

Mr. Edward Byrne

Edward Byrne Associates

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 27 June 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

Edward Byrne and Associates Dental Practice is a mixed dental practice providing mainly private dental care with

some NHS care for both adults and children. Where private treatment was provided half was provided under a fee per item basis and half under a dental insurance plan. The practice holds an NHS contract for the provision of the surgical removal of teeth on a referral basis only. The practice is situated in a converted domestic property. The practice had four dental treatment rooms and separate decontamination rooms for cleaning, sterilising and packing dental instruments. Also included were a reception and waiting area and other rooms used by the practice for office facilities, storage and housing a specialised X-ray machine.

The practice is open 9am – 5.30pm Monday, Wednesday and Thursday, Tuesday 9am – 7.30pm, Friday 9am – 4.30pm and alternate Saturday's 9am – 12.30pm. The practice has four dentists and three visiting dentists who provide surgical dentistry including the provision of dental implants. They are supported by seven dental nurses, a dental hygiene/therapist, a dental hygienist and a practice manager. Other staff include a dedicated decontamination technician and two receptionists.

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

Summary of findings

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 practice manager.

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 46 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:

- The practice had a mission statement to reflect the aims and objectives of the practice.
- Strong and effective clinical leadership was provided by the practice owner.
- The practice benefitted from a stable staff base 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.
- Dentists provided dental care in accordance with current professional and National Institute for Health and Care Excellence (NICE) guidelines
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Patients could access treatment and urgent and emergency care when required.
- Staff 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 to felt well supported by the practice owner and practice manager and were committed to providing a quality service to their patients.
- Information from 46 completed Care Quality Commission (CQC) comment cards gave us a 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.

No action



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 including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals. The staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

No action



Are services caring?

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

We collected 46 completed Care Quality Commission patient comment cards. These provided a positive view of the service the practice provided. All of the patients commented that the quality of care was very good. Patients commented on friendliness and helpfulness of the staff and dentists were good at explaining the treatment that was proposed.

No action



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 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. The practice had two ground floor treatment rooms and level access into the building for patients with mobility difficulties and families with prams and pushchairs.

No action



Summary of findings

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.

No action



Edward Byrne Associates

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 27 June 2016 was led by a CQC inspector who had support from a dental specialist advisor and a second CQC inspector. 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.

During the inspection, we spoke with the practice owner, practice manager, dentists and dental nurses, the decontamination technician, reception staff and reviewed policies, procedures and other documents. We reviewed 46 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 demonstrated 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 records we saw demonstrated that the reporting forms were completed in full with details of how the incidents could be prevented in future. The practice received national patient safety alerts such as those issued by the Medicines and Healthcare products Regulatory Agency (MHRA). Where relevant these incidents were sent to all members of staff by the practice manager. The practice manager explained that relevant alerts would also be discussed during staff meetings to facilitate shared learning these meetings occurred every month.

Reliable safety systems and processes (including safeguarding)

We spoke to the dental nurse responsible for decontamination procedures 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. The practice used a system whereby needles were not manually resheathed using the hands following administration of a local anaesthetic to a patient. The dentists were responsible for ensuring safe recapping using a special metal block. This is a recognised method used in dentistry for the recapping of used needles. Dentists were also responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps. There had been no needle stick injuries since this location opened a year ago.

We asked a dentist how they treated the use of instruments used during root canal treatment. They explained that these instruments were single use only. They also explained that 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). This was also confirmed when we spoke to other dentists. Patients can be assured that the practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam.

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 maintained separate emergency medicines kits and oxygen on both the ground and first floor. The practice held training sessions in cardio pulmonary resuscitation which included dealing with specific medical emergency scenarios each year for the whole team so that they could maintain their competence in dealing with medical emergencies.

Staff recruitment

Are services safe?

All relevant staff 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 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 in a locked cabinet to protect the confidentiality of staff personal information. We saw that all staff had received appropriate checks from the Disclosure and Barring 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 very comprehensive bespoke manual which contained a raft of risk assessments including 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 a robust infection control policy that was regularly reviewed and the practice had employed a dedicated decontamination technician to carry out the infection control procedures in the decontamination room. 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 that audit of infection control processes carried out in April 2016 confirmed compliance with HTM 01 05 guidelines.

The decontamination technician described to us the end-to-end process of infection control procedures at the practice. Another dental nurse 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.

We saw that the four 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 two treatment rooms were inspected and these were clean, ordered and free from clutter. Appropriate single use for patient treatment was evident. Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

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 in 2011 and had been updated each year since. 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 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 decontamination technician 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 combination of an automated washer disinfectant and an ultra-sonic cleaning bath for the initial

Are services safe?

cleaning process, following inspection with an illuminated magnifier they were placed in a vacuum autoclave (a device for sterilising dental and medical instruments). When instruments had been sterilized, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines. We were shown the systems in place to ensure that the 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. All recommended tests utilised as part of the validation of the washer disinfectant and ultra-sonic cleaning bath were carried out in accordance with current guidelines, the results of which were recorded in an appropriate data sheets.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained and was in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. This was stored in a separate locked location adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection. We also saw that general environmental cleaning was carried out according to a cleaning plan developed by the practice. Cleaning materials and equipment were stored in accordance with current national guidelines. 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 and washer disinfectant had been serviced

and calibrated in October 2015. The practice compressor had been serviced in November 2015 in accordance with the Pressure Vessel Regulations 2000. We noted that the practices' X-ray machines had been serviced and calibrated as specified under current national regulations in July 2015. Portable appliance testing (PAT) had been carried out in September 2014. 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. Prescription pads were stored securely to prevent theft or misuse by staff or unauthorised persons.

