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Station House Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 18 August 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.

This was the first inspection of the service since registering with CQC in February 2015.

Station House Dental Practice is located in Barnoldswick town centre. The practice provides both NHS and private dental care. There are two dentists one of whom is the owner/principal dentist, two dental nurses one of whom is the practice manager and a marketing manager. At the time of this inspection there were 1239 patients registered with the practice. Station House offers (30%) NHS dental care services to patients of all ages and the remaining patients (70%) paid privately or had a dental payment plan in place.

The principal dentist is registered with CQC as the registered provider for the practice. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

We received feedback in CQC comment cards from 40 patients. In addition we spoke with three patients on the day of our inspection. Feedback from patients was extremely positive about the treatment and care they received at the practice. Patients were complimentary about the staff and told us they were treated with kindness, respect and compassion.

Summary of findings

The practice was situated in a converted residential property access is suitable for patients who used a wheelchair. Disabled toilet facilities were not provided but patients were made aware that these facilities were available in the nearby library. There was a treatment room and a waiting room on the ground floor. The decontamination room was adjacent to the treatment room.

There were two dentists working at the practice. The principal dentist treated patients Monday to Thursday and the other dentist worked at the practice on Fridays. They were supported by two registered dental nurses, a casual receptionist, a marketing manager and a practice manager.

The practice opening times are Monday, Tuesday, Thursday and Friday 9am until 5pm and Wednesday 9am until 8pm and alternate Saturdays 9am until 1pm.

Our key findings were:

- Staff had attended training in relation to safeguarding and whistleblowing and understood their responsibilities to protect patients from harm**.**
- There were systems in place to assess and manage risks to patients, including health and safety and the management of medical emergencies.
- Patients were involved in making decisions about their treatment and were given clear explanations about their proposed treatment including costs, benefits and risks.
- The practice had procedures in place to take into account any comments, concerns or complaints.
- There were maintenance contracts in place to ensure all equipment had been serviced regularly, including, autoclave, fire extinguishers, the suction compressor, oxygen cylinder and X-ray equipment.
- There were effective systems in place to reduce the risk and spread of infection. The premises were visibly clean and well maintained. There were policies and procedures providing guidance on how to maintain a clean and hygienic environment.
- The patients we spoke with and all the comment cards we reviewed indicated that staff were kind and respectful.
- Patients gave signed consent before treatment commenced. Patient's dental care records showed on-going monitoring of their oral health.
- Patients were asked to provide information about their general health and any medications they were taking before treatment started.
- Patients were provided with a written copy of their treatment plan which also indicated the costs of individual treatments.
- The practice had an accessible and visible leadership team. Staff were supported to maintain their continuing professional development (CPD) and had undertaken training appropriate to their roles.
- The patients we spoke with and staff reported that patients were at the heart of the practice.

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

- Ensure the local rules relating to radiation protection are practice specific and review the arrangements for seeking advice from a radiation protection advisor (RPA) regarding the Ionising Radiation Regulations 1999 (IRR99).
- Review policies and procedures to ensure they are practice specific.

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.

There were safeguarding procedures in place for staff to follow. Staff had received training in relation to child protection and adult safeguarding and knew how to make a referral if they suspected abuse was taking place. Staff were aware of their responsibilities to raise concerns and

report incidents and accidents.

There were recruitment procedures that included a criminal records check with the Disclosure and Barring Service (DBS). This was to make sure people employed were not barred from working in the health and social care sectors.

There were systems in place for the safe management of medical emergencies and infection prevention and control. Emergency medicines in use at the practice were stored safely and checked to ensure they were within the manufacturer's expiry dates and safe for use. Audits of the quality of X-ray images were carried out on a regular basis. Records did not identify if a radiation protection advisor (RPA) was available to provide advice when required.

Patients' were asked to provide information about their medical histories before any treatment took place. This was to ensure the dentist was aware of any health or medication issues which could affect the planning of treatment.

Are services effective?

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

Treatments were carried out in accordance with best practice guidelines from the Faculty of General Dental Practice (FGDP) and National Institute for Health and Care Excellence (NICE).

Patients' oral health was monitored and appropriate health promotion advice was provided in line with the 'Delivering Better Oral Health' toolkit (DBOH) with regards to fluoride application and oral hygiene advice.

Are services caring?

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

Feedback in CQC comment cards was complimentary and showed that patients felt well supported. We also saw the practice used practice patient questionnaires and the practice website to gather feedback from patients.

Patients were treated with respect and involved in planning their treatment.

Patients who were in pain were responded to in a timely manner and usually were seen by the dentist on the same day or within 24 hours. Information about emergency treatment and out of hours contact details were available on the telephone answering machine, in the patient folder and on the website.

Are services responsive to people's needs?

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

There were procedures in place to guide staff on responding to complaints. This included acknowledging the complaint, a record of the investigation and the response. Staff were familiar with the complaints procedure. There had been no complaints since the principal dentist took over the practice in November 2014.

Summary of findings

Information about the practice and the services offered was available in the practice information leaflet and via the practice website.

There was an efficient appointment system in place and appointments slots were held each day for urgent or emergency appointments.

Are services well-led?

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

There were clear lines of accountability and leadership within the practice and staff told us they felt supported in their roles.

Staff were supported with their development and learning which was a requirement of their professional registration. The practice staff met regularly to review all aspects of the delivery of dental care and the management of the practice.

The practice carried out regular audits of clinical and non-clinical areas as part of a system of continuous improvement.

Station House Dental Practice

Detailed findings

Background to this inspection

This inspection was carried out on 18 August 2015. The inspection was carried out by a CQC inspector and a dental specialist advisor.

Prior to the inspection we reviewed information we held about the provider including any notifications.

During the inspection we were given a tour of the premises and spoke with the principal dentist, the dental nurses one of whom was the practice manager and the marketing manager. In order to assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

The practice sent us their statement of purpose, staffing levels and a summary of complaints/compliments they had received in the last 12 months.

We informed NHS Area Team that we were inspecting the practice; however we did not receive any information of concern from them.

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 were policies and procedures in place to investigate, respond to and learn from complaints, accidents and incidents. We saw minutes of a staff meeting where an incident was discussed and additional procedures put in place to prevent repeat incidents.

If there was an accident or incident that affected a patient the principal dentist would offer an apology and inform the patient of the action taken to prevent a reoccurrence. We reviewed one

significant incident the practice had recorded in the last 12 months. Lessons learnt from this incident were shared with all staff. The principal dentist and dental nurses understood their responsibilities in respect of the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR).

The practice responded to national patient safety and medicines alerts that affected the dental profession.

Reliable safety systems and processes (including safeguarding)

The principal dentist was the named practice lead for child and adult safeguarding. There were child protection and vulnerable adult policies and procedures in place to guide staff. These included identifying and reporting suspected abuse and the contact details of the local safeguarding authority. Staff were able to tell us how they would respond/report concerns if they suspected abuse or neglect.

The practice had a policy and procedure in place for responding to complaints. The policy detailed how complaints and concerns would be investigated, responded to and how lessons learned would be shared with staff. The complaint policy gave details of other bodies patients could contact such as; The Parliamentary Health Services Ombudsman (PHSO).

There was a whistle blowing policy and the staff we spoke with were aware of the policy and told us they would feel confident in reporting any concerns about another staff member if it was necessary. Staff told us that they were confident that the principal dentist would support them through this process.

The practice had safety systems in place to help ensure the safety of staff and patients. There was guidance about responding to a sharps injury (where a used needle or sharp instrument punctures the skin). The practice used dental safety syringes which had a needle guard in place to support staff use and to dispose of needles safely in accordance with the European Union Directive; Health and Safety (Sharps Instruments in Healthcare) Regulations 2013.

There were adequate supplies of personal protective equipment such as face visors and heavy duty rubber gloves for use when manually cleaning instruments. The principal dentist told us that endodental files used during root canal treatments were single use only. Rubber dams were used in root canal treatment in line with guidance from the British Endodontic Society. A rubber dam is a thin, rectangular sheet, usually latex, used in dentistry to isolate the site and prevent patients inhaling or swallowing debris or small instruments.

Medical emergencies

There was a written procedure to follow in the event of a medical emergency. The practice had an oxygen cylinder and emergency medicines for use in the event of a medical emergency including angina, asthma, chest pain and epilepsy. This was in line with the Resuscitation Council UK guidelines and the guidance on emergency medicines in the British National Formulary (BNF). We saw regular checks were carried out to ensure oxygen levels and flow rates were sufficient and that medicines were within the manufacturers use by date and safe to use.

The practice had an automatic external defibrillator (AED). An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. We saw records to demonstrate that all staff had attended cardiopulmonary resuscitation (CPR) training in May 2015.

There was an appointed first-aider, and an easily accessible first aid kit. All of the staff knew where the emergency equipment was located in the practice and were trained in how to use it.

Staff recruitment

There were effective recruitment and selection procedures in place that described the process for employing new staff.

Are services safe?

We looked at the recruitment files of two members of staff and found they contained appropriate documentation which included education and employment history, evidence of qualifications and professional registration with the General Dental Council (GDC). The GDC registers all dental care professionals to make sure they are appropriately qualified and competent to work in the United Kingdom. The practice had a system in place for monitoring professional registration and medical indemnity.

All of the clinical staff had a Disclosure and Barring Service (DBS) check to ensure they were not barred from working in the health and social care sector.

There was an induction programme in place for all new staff to familiarise them with how the practice worked.

Monitoring health & safety and responding to risks

There were arrangements in place to manage any foreseeable emergencies. The practice had a risk management process to ensure the safety of patients, visitors and staff members.

The practice had policies and procedures designed to manage any risks to patients, staff and visitors associated with substances hazardous to health. This was in line with the Control of Substances Hazardous to Health 2002 (COSHH) regulations.

A fire risk assessment had been carried out, fire extinguishers had been serviced and staff attended regular fire drills so they were aware of how to respond in the event of a fire at the practice. There was a business continuity plan that detailed the process for dealing with any emergencies that would disrupt the safe running of the practice. This included failure of the electricity or water supplies, damage to the premises and disruption of the telephone service. Emergency contact numbers were recorded, a copy of the plan was held in the practice and a copy held by the principal dentist.

In the event of the emergency closure of the practice arrangements were in place for another local dentist to see any patients requiring treatment.

Infection control

There was a cleaning plan and cleaning equipment was stored appropriately in line with Control of Substances Hazardous to Health (COSHH). We were given a tour of the premises and found all areas were visibly clean and free from clutter. Floor covering was impervious and surfaces in the treatment area and decontamination room were sealed to minimise the risk of cross contamination. Patients we spoke with and who completed Care Quality Commission comments cards gave positive comments on how clean the practice was.

There was an infection control policy which included minimising the risk to staff of blood-borne viruses, sharps injuries, decontamination of dental instruments, segregation and disposal of clinical waste and hand hygiene. There was a service level agreement with a clinical waste collection contractor. There were protocols for the management of clinical waste and sharp instruments.

The practice had followed guidance about decontamination and infection control in accordance with the Department of Health: Health Technical Memorandum 01-05; Decontamination in primary care dental practices (HTM 01-05) and the 'Code of Practice about the prevention and control of infections and related guidance'.

One of the dental nurses described the decontamination process to us. Personal protective equipment (PPE) such as heavy duty gloves, plastic apron, masks and eye protection were worn. The practice used an instrument transportation system (a rigid plastic box with a clip lock) to ensure the safe movement of instruments between treatment rooms and the decontamination room. There was a clear flow from dirty to clean areas within the decontamination room. Sinks were clearly identified as clean and dirty. The practice used manual cleaning; used instruments were washed and scrubbed in the dirty sink before rinsing in the clean sink. Once cleaned the instruments were examined under an illuminated magnifying glass to check they were free from debris and placed into the autoclave (a high temperature high pressure vessel used for sterilisation). Sterilised instruments were then placed in sealed pouches with a use by date. Any instruments not used within this date went through the decontamination process again.

The autoclave was maintained and serviced in accordance with the manufacturers guidelines. We saw the documents staff used to record the essential validation checks of the sterilisation cycles to show the equipment was in good working order.

Are services safe?

Posters about good hand washing techniques and the decontamination procedures were displayed to support staff in following practice procedures.

There was a system in place to check water lines every three months using a dip stick to test for Legionella. (Legionella is a term for particular bacteria which can contaminate water systems in buildings).

Equipment and medicines

The practice maintained a comprehensive list of all equipment including dates when maintenance contracts required renewal. We saw documentary evidence that equipment such as; fire extinguishers, X-ray equipment and the air compressor had been serviced on a regular basis.

There were medicines available for use in the event of an emergency. One of the dental nurses was responsible for auditing these medicines to ensure they were within the use by date and safe to use. We checked the emergency medicines and found all but the GTN spray were in date. This was raised with the principal dentist and arrangements were made to replace the spray.

Where local anaesthesia was used we saw the batch number and expiry dates were recorded in dental care records.

Radiography (X-rays)

We reviewed the radiation protection file which was the file used by the previous owner of the practice. We found the local rules made reference to the previous owner. This was discussed with the principal dentist and they gave assurances that the local rules would be updated at the end of the day.

The principal dentist was the named radiation protection supervisor (RPS). There was a maintenance contract in place with an external company but it was not clear if this covered the role of radiation protection adviser (RPA an expert in radiation protection). The principal dentist should ensure a suitably qualified radiation protection advisor (RPA) is appointed to give advice on the Ionising Radiation Regulations 1999 (IRR99).

We saw all the necessary documentation relating to the maintenance of the X-ray equipment. We saw that the justification for taking dental X-rays was recorded and reported on. The practice monitored the quality of the X-rays images on a regular basis and records were being maintained. We also saw a copy of the most recent audit of X-ray images and this demonstrated that X-rays were of the appropriate standard and highlighted any areas for improvements.

Continuing professional development records showed staff responsible for carrying out X-rays had attended training.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Patient's dental care records were held in both paper and electronic formats. Paper records were securely stored in a locked office, access to electronic records was password protected and files were backed up.

Dental assessments were carried out in line with recognised guidance from the Faculty of General Dental Practice UK (FGDP) and General Dental Council (GDC) guidelines.

Each patient was asked to provide a medical history outlining any health conditions, current medicines being taken and any allergies identified. We saw evidence that the medical histories were updated at subsequent visits. We saw patients were asked for verbal and written consent to treatment and a copy was retained in their dental care record.

We reviewed a sample of 10 dental care records and found they contained the findings of the assessment and details of the treatment carried out. We saw details of the condition of the teeth, gums and soft tissues lining the mouth using the basic periodontal examination (BPE) scores. (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 at each dental health assessment and BPE scores were noted in patient's dental care records.

Patients requiring specialised treatment such as conscious sedation were referred to other dental specialists. They were then referred back to the practice for on-going monitoring and treatment.

We saw the justification for taking X-rays was recorded in line with guidance issued by the FGDP and Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000 about selection criteria for dental radiography.

Health promotion & prevention

All of the staff we spoke with were aware of the Department of Health publication -'Delivering Better Oral Health; a toolkit for prevention' which is an evidence based toolkit to support dental practices in improving their patient's oral and general health.

Information leaflets on oral health were available in patient areas. The principal dentist gave advice regarding good oral health including; fluoride applications, dietary advice, smoking cessation and alcohol consumption. General dental hygiene procedures such as prescribing dental fluoride treatments were also discussed and recorded.

The dentist referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to deciding appropriate intervals for recalling patients for check-ups.

Staffing

The staff group consisted of the principal dentist/owner and an associate dentist. They were supported by three dental nurses one of whom was also practice manager, a temporary receptionist and a marketing manager. There was an induction programme in place for new members of staff and records confirmed this was used.

Dentists and dental nurses were responsible for their own continuing professional development (CPD). Providing evidence to demonstrate continued learning was a requirement of their professional registration with the General Dental Council (GDC). We saw CPD files containing records of all training they had attended including areas such as responding to medical emergencies and infection control. This ensured that staff had the right skills and knowledge to carry out their work. Records showed professional registration with the GDC was up to date for all relevant staff. There was an effective appraisal system in place which was used to identify training and development needs.

The associate dentist and/or a locum dentist provided cover for the principal dentist when they were on leave. Dental nurses covered for each other's leave to make sure patient care was not disrupted.

Working with other services

The practice had a system in place for referring, recording and monitoring patients for dental treatment/surgery and specialist procedures. We saw that referral letters were detailed and if requested patients were given a copy. Progress was monitored by the practice manager to ensure patients received care and treatment needed in a timely manner. Following specialist treatment patients were referred back to the practice for on-going monitoring.

Consent to care and treatment

Are services effective?

(for example, treatment is effective)

There was guidance for staff about implied, verbal or written consent and in which situations each could be used. The dentist and dental nurses were knowledgeable with regard to gaining informed consent prior to treatment commencing. Examples were given; verbal consent when a patient says they are happy to have an X-ray and implied consent when the patient opens their mouth for the dentist to examine them.

Staff showed an understanding of the principles of the Mental Capacity Act 2005 (MCA) and how it was relevant to dentistry and ensuring patients had the capacity to consent to treatment. We saw evidence to show staff had attended training sessions relating to the MCA.

The dentist told us they would use the Gillick competence to assess if a young person was able to give informed consent. The Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

We looked at a sample of 10 dental care records and saw evidence that patients were advised of their treatment options. We saw consent forms which were signed by the patient.

The feedback in CQC comment cards and the patients we spoke with demonstrated that patients were given enough information to make an informed decision about treatment options before they signed consent forms.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We saw that all staff at the practice treated patients with respect and maintained their privacy and dignity. We observed positive interactions between staff and patients arriving for their appointment staff engaged well with their patients asking about their weekend or family. Patients were greeted with a smile and staff were courteous and friendly.

There was a small enclosed hallway between the waiting room and treatment room. The treatment room door was closed when patients were with the dentist and conversations could not be heard from the waiting room. If a patient wanted to speak privately when booking in a separate room was available to use.

To maintain confidentiality electronic dental care records were password protected and paper records were securely stored in a locked office accessed by a digital key code. The design of the reception desk ensured any paperwork and the computer screen could not be viewed by patients booking in for their appointment.

Policies and procedures in relation to data protection and confidentiality were in place and staff were aware of these. The policy covered disclosure and the secure handling of patient information. The principal dentist was responsible for protecting patients' data in accordance with the Caldecott principles (The Caldecott report 1997 the Review of Patient-Identifiable Information the aim of the report was to ensure that patient-identifiable information was shared only for justified purposes).

We reviewed 40 completed CQC comments cards and found patient comments were overwhelmingly positive about staff at the practice. Patients commented that the team were courteous, efficient and kind and that they were happy with the quality of treatment provided.

Involvement in decisions about care and treatment

The patients we spoke with and feedback in CQC comment cards confirmed treatment options, costs, risks and benefits of any treatments were discussed with them. Patients were given time to consider their treatment options and commented that they felt involved in any decisions and trusted the practice.

Patient's told us they felt very involved in their treatment, it was fully explained to them and they did not feel any pressure to make a decision on the day treatment was discussed. Dental care records contained a detailed explanation of the treatment and treatment specific consent forms.

The practice provided patients with information to enable them to make informed choices. Staff told us if they were concerned about a patient's ability to make an informed decision they would check if a capacity assessment had been carried out and involve the patients' relatives or carers.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The patient folder in the waiting gave information about the types of treatments provided information was also available on the practice website. Treatments included; regular check-ups, tooth whitening, bridges, fillings, extractions, root canal treatments and crowns.

Patients told us they did not have any problems arranging an appointment at the practice. Vacant appointment slots were kept to accommodate urgent or emergency appointments. Patients with dental emergencies were seen on the same day or within 24 hours of contacting the practice. The practice had an answer phone for patients that gave them details about how to access emergency treatment when the practice was closed. We checked the provider's website and the patient information folder and found both included this information.

Patient feedback in CQC comment cards and from patients we spoke with on the day confirmed they had flexibility and choice to arrange appointments to fit in with work and family commitments.

Tackling inequity and promoting equality

The practice was located in a converted residential property in the centre of the village close to a municipal car park. The reception/waiting room and treatment room were situated on the ground floor and accessible for patients who had limited mobility.

Patients who used a wheelchair would be offered assistance from staff to access the treatment room. The practice did not have disabled toilet facilities and had considered how they could make reasonable adjustments to remedy this. Patients were able to use facilities in the library which was close by, alternatively information about other dentists in the area was provided.

The practice had an equality and diversity policy in place to support staff in understanding and meeting the needs of patients. The staff had access to a telephone language translation service should this be required for any patients to whom English was a second language.

Access to the service

The practice opening times were Monday, Tuesday, Thursday and Friday 9am until 5pm and Wednesday 9am until 8pm and alternate Saturdays 9am until 1pm. The patient folder and website detailed the range of services offered to patients. The practice provided NHS (30%) and private (70%) treatments and a dental payment plan was available for patients who preferred this method of payment. There was information in the waiting area and patient folder with details of NHS and private dental charges.

The arrangements for accessing emergency dental treatment were clearly displayed in the patient folder in the waiting room.

There was a comments box in reception and the practice used the friends and family test (FFT a comment card asking if patients would recommend the service to friends and family if they needed similar care or treatment). We looked at the completed FFT cards for the two months prior to our inspection and found all of the patients who completed a card would be extremely likely to recommend the practice.

Concerns & complaints

There was a complaint policy and procedure in place. Information on how to raise a complaint and how it would be dealt with was available in the patient folder in the waiting room. The principal dentist or practice manager were responsible for dealing with any concerns or complaints. There had been no complaints in the past 12 months but the principal dentist told us they would learn from any complaints and take action to ensure the situation was not repeated.

The patients we spoke with on the day of our inspection told us they had no complaints about their treatment at this practice. If they did have to raise any concerns the patients we spoke with felt that staff at the practice would take them seriously and investigate.

Are services well-led?

Our findings

Governance arrangements

The practice had a statement of purpose that described their vision, values and objectives. There were a range of policies and procedures in place to guide staff on; infection prevention and control, safeguarding, health and safety, confidentiality and recruitment. There were systems in place for monitoring and improving the services provided for patients.

There was a clear leadership structure in place and staff were aware of their roles and responsibilities within the practice. We saw the principal dentist and practice manager shared lead roles such as; infection control, health and safety and safeguarding.

We saw the practice identified and managed risks relating to cross contamination, the environment and fire safety had been recognised and there were plans in place to minimise these risks.

The practice had robust governance procedures in place. Quality assurance processes used to drive improvement included a system of clinical and non-clinical audits of dental care records, consent, confidentiality, emergency medicines, radiography to check the quality of X-ray images, infection control, training and record keeping. We saw where areas for improvement were identified appropriate action had been taken.

Leadership, openness and transparency

We spoke with dental nurses who described a culture of candour, openness and honesty. The dental nurses reported there was a positive atmosphere and they felt valued and supported by the principal dentist. They told us they felt able to raise any issues or concerns that would be listened to and acted upon. They were aware that they could raise concerns with external agencies, such as; NHS England, the GDC and the Care Quality Commission (CQC), if they felt this was needed.

We found the staff were enthusiastic about their role within the practice and were complimentary about the principal dentist. The principal dentist told us their aim was to provide a high quality of care and improve outcomes for patients.

Management lead through learning and improvement

All of the staff at the practice were focused on achieving high standards of clinical excellence and improving the patient experience. There were regular monthly staff meetings used to method for cascading information to all practice staff.

We reviewed a sample of the minutes kept for staff meetings and found that topics such as; audits and accounts were discussed. For example, we looked at the minutes of a meeting in July 2015 during which staff had discussed the results of the recent X-ray audit. We saw that staff signed the minutes of the meeting to show they agreed with the content.

Staff told us that the principal dentist supported them to maintain their continuing professional development (CPD) which is a requirement of their registration with the General Dental Council (GDC).

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

Staff told us that patients could give feedback at any time they visited. A patient survey had been

carried out in the period from February 2015 to August 2015 and the results of this had been positive. We reviewed the completed surveys and found patients expressed a high level of satisfaction with the comfort of the waiting room, promptness of the dentist, explanation of treatment and costs and the attitude of staff.

We looked at completed NHS Friends and Family comment cards that had been collated over the last two months. We found patient comments were positive with the majority stating they would be extremely likely to recommend the practice to friends and family. In addition the practice had a comments box which was reviewed weekly and patients were able to leave comments on the practice website.