

Total Orthodontics Limited

Total Orthodontics Horsham

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 15 March 2017 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

Total Orthodontics is part of a group of specialist dental practice's providing orthodontic treatment to children and adults 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 teeth and their function).

Orthodontic treatment is provided under NHS for children except when the problem falls below the accepted eligibility criteria. Private treatment is available for these patients as well as adults who require orthodontic treatment.

The practice is situated in a converted commercial property. The practice has a suite of treatment and consulting rooms and a separate decontamination room on the first floor of the building with a reception and waiting area on the ground floor.

The practice is open; Monday 8.30am – 6.30pm, Tuesday 8.30am – 5.00pm, Wednesday 8.30am – 4.30pm, Thursday 8.30am – 5.00pm, Friday 8.30am – 4.30pm, Saturday 9.00am – 1.00pm (one in four).

The practice has four orthodontists providing orthodontic care and are supported by three orthodontic therapists, four dental nurses, a practice manager, administrative staff and two receptionists.

The practice manager and the lead clinician are the registered manager's. A registered manager is a person

Summary of findings

who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

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 12 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 clinical leadership was provided by the clinical lead who was supported by 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 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 provider and practice manager.

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 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 (BOS) 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 12 completed CQC patient comment cards. 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.

Staff were aware of the importance of protecting patients' privacy and dignity and the importance of data protection and confidentiality.

No action



Are services responsive to people's needs?

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

No action



Summary of findings

Patients had good access to appointments, including emergency appointments, which were available on the same day. The culture of the practice promoted equality of access for all. The practice was wheelchair accessible with a treatment room and consultation room situated on the ground floor.

There was a complaints policy in place. Any complaints received had been recorded and appropriately investigated. Patient feedback was also used to monitor the quality of the service provided.

Are services well-led?

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

The clinical lead, 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. All the staff we met said that they were happy in their work and the practice was a good place to work.

No action



Total Orthodontