practice provided more specialised care including orthodontics (treatment for dealing with maligned teeth and jaws) and dental implants. The dentist carried out consultations, assessments and treatment in line with recognised general professional guidelines. They described to us how they carried out their assessment of patients for routine care as well as more specialised care that included dental implants.

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 the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained in detail.

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

Dental care records we saw showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE is a simple and rapid screening tool that is used 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 waiting room and reception area at the practice contained leaflets that explained the services offered at the practice. This included information about how to carry out effective dental hygiene and how to reduce the risk of poor dental health. The practice also sold a wide range of dental hygiene products to maintain healthy teeth and gums. These were available in the reception area. The practice web site also provided information and advice to patients about how to maintain healthy teeth and gums.

The practice used a dental hygienist alongside the dentist to deliver preventive dental care. Adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. Tooth brushing techniques were explained to them 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 about prevention known as 'Delivering Better Oral Health'. Dental care records we observed demonstrated the dentist and dental hygienist 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 were 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 who was based at the practice. They told us they felt they had acquired the necessary skills to carry out their role and were encouraged to progress.

The practice employed a dentist who was supported by a dental nurse. The practice also employed a dental hygienist. However we did note the dental hygienist was working without chairside support. We drew the practice manager's attention to the advice given in the General Dental Council's Standards for the Dental Team about dental staff being supported by an appropriately trained member of the dental team at all times when treating patients in a dental setting.

Working with other services

The dentist was able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. However the practice did not need to refer many patients to other centres because of the diverse range of care provided by the dentist. The practice was relatively self-contained. The practice explained how they would work with other services when required. The practice used

Are services effective?

(for example, treatment is effective)

referral criteria and referral forms developed by other primary and secondary care providers such as oral surgery. This ensured patients were seen by the right person at the right time.

Consent to care and treatment

We spoke with the dentist about how the practice implemented the principles of informed consent; they had a clear understanding of consent issues. They explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options.

They also explained how to obtain consent from a patient who suffered with any mental health impairment that may mean they might be unable to fully understand the implications of their treatment. If there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed. They went on to say they would involve relatives and carers 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 principles help clinicians to identify children aged under 16 who have the legal capacity to consent to examination and treatment.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

All of the patients we asked said they had confidence and trust in the dentist. Treatment rooms were situated away from the main waiting area and we saw that doors were closed at all times patients were with dentists. Conversations between patients and dentists could not be heard from outside the rooms thus protecting patient's privacy.

Patients clinical records were stored electronically. Computers were password protected and regularly backed up to secure storage. Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality. On the day of our visit we witnessed patients being treated with dignity and respect by the reception staff when making appointments or dealing with other administrative enquiries.

Before the inspection, we sent Care Quality Commission comment cards to the practice for patients to use to tell us about their experience of the practice. We collected 24 completed CQC patient comment cards and obtained the views of six patients on the day of our visit. These provided a positive view of the service the practice provided. Patients commented the quality of care was very good. Patients commented that treatment was explained clearly and the staff were caring and put them at ease. They also said the reception staff were always helpful and efficient. During the inspection, we observed staff in the busy reception area 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 management options and indicative costs. Private treatment costs were displayed in the waiting area and on the practice website. The dentist 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 dentist recorded the information they had provided to patients about their treatment and the options open to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The waiting room also displayed details of private dental charges. The practice had a comprehensive website. We saw a patient information folder which contained 20 policy documents explaining the practice policies which covered a range of areas including, practice quality standards, treatment planning, prevention of dental problems and data protection. The web site and policy folder also gave details of out of hours care, the types of care offered and details of professional charges. This ensured patients had access to appropriate information in relation to their care.

We observed appointment diaries were not overbooked and this provided capacity each day for patients with pain to be fitted into specifically allocated urgent slots for each dentist. The dentists decided how long a patient's appointment needed to be and took into account any special circumstances such as whether a patient was very nervous or had a disability.

Tackling inequity and promoting equality

The practice had an equality and diversity policy and provided training for the staff team about this. Information was readily available about the Equality Act 2010 and supporting national guidance. The practice had access to translation services. A hearing loop was available for the hard of hearing and displayed in a prominent position in the reception area. The practice had a ramp available which provided level access to the waiting area and ground floor treatment room for patients with mobility difficulties and families with prams and pushchairs.

Access to the service

The practice provided extended hours to meet the needs of patients unable to attend during the working day. Appointments were available on Thursdays until 7.30pm. The practice manager told us as well as being flexible for patients the hours also enabled the practice to make appointments for courses of treatment in a timely way so patients did not have to wait too long and it also reduced pressure on appointments between 9.00am and 5.00pm. We asked 14 patients if they were satisfied with the practice opening hours and all but two said they were.

Concerns & complaints

The practice had a complaint policy and a procedure that set out how complaints would be addressed, who by, and the timeframes for responding. For example, a complaint would be acknowledged within three days and a full response would be provided to the patient within ten days. This was seen to be followed. We were told no complaints had been made in the previous 12 months.

Information for patients about how to make a complaint was seen in the patient leaflet, patient information poster in the waiting area and patient website. We asked six patients if they knew how to complain if they had an issue with the practice. Four patients said they did but two did not respond to our question.

Are services well-led?

Our findings

Governance arrangements

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

Leadership, openness and transparency

It was apparent through our discussions with the dentist and nurses the patient was at the heart of the practice with the dentist adopting a holistic approach to patient care. We found staff to be hard working, caring and committed to the work they did. Staff told us they enjoyed their work and were well supported by the owner and dentists.

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 dentists, practice manager or owner of the practice. They felt they were listened to and responded to when they did raise a concern.

Learning and improvement

We saw evidence of a programme of clinical audit, this included, dental radiography, clinical record keeping, infection prevention control, patient waiting time audit and oral cancer. This programme of audit ensured the practice maintained consistently high standards. There was evidence of repeat audits at appropriate intervals and these reflected standards and improvements were being maintained. For example Infection Prevention Society audits were undertaken every six months in accordance with current guidelines.

Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. Training was completed through a variety of resources and media provision. Staff were given time to undertake training which would increase their knowledge of their role.

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

The practice gathered feedback from patients through patient surveys, feedback cards in waiting areas, compliments and complaints. Changes made as a result of this feedback included extending opening hours of the practice on one evening a week and adding specific magazines to the list of patient reading material in the waiting room.

We saw there was a robust complaint procedure in place, with details available for patients in the waiting area and practice leaflet. All of the staff told us they felt included in the running of the practice and how the practice manager and registered provider listened to their opinions and respected their knowledge and input at meetings. A member of staff told us stocks of a specific brand of toothbrushes and consumables were added to stock as a result of their feedback.

We were told staff turnover and sickness rates were low. Staff told us they felt valued and were proud to be part of the team.