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. We also noted that the file contained details of a quality assurance programme and radiation risk assessment. We saw training records that showed all staff where appropriate had received training for core radiological knowledge under IRMER 2000 Regulations.

We saw details of a comprehensive radiological audit for each dentist which were carried out on an annual 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.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

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

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

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 tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums). These were carried out where appropriate during a dental health assessment. The records we saw were comprehensive, detailed and well maintained.

Health promotion & prevention

The dentists were very focussed on the preventive aspects of their practice, to facilitate this aim the practice appointed a dental therapist/hygienist and a dental

hygienist to work alongside of the dentists to deliver preventive dental care. All of the dentists we spoke with explained that children at high risk of tooth decay were identified and were offered fluoride varnish applications or the prescription of high concentrated fluoride tooth paste to keep their teeth in a healthy condition. They also placed fissure sealants (special plastic coatings on the biting surfaces of permanent back teeth in children) who were particularly vulnerable to dental decay. Other preventative advice included tooth brushing techniques explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health: an evidence based toolkit for prevention.'

Dental care records we observed demonstrated that dentists, the dental hygiene/therapist and the dental hygienist had given appropriate oral health advice to patients. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area.

Practice staff had established links with the local community by promoting good oral health in local schools and displaying information about mouth cancer during 'mouth cancer action month' (November).

Staffing

The practice has four dentists and three visiting dentists who provide surgical dentistry including the provision of dental implants. They are supported by seven dental nurses, a dental hygiene/therapist, a dental hygienist and a practice manager. Other staff include a dedicated decontamination technician and two receptionists.

We observed a friendly atmosphere at the practice. Staff we spoke with told us the staffing levels were suitable for the size of the service. 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.

Working with other services

We found that there were dentists working in the practice who had additional skills in minor oral surgery and dental implants. Dentists with additional skills in minor oral surgery enabled the practice to deliver a locally

Are services effective?

(for example, treatment is effective)

commissioned NHS dental contract for the surgical removal of teeth on a referral basis only. This service was able to deliver care to patients within four to six weeks on receipt of a referral from local general dental practitioners. Dentists working in the practice were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice manager explained how they would work with other services when required. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as special care dentistry and hospital based orthodontics. This ensured that patients were seen by the right person at the right time.

Consent to care and treatment

We spoke with three dentists about how they implemented the principles of informed consent; all of the dentists had a very 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.

The dentists went on to 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. They were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting areas and we saw that doors were closed at all times when patients were with dentists. Conversations between patients and dentists could not be heard from outside the treatment rooms which protected 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 behind 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 46 completed CQC patient comment cards. These provided a positive view of the service the practice provided. All of the patients

commented that the quality of care was very good. Patients commented that treatment was explained clearly and the staff were caring and put them at ease. 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

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. A poster detailing NHS was displayed on the patient notice board in the waiting area. Information on the practice website detailed the costs of both NHS and private treatment. The dentists we spoke with paid particular attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them. This included information recorded on the standard NHS treatment planning forms for dentistry where applicable.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we looked at examples of information available to people. We saw that adjacent to the practice waiting the patient notice board 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 website also contained useful information to patients such as details about different types of treatments, preventive advice, staff profiles and how to provide feedback on the services provided.

We observed that the appointment diaries were not overbooked and that this provided capacity each day for patients with dental pain to be fitted into urgent slots for each dentist at the end of each day. 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, had a disability and the level of complexity of treatment.

The practice team had a daily morning meeting to discuss the day ahead and if any patients may require additional support.

Tackling inequity and promoting equality

We asked staff to explain how they communicated with people who had different communication needs such as those who spoke another language. Staff told us they responded to people's individual needs and welcomed

patients from different backgrounds, cultures and religions. They would encourage a relative or friend to attend who could translate or if not they would contact a translator. The practice was accessible to people using wheelchairs.

Access to the service

The practice is open 9am – 5.30pm Monday, Wednesday and Thursday, Tuesday 9am – 7.30pm, Friday 9am – 4.30pm and alternate Saturday's 9am – 12.30pm. The practice provided a variety of out of hours' telephone numbers for patients to contact depending whether the patient was an NHS patient, private or part of the insurance plan 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

There was a complaints policy which provided staff with information about handling formal and informal complaints from patients.

Information for patients about how to make a complaint was available in the practice waiting room. This included contact details of other agencies to contact if a patient was not satisfied with the outcome of the practice investigation into their complaint.

We looked at 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. The practice team viewed complaints as a learning opportunity and discussed those received in order to improve the quality of service provided.

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

Strong and effective leadership was provided by the practice owner. The practice ethos focussed on providing patient centred dental 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 principal dentist. There was a no blame culture within the practice. 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 found there was a rolling programme of clinical and non-clinical audits taking place at the practice. These included infection control, clinical record keeping and X-ray quality. We also saw that there was an audit on the use of rubber dam, updating medical history and the use of the BPE. The audits demonstrated a comprehensive process where the practice had analysed the results to discuss and identify where improvement actions may be needed.

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

There was a system in place to act upon suggestions received from patients using the service.

The practice conducted regular staff meetings. Staff members told us they found these were a useful opportunity to share ideas and experiences which were listened to and acted upon.