Arc Orthodontics Limited

Shrewsbury Orthodontic Centre

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 25 February 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

Shrewsbury Orthodontic Centre is a specialist dental practice providing orthodontic treatment to children and some adults mainly on a referral basis (Orthodontics is a specialist branch of dentistry concerned with the alignment of the teeth and jaws to improve the appearance of the face, the teethand their function). Orthodontic treatment is provided under NHS regulations for children except when the problem falls below the accepted eligibility criteria for NHS treatment. Private treatment is available for these patients as well as adults who require orthodontic treatment. The practice is situated in a converted residential property, a Grade 2 listed building. The practice had three dental treatment rooms and a separate decontamination room for cleaning, sterilising and packing dental instruments. Also included were a reception and waiting area.

The practice is open 8.45am - 5.00pm Monday to Thursday and Friday 8.45 - 1.30pm. The practice has two specialist dentists known as orthodontists and are supported by four dental nurses, an orthodontic therapist, a practice manager and two receptionists.

The practice manager is the registered manager. A registered manager is a person who is registered with the

Summary of findings

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.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice. We received feedback from 49 patients. These provided a completely 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:

- We found that the practice ethos was to provide patient centred quality orthodontic care.
- Strong and effective leadership was provided by the practice owner and an empowered practice manager.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice appeared very clean and well maintained.
- Infection control procedures were robust and the practice followed published guidance.
- The practice had a safeguarding lead with effective processes in place for safeguarding adults and children living in vulnerable circumstances.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- The orthodontists provided care in accordance with current professional guidelines.
- The practice had fully embraced the concept of skill mix to assist in the delivery of effective orthodontic care to patients.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Staff recruitment files were organised and complete.
- Staff had received training appropriate to their roles and were supported in their continued professional development (CPD) by the practice owner and practice manager.
- Staff we spoke with felt well supported by the practice owner and practice manager and were committed to providing a quality service to their patients.
- Information from 49 completed Care Quality Commission (CQC) comment cards gave us a completely positive picture of a friendly, caring, professional and high quality service.

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 areas such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found that all the equipment used in the dental practice was 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 orthodontic care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance in relation to orthodontics including that from the British Orthodontic Society to guide their practice. We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals. The staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

Are services caring?

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

We collected 49 completed Care Quality Commission patient comment cards and obtained the views of a further six patients on the day of our visit. These provided a completely positive view of the service the practice provided. All of the patients commented that the quality of care was very good. Patients commented on friendliness and helpfulness of the staff and the orthodontists were good at explaining the treatment that was proposed.

Are services responsive to people's needs?

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

The service was aware of the needs of the local population and took those these into account in how the practice was run. Patients could access treatment and urgent and emergency care when required. The practice provided patients with written information in language they could understand and had access to telephone interpreter services when required. Patients who could not access the building because it's Grade 2 listed status were referred to the local hospital for their orthodontic treatment.

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 that they felt well supported and could raise any concerns with the practice owner and practice manager. All the staff we met said that they were happy in their work and the practice was a good place to work.

Shrewsbury Orthodontic Centre

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 25 February 2016 was led by a CQC inspector who was supported by a specialist dental adviser. Prior to the inspection, we asked the practice to send us some information that we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, and the details of their staff members including proof of registration with their professional bodies.

We informed NHS England area team that we were inspecting the practice; however, we did not receive any information of concern from them.

During the inspection, we spoke with the practice owner, a specialist orthodontist, practice manager, dental nurses and receptionist and reviewed policies, procedures and other documents. We also obtained the views of six patients on the day of our visit. We reviewed 49 comment cards that we had left 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 manager described a good awareness of RIDDOR (The reporting of injuries diseases and dangerous occurrences regulations). The practice had an incident reporting system in place when something went wrong; this system also included the reporting of minor injuries to patients and staff. The practice reported that there were several incidents during 2015 that required investigation. We found that these incidents had been investigated thoroughly and the learning outcomes had been shared with staff during regular practice meetings in accordance with the practice policy. The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA). The practice manager explained that relevant alerts would also be discussed during staff meetings to facilitate shared learning these meetings occurred on a regular basis, usually between one and three months.

Reliable safety systems and processes (including safeguarding)

We spoke to the practice manager about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current EU directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne diseases. Due to the nature of the treatment, local anaesthetic was used very infrequently. When it was used the practice operated a system whereby needles were not manually resheathed using the hands following administration of a local anaesthetic to a patient. The orthodontists were responsible for ensuring safe recapping using a specialised metal block. This is a recognised method used in dentistry for the recapping of used needles. Orthodontists were also responsible for the disposal of wires and other sharps used in orthodontic treatment. A practice protocol was in place should a needle stick injury occur. The systems and processes we observed were in line with the current EU directive on the use of safer sharps.

We saw that the practice treated the risk of fire very seriously due to the listed nature of the building. The practice manager was responsible for fire safety and acted as the fire warden for the building. We saw detailed fire risk assessments and that these fully mitigated the risks against fire. The practice had appropriate signage and floor plans on display and the fire extinguishers and emergency lighting were maintained on a regular basis. On the day of our visit the practice carried out their regular fire alarm test.

The practice manager acted as the safeguarding lead and 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 that all staff had received appropriate safeguarding training for both vulnerable adults and children. Information was displayed in the practice that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an automated external defibrillator (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 oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines and oxygen we saw were all in date and stored in a central location known to all staff. The practice held training sessions each year for the whole team so that they could maintain their competence in dealing with medical emergencies. Staff we spoke with demonstrated they knew how to respond if a person suddenly became unwell.

Staff recruitment

All of the orthodontists, orthodontic therapist and dental nurses had current registration with the General Dental Council, the dental professionals' regulatory body.The practice had a recruitment policy that detailed the checks required to be undertaken before a person started work.For

Are services safe?

example, proof of identity, a full employment history, evidence of relevant qualifications, adequate medical indemnity cover, immunisation status and references. The systems and processes we saw were in line with the information required by Regulation 18, Schedule 3 of Health & Social Care Act 2008 (Regulated Activities) Regulations 2015. Staff recruitment records were stored securely to protect the confidentiality of staff personal information. We saw that all staff had received appropriate checks from the Disclosure and Baring Service (DBS). These are checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice maintained a comprehensive system of policies and risk assessments and included radiation, fire safety, general health and safety and those pertaining to all the equipment used in the practice. The practice had in place a well-maintained Control of Substances Hazardous to Health (COSHH) file. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The practice had in place a robust infection control policy that was regularly reviewed. It was demonstrated through direct observation of the cleaning process and a review of practice protocols that HTM 01 05 (national guidance for infection prevention control in dental practices') Essential Quality Requirements for infection control were being exceeded. It was observed that audit of infection control processes carried out in February 2016 confirmed compliance with HTM 01 05 guidelines.

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

The drawers of a treatment room were inspected and these were clean, ordered and free from clutter. Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

A 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 water lines.

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) they described the method they used which was in line with current HTM 01 05 guidelines. We saw that a Legionella risk assessment had been carried out at the practice by a competent person. The recommended procedures contained in the report were carried out and logged appropriately. These measures ensured that patients' and staff were protected from the risk of infection due to Legionella.

The practice had a separate decontamination room for instrument processing. The 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 and a washer disinfector for the initial cleaning process, following inspection with an illuminated magnifier they were placed in an autoclave (a device for sterilising dental and medical instruments). When instruments had been sterilized, they were pouched and stored until required. We were shown the systems in place to ensure that the autoclaves used in the decontamination process were working effectively. It was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were always complete and up to date.

Are services safe?

All recommended tests utilised as part of the validation of the washer disinfector were carried out in accordance with current guidelines, the results of which were recorded in an appropriate log book.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained and was in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. This was stored securely prior to collection by the waste contractor. Waste consignment notices were available for inspection. Patients' could be assured that 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 two autoclaves had been serviced and calibrated in April 2015. The practices' X-ray machines had been serviced and calibrated as specified under current national regulations in December 2014. Portable appliance testing (PAT) had been carried out in February 2016.The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored securely for the protection of patients. We found that the practice stored prescription pads in a safe overnight to prevent loss due to theft. We observed that the practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid and mercury spillage.

Radiography (X-rays)

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 packs for each X-ray set along with the three yearly maintenance logs and a copy of the local rules. The maintenance logs were within the current recommended interval of three years.

The file included a copy of the radiological audits for each orthodontist was carried out on a quarterly basis. Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured. These findings showed that 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 Regulations.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The orthodontist we spoke with carried out consultations, assessments and treatment in line with recognised general professional guidelines and the guidance provided by the British Orthodontic Society. The orthodontist described to us how they carried out their assessment of patients for a course of orthodontic treatment. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination of the patients jaw and tooth relationships and the factors that affected these relationships. Following the clinical assessment the diagnosis was then discussed with the patient their parents, guardians or carers and treatment options explained in detail.

Where relevant, preventative dental information was given in order to improve the outcome of orthodontic treatment for the patient. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products specifically designed for orthodontic patients. 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 if private orthodontic treatment had been proposed. Patients were monitored through follow-up appointments and these typically lasted between eighteen months to two years for a course of orthodontic treatment.

The practice used an orthodontic therapist to improve the outcomes for patients (Orthodontic therapists are registered dental professionals who carry out certain parts of orthodontic treatment under prescription from a dentist). They worked within their scope of practice to prescriptions provided by the orthodontist. We saw several examples of detailed treatment plans provided by the orthodontist which the therapist followed to complete each patient's treatment plan. Dental care records that were shown to us by the orthodontist demonstrated that the findings of the assessment and details of the treatment carried out were recorded appropriately. The records were comprehensive, detailed and well maintained.

To monitor the quality of the orthodontic treatment provided the practice used a system known as peer assessment rating or PAR scoring. The PAR index is a fast, simple and robust way of assessing the standard of orthodontic treatment that an individual provider is achieving. The orthodontist explained that the practice was achieving a high level of improved outcomes for patients when judged by an independent scoring assessor.

Health promotion & prevention

The practice was very focussed on the prevention of dental disease and the maintenance of good oral health during the patients' course of orthodontic treatment. To facilitate this aim the practice used a number of strategies. For example, the waiting room at the practice contained literature in leaflet form and a video screen that explained about how to reduce the risk of poor dental health. Following the first treatment session a dental nurse would provide intensive oral hygiene instruction and details on how to look after the orthodontic braces to prevent problems during the course of orthodontic treatment. Patients would then be given a list of dental hygiene products suitable for maintaining their orthodontic braces; these were available for sale in reception. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. Underpinning this was a range of leaflets explaining how patients could maintain good oral health during their orthodontic treatment. The practice manager explained that the practice owner also visited local schools where they supported teachers and demonstrated to children how to maintain healthy teeth and gums and the importance of maintaining a healthy diet.

Staffing

The practice has two specialist orthodontists and are supported by four dental nurses, an orthodontic therapist, a practice manager and two receptionists. We observed a friendly and professional atmosphere at the practice. The staff appeared to be a very effective and cohesive team; they told us they felt supported by the practice owner and practice manager. They told us they felt they had acquired the necessary skills to carry out their role and were encouraged to progress.

There was effective use of skill mix in the practice. The practice encouraged the development of the extended duty dental nurse role (EDDN). For example, we found that

Are services effective?

(for example, treatment is effective)

dental nurses had received additional training in the taking of dental X-rays, specialist orthodontic nursing, impression taking, dental photography and oral health education. We confirmed that the dental nurses received an annual appraisal and had personal development plans. These appraisals were carried out by the practice manager.

The practice manager showed us their system for recording training that staff had completed. These contained details of continuing professional development (CPD), confirmation of current General Dental Council (GDC) registration, and current professional indemnity cover where applicable. All of the patients we asked on the day of our visit said they had confidence and trust in the dentists. This was also reflected in the Care Quality Commission comment cards we received.

Working with other services

The practice was a specialist referral practice for orthodontics for practices across the Shropshire area and into Powis in Wales. Referring practices were required to complete a bespoke referral form to access services at the practice that had been developed by the local managed clinical network for orthodontics. The practice owner explained how they would work with other services if the referral required other specialist input such as that from consultant restorative and maxillo-facial services. To engage with local dentists and secondary care services, the practice provided 'open evenings' from time-to-time to explain about the services offered by the practice. This involved the use of 'table' clinics' where all of the practice staff provided information on how to refer to the practice, the criteria for NHS orthodontic services, the different types of appliances used and care of orthodontic appliances.

Consent to care and treatment

We spoke with the orthodontists about how they implemented the principles of informed consent; they had a very clear understanding of consent issues. They explained how individual treatment options, risks, benefits and costs where appropriate 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. This included the extensive use of dental photography which was used as part of the initial patient assessment and throughout the course of the orthodontic treatment to provide a record of the progression of the treatment through to the final treatment outcome.

Staff were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. The orthodontists went onto explain how they would obtain consent from a patient who suffered with any mental impairment that may mean that 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 if appropriate to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting areas and we saw that doors were closed at all times when patients were with dentists. Conversations between patients and dentists could not be heard from outside the treatment rooms which protected patient's privacy. Patients' clinical records were stored electronically and in paper form. Computers were password protected and regularly backed up to secure storage with paper records stored in lockable records storage cabinet in the reception area. 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.

Before the inspection, we sent Care Quality Commission (CQC) comment cards so patients could tell us about their experience of the practice. We collected 49 completed CQC patient comment cards and obtained the views of six patients on the day of our visit. These provided a completely positive view of the service the practice provided. All of the patients commented that the quality of care was very good. Patients commented that treatment was explained clearly and the staff were caring and put them at ease. They also said that the reception staff were always helpful and efficient. During the inspection, we observed staff in the reception area. We observed that they were polite and helpful towards patients and that the general atmosphere was welcoming and friendly.

Involvement in decisions about care and treatment

Although the vast majority of orthodontic treatment that is provided to young people under the age of 18 is free of charge under NHS regulations, the practice provided details of the costs of private orthodontic treatment. These details were available in the waiting room and on the practice website. The orthodontist 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 orthodontists recorded the information they had provided to patients about their treatment and the options open to them. This included information recorded on the standard orthodontic NHS treatment planning forms where applicable.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

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 the practice patient information leaflet. This explained opening hours, emergency 'out of hours' contact details and arrangements, staff details and how to make a complaint. The practice web site also contained useful information to patients such as how to book appointments on-line and how to provide feedback on the services provided. We observed that the appointment diaries were not overbooked and the orthodontists 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 and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to help prevent inequity for patients that experience limited mobility or other issues that hamper them from accessing services. Due to the fact that the building had listed status the practice were limited to the adjustments that could be made. We did observe that hand rails had been placed on some of the stairways that were steep to assist patients with limited mobility. The form used by referring dentists did give the opportunity of providing details of problems of a physical nature that prevented patients from accessing the building. In these cases, the practice would then refer patients to the local hospital for their orthodontic care.

Access to the service

The practice is open 8.45am - 5.00pm Monday to Thursday and Friday 8.45am - 1.30pm. The practice used the NHS 111 service to give advice in case of a dental emergency when the practice was closed. This information was publicised in the practice information leaflet, practice website and on the telephone answering machine when the practice was closed.

Concerns & complaints

The practice had a complaints policy and a procedure that set out how complaints would be addressed, who by, and the time frames for responding. The practice manager explained the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was an effective system in place which ensured a timely response. Information for patients about how to make a complaint was seen in the patient leaflet, poster in the waiting area and patient website. The practice had received no complaints. The absence of complaints reflected the caring and compassionate ethos of the whole practice.

Are services well-led?

Our findings

Governance arrangements

The governance arrangements of the practice were developed through a process of continual learning and improvement. The governance arrangements for this location consisted of the practice owner and the practice manager who were responsible for the day to day running of the practice. The practice maintained a comprehensive system of policies and procedures. All of the staff we spoke with were aware of the policies and how to access them. We noted management policies and procedures were kept under review by the practice manager on a regular basis.

Leadership, openness and transparency

The practice ethos focussed on providing patient centred quality orthodontic care in a relaxed and friendly environment. The comment cards we saw reflected this approach. The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said they felt comfortable about raising concerns with the practice manager or the practice owner. They felt they were listened to and responded to when they did raise a concern. We found staff to be hard working, caring and committed to the work they did. All of the staff we spoke with demonstrated a firm understanding of the principles of clinical governance in dentistry and were happy with the practice facilities. Staff reported that the practice owner and practice manager were proactive and resolved problems very quickly. As a result, staff were motivated and enjoyed working at the practice and were proud of the service they provided to patients.

Learning and improvement

We saw evidence of systems to identify staff learning needs which were underpinned by an appraisal system and a programme of clinical audit. For example we observed that the dental nurses and receptionists received an annual appraisal; these appraisals were carried out by the practice manager. We found there were a number of clinical and non-clinical audits taking place at the practice. These included reasons for discharge from the service, infection control, clinical record keeping and X-ray quality. The audits demonstrated a comprehensive process where the practice had analysed the results to discuss and identify where improvement actions may be needed.

Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. The registered manager told us that the practice ethos was that all staff should receive appropriate training and development. The practice used a variety of ways to ensure staff development including internal training and staff meetings as well as attendance at external courses and conferences. The practice provided a rolling programme of professional development. This included training in cardio pulmonary resuscitation (CPR), infection control, child protection and adult safeguarding, dental radiography (X-rays).

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

The practice had gathered feedback from patients through the NHS Friends and Family test, NHS Choices, compliments and complaints. The waiting room had on display many compliment cards that reflected the high quality of patient care and customer service provided by the practice. We saw that there was a robust complaints procedure in place, with details available for patients in the waiting area, practice leaflet and on the website. Results of the Family and Friends Test we saw indicated that 100% were happy with the quality of care provided by the practice and patients were either highly likely or likely to recommend the practice to family and friends.

Staff told us that the practice manager and practice owner were very approachable and they felt they could give their views about how things were done at the practice. Staff confirmed that they had practice meetings between one and three months. Staff described the meetings as good with the opportunity to discuss successes, changes and improvements. Staff we spoke with said they felt listened to.