Dr. Ceinwen Mary Jones

The Mary Jones Dental Practice

Inspection Report

1 Street House
George lane
Bromley
BR2 7LQ
Tel: 020 8462 0200
Website: www.maryjonesdental.co.uk

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Overall summary

We carried out an announced comprehensive inspection on 08 October 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

The Mary Jones Dental Practice is located in the London Borough of Bromley. The premises are laid out over the ground floor of a converted residential building. There are two treatment rooms, a dedicated decontamination room, waiting room with reception area, and toilet.

The practice provides private dental services for adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers, crowns and bridges, root canal treatments and oral hygiene.

The staff structure of the practice is comprised of a principal dentist (who is also the owner), four associate dentists, a hygienist, and three dental nurses who also work as receptionists.

The practice opening hours are from 9.00 am to 6.00pm on Monday, Tuesday and Thursday, from 9.00am to 8pm on Tuesday and from 9.00am to 1.00pm on Friday.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. Like registered

Summary of findings

providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

The inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

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

Our key findings were:

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were effective systems in place to reduce and minimise the risk and spread of infection, although further checks were needed to monitor for the risk of Legionella.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Staff knew how to report incidents and how to record details of these so that the practice could use this information for shared learning.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- The principal dentist had a clear vision for the practice and staff told us they were well supported by the management team.
- Governance arrangements and audits were used effectively for monitoring the quality and safety of the services, although additional auditing, for example, of dental care records, could be used to monitor performance and drive improvements.

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

- Monitor and record the fridge temperature to ensure that medicines are being stored in line with the manufacturer's guidance.
- Review and embed the use of staff appraisals as part of a system for identifying staff concerns and ensuring that staff remain skilled and competent in their role.
- Review audit protocols to ensure audits of dental care records are undertaken at regular intervals and learning points are documented and shared with all relevant staff.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

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

There were some areas where improvements could be made to safety systems. For example, risk-assessments for Legionella and the management and Control of Substances Hazardous to Health 2002 (COSHH) needed to be reviewed and followed up. The principal dentist confirmed to us after the inspection that these assessments had been updated and acted on.

Are services effective?

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

The practice could demonstrate they followed relevant guidance, for example, issued by the National Institute for Health and Care Excellence (NICE). The practice monitored patients' oral health and gave appropriate health promotion advice. The practice maintained appropriate dental care records and details were updated appropriately. The practice worked well with other providers and followed patients up to ensure that they received treatment in good time.

Clinical staff worked towards meeting professional standards and completing continuing professional development (CPD) standards set by the General Dental Council (GDC). Staff told us they were well-supported by the principal dentist through informal supervision and ad hoc staff meetings. However, improvements could be made to embed the use of staff appraisals to support staff development.

Are services caring?

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

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

Are services responsive to people's needs?

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

The practice had access to telephone interpreting services to support people who did not have English as their first language. The needs of people with disabilities had been considered and there was level access to the waiting area and treatment room on the ground floor. Patients were invited to provide feedback via a satisfaction survey.

Patients generally had good access to appointments, including emergency appointments, which were available on the same day.

Summary of findings

No complaints had been received in the past year, but there was a policy in place to handle complaints as they arose.

Are services well-led?

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

The practice had clinical governance and risk management structures in place. A system of audits was used to monitor and improve performance. Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the principal dentist. They were confident in the abilities of the management team to address any issues as they arose. However, improvements could be made to strengthen the governance structures and protocols.

The Mary Jones Dental Practice

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 08 October 2015. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a dental specialist advisor.

We reviewed information received from the provider prior to the inspection. During our inspection visit we reviewed policy documents and spoke with four members of staff, including the principal dentist. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We asked one of the dental nurses to demonstrate how they carried out decontamination procedures of dental instruments.

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

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There was an effective system in place for reporting and learning from incidents. There was a policy for staff to follow for the reporting of these events and the staff we spoke with were aware of the reporting procedures. No adverse incidents had occurred in the past year that required to be recorded.

We noted that the practice policy in relation to incidents and complaints stated that they would offer an apology when things went wrong. Staff were encouraged to operate in an open and transparent manner in the event that something went wrong.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There was a book for the recording of any accidents.

Reliable safety systems and processes (including safeguarding)

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

The practice had a safeguarding policy which referred to national guidance and held local authority telephone numbers for escalating concerns that might need to be investigated. However, we found that not all staff had received relevant training in child protection and the protection of vulnerable adults. We discussed this with the principal dentist who told us that they had already identified this issue and they provided us with evidence of a training course which had been requested for relevant staff members.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, there was a risk assessment and written protocol for what to do in the event of a sharps injury or accident (e.g. related to needles used for injections). Our discussions with staff demonstrated that all staff were following the same sharps protocol, for example, the re-sheathing and disposal of needles was the responsibility of the dentist.

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

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. The practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. An automated external defibrillator (AED), oxygen and other related items, such as manual breathing aids and portable suction, were available in line with the Resuscitation Council UK guidelines. (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm). The emergency medicines were all in date and stored securely with emergency oxygen in a location known to all staff. Staff received annual training in using the emergency equipment. The staff we spoke with were all aware of the locations of the emergency equipment.

Staff recruitment

The practice staffing consisted of a principal dentist, four associate dentists, one hygienist and three dental nurses who also worked as receptionists.

There was a recruitment policy in place which stated that all relevant checks would be carried out to confirm that the person being recruited was suitable for the role. This included the use of an application form, interview notes, review of employment history, evidence of relevant qualifications, the checking of references and a check of registration with the General Dental Council. The majority of the staff had been employed at the practice over a long period of time. One dentist has been recruited in April 2015 and the principal dentist was in the process of recruiting an additional dental nurse. We discussed the recruitment process with the principal dentist who told us they had followed their policy when recruiting new members of staff. However, they said that they received a verbal reference for

Are services safe?

the new dentist, but had not kept a record of this. They had also not yet followed up on references for the new dental nurse, but would do so before the staff member started work.

It was practice policy to carry out a Disclosure and Barring Service (DBS) check for all members of staff prior to employment and periodically thereafter. We checked four staff files and found that a DBS) check had been carried out for all members of staff.

Monitoring health & safety and responding to risks

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

There were effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. Actions were described to minimise identified risks. COSHH products were securely stored. Staff were aware of the COSHH file and of the strategies in place to minimise the risks associated with these products. However, we noted that the COSHH file had not been reviewed and updated since 2012. The principal dentist confirmed to us after the inspection that the file had been updated.

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

There was a business continuity plan in place. There was an arrangement in place to use another practice for emergency appointments in the event that the practice's own premises became unfit for use. Key contacts in the local area were displayed in the staff room for prompt access in the event that a maintenance problem occurred at the premises.

Infection control

There were systems in place to reduce the risk and spread of infection. There was an infection control policy which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. The practice had carried out practice-wide infection control audits every six months, with the most recent one having been completed in July 2015. One of the dental nurses was the infection control lead. Staff files showed that staff regularly attended training courses in infection control. Clinical staff were required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients.

There were good supplies of protective equipment for patients and staff members including gloves, masks, eye protection and aprons. There were hand washing facilities in the treatment rooms and the toilets.

The practice had followed the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)'. In accordance with HTM 01-05 guidance an instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which ensured the risk of infection spread was minimised.

We examined the facilities for cleaning and decontaminating dental instruments. There was one decontamination room. It was well organised with a clear flow from 'dirty' to 'clean'. One of the dental nurses demonstrated how they used the room. They showed a good understanding of the correct processes. The nurse wore appropriate protective equipment, such as heavy duty gloves and eye protection. The practice used a system of ultra-sonic cleaning bath and manual scrubbing (utilising the double sink method) as part of the initial cleaning process. Following inspection of cleaned items, they were placed in an autoclave (steriliser). When instruments had been sterilized they were pouched and stored appropriately until required. All pouches were dated with an expiry date in accordance with current guidelines.

The dental nurse showed us that systems were in place to ensure that the autoclaves and ultra-sonic bath were working effectively. These included the automatic control test and steam penetration tests for the autoclave and foil tests for the ultrasonic cleaning bath. It was observed that the data sheets used to record the essential daily validation were complete and up to date.

Are services safe?

The practice had a cleaning schedule that covered all areas of the premises and detailed what and where equipment should be used. This took into account national guidance on colour coding equipment to prevent the risk of infection spread.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. For example, we observed that sharps containers, clinical waste bags and municipal waste were properly maintained and stored. The practice used a contractor to collect dental waste from the practice. Waste consignment notices were available for inspection.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). The method described was in line with current HTM 01-05 guidelines. A Legionella risk assessment had also been carried out by an external contractor in February 2015. The assessment process had not been wide-ranging and did not include, for example, a survey or schematic of the water systems. The recommendations to check water temperatures at monthly and six-monthly intervals had not been followed up. The principal dentist confirmed to us that, following the inspection, the assessment had been updated and water temperature checks were being documented.

Equipment and medicines

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

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

The expiry dates of medicines, oxygen and equipment were monitored using a monthly check sheet which enabled the staff to replace out-of-date drugs and equipment promptly. There were some medicines, for example, items used for teeth whitening, which were being stored in a refrigerator in line with the manufacturer's guidance. However, the practice did not have a system in place for monitoring the temperature of the fridge to ensure that these items were stored at the correct temperature.

Radiography (X-rays)

The practice had in place a Radiation Protection Adviser and a Radiation Protection Supervisor in accordance with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). A radiation protection file, in line with these regulations, was present. This file was well maintained and complete. Included in the file were the critical examination pack for the X-ray set, the three-yearly maintenance log, a copy of the local rules and appropriate notification to the Health and Safety Executive. The maintenance log was within the current recommended interval of three years with the next service was due in 2018. We saw evidence that staff had completed radiation training.

A copy of the most recent radiological audit was available for inspection. This demonstrated that a high percentage of radiographs were of grade one or two (the higher) standards. We checked a sample of individual dental care records to confirm the findings. These records showed that dental X-rays were justified, reported on and quality assured every time.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. A dentist we spoke with described how they carried out patient assessments using a typical patient journey scenario. The practice used a pathway approach to the assessment of the patient which was supported and prompted by the use of computer software. The assessment began with a review of the patient's medical history and patients were also asked to complete a social history (for example, exploring current diet and alcohol intake). This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were made aware of the condition of their oral health and whether it had changed since the last appointment.

Following the clinical assessment, the diagnosis was discussed with the patient and treatment options explained in detail. The dental care record was updated with the proposed treatment after discussing options with the patient. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

A check of a random sample of dental care records to confirm the findings showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw notes containing details about the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums.) These were carried out at each dental health assessment. Details of the treatments carried out were also documented.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. Staff told us they discussed oral health with their patients, for example, effective tooth brushing or dietary advice. The principal dentist was also aware of the need to discuss a general preventive agenda with their patients. This included discussions around smoking cessation, sensible alcohol use and weight management. The dentist also carried out examinations to check for the early signs of oral cancer. They cited an example where a fast track referral for oral cancer had successfully identified cancer at an early, and treatable, stage.

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

Staffing

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

The principal dentist told us that they did not hold formal appraisals with each member of staff to review their performance and discuss training needs or aspirations. They told us that they did have regular, informal discussions with staff about their role and were generally available for advice and supervision. They were able to demonstrate knowledge about different members of staffs' career goals and how they were supported to achieve these. For example, they were supporting one of the dental nursing team to pursue further qualifications with a view to becoming a hygienist and were supportive of an associated dentist working towards a specialist post-graduate degree in the provision of root canal treatment.

Working with other services

The principal dentist explained how they worked with other services, when required. Dentists were able to refer patients internally to the hygienist and to a dentist who specialised in root canal treatments. They could also refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. A referral letter was prepared and sent to the hospital with full details of the dentist's findings and a copy was stored on the practices' records system. When the patient had received their treatment they were discharged back to the practice. Their treatment was then monitored after being

Are services effective?

(for example, treatment is effective)

referred back to the practice to ensure patients had received a satisfactory outcome and all necessary post-procedure care. A copy of the referral letter was always available to the patient if they wanted this for their records.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. Staff discussed treatment options, including risks and benefits, as well as costs, with each patient. Notes of these discussions were recorded in the dental care records. Patients were asked to sign to indicate they had understood their treatment plans and formal written consent forms were completed.

Staff were aware of the Mental Capacity Act 2005. They could accurately explain the meaning of the term mental capacity and described to us their responsibilities to act in patients' best interests, if patients lacked some decision-making abilities. The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We collected feedback from nine patients. They described a positive view of the service. The practice had also carried a patient survey in 2014 which indicated a high level of satisfaction with care. Patients commented that the team were friendly, kind and respectful. Patients were happy with the quality of treatment provided. During the inspection we observed staff in the reception area. They were polite and helpful towards patients and the general atmosphere was welcoming and friendly. Some of the patients visiting on the day of the inspection were clearly well known to the practice staff, who greeted them by name. The patient feedback we received also indicated that some patients had a long-term relationship with the practice and appreciated the continuity of care with their preferred dentist.

All the staff we spoke with were mindful about treating patients in a respectful and caring way. They were aware of the importance of protecting patients' privacy and dignity. There were systems in place to ensure that patients' confidential information was protected. Dental care records were kept in a paper format. These were stored in a locked cupboard. Some personal information was stored on a computer in a password-protected file and the staff also had personal passwords to access the computer. Staff understood the importance of data protection and confidentiality and described the practices for protecting patient information. For example, staff were careful to make sure that paper records were not left visible to patients as they walked through the practice and they filed the records promptly after use.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area and on its website which gave details of the private dental charges and fees. There were a range of information leaflets in the waiting area which described the different types of dental treatments available. Patients were routinely given copies of their treatment plans which included useful information about the proposed treatments, any risks involved, and associated costs. We checked a sample of dental care records and saw examples where notes had been kept of discussions with patients around treatment options, as well as the risks and benefits of the proposed treatments.

We spoke with the principal dentist, the hygienist, and two of the dental nurses on the day of our visit. All of the staff told us they worked towards providing clear explanations about treatment and prevention strategies. The patient feedback we received via comments cards, together with the data gathered by the practice's own survey, confirmed that the majority of patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. Each dentist could decide on the length of time needed for their patient's consultation and treatment. The principal dentist told us they scheduled additional time for patients depending on their knowledge of the patient's needs, including scheduling additional time for patients who were known to be anxious or nervous. Staff told us they did not feel under pressure to complete procedures and always had enough time available to prepare for each patient.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. The practice had access to a telephone translation service, although they had not had to use this so far. Staff kept a note of which patients may require additional assistance by highlighting this on each person's dental care record. For example, it was noted if someone had some mobility issues, were hard of hearing or had some visual impairment so that staff could offer appropriate assistance when they attended for their appointment.

Staff told us that some people who used the service came in a wheelchair. There was a ramp up towards the reception area, although not level access at the threshold. Staff told us that carers accompanied wheelchair users to help them across this threshold, but the practice did not have a portable ramp to support this process. Otherwise there was level access throughout the practice with both treatment rooms and toilet situated on the ground floor.

Access to the service

The practice opening hours were 9.00 am to 6.00pm on Monday, Tuesday and Thursday, from 9.00am to 8pm on Tuesday and from 9.00am to 1.00pm on Friday. The practice displayed its opening hours at their premises and on their website.

The reception staff we spoke with told us that the dentists always planned some spare time in their schedule on any given day. This ensured that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, could be accommodated. We reviewed the appointments book and saw that this was the case.

Staff told us they had enough time to treat patients and that patients could generally book an appointment in good time to see the dentist of their choice. Reception staff told us that there were generally appointments available within a reasonable time frame. The feedback we received from patients confirmed that they could generally get an appointment when they needed one and that they had adequate time scheduled with the dentist.

Concerns & complaints

There was a complaints policy which described how the practice handled formal and informal complaints from patients. We noted that the policy stated that patients would be offered an apology when the practice identified that something had not been managed appropriately. Information about how to make a complaint was displayed in the reception area. There had been no complaints received in the past year.

Staff told us that patients were invited to give ad hoc feedback when they visited and any issues were discussed on the day and acted on immediately. For example, if a patient had a problem making a suitable appointment time, the process was reviewed to identify whether or not the staff could have done anything better. The practice had also carried out a satisfaction survey in the previous year (2014). This had not identified any areas of concern and the patients who responded to the survey were satisfied with the quality of care.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements and a clear management structure. There were relevant policies and procedures in place. Staff were aware of these and acted in line with them. Records, including those related to patient care and treatment, as well as staff employment, were kept accurately.

There were the arrangements for identifying, recording and managing risks through the use of risk assessment process. However, there was one instance where this process had not led to an appropriate risk-reduction strategy. The Legionella risk assessment process had not been wide-ranging and did not include, for example, a survey or schematic of the water systems. The recommendations to check water temperatures at monthly and six-monthly intervals had not been carried out. We also noted that the COSHH file had not been kept up to date; the most recent review had taken place in 2012. The principal dentist confirmed to us after the inspection that these assessments had been updated and acted on.

Staff told us that if any governance issues arose then these were dealt with promptly by convening an impromptu staff meeting on the same day.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. All of the staff we spoke with said that they felt comfortable about raising concerns with the principal dentist and that they were listened to and responded to when they did so. We found staff to be hard working, caring and committed. However, staff appraisals had not occurred at regular intervals and there were no formal supervisory arrangements to support staff development or identify career aspirations. We discussed these concerns with the principal dentist who was able to demonstrate knowledge about different members of staffs' career goals and how they were supported to achieve these. The staff we spoke with told us they were satisfied with the supervision arrangements and could ask the principal dentist for advice and support when they needed it.

We also asked the principal dentist about their ethos and future plans for the practice. They told us their plans for the practice included expanding the range of clinical skills available, through staff recruitment and training, so that a wider range of treatments could be offered at the practice.

Learning and improvement

The practice had a rolling programme of clinical audit and risk assessments in place. There were audits for infection control and X-ray quality. Audits were repeated at appropriate intervals to evaluate whether or not quality had been maintained or if improvements had been made. However, we noted that there were no formal systems in place to monitor clinical staff performance in other areas, for example, through the use of a recording keeping audit.

Staff were also being supported to meet their professional standards and complete continuing professional development (CPD) standards set by the General Dental Council (GDC). We saw evidence that staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the GDC.

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

The practice had gathered feedback from patients through the use of a patient satisfaction survey in 2014. The survey covered topics such as the quality of staff explanations, cleanliness of the premises, and general satisfaction with care. The responses indicated a high level of satisfaction. We noted that the practice acted on feedback from patients where they could. Staff told us they also obtained ad hoc feedback from patients when they visited the practice. They could cite examples where this had led to a change in the provision of care. For example, the practice had changed the opening hours in January 2015. This was in response to patient feedback that opening for longer in the evening would be preferable. The practice was now open a Tuesday evening until 8.00pm.

Staff commented that the principal dentist was open to feedback regarding the quality of the care. They told us that time was set aside each day to discuss issues as they arose and they were satisfied with these arrangements for discussing the quality of the care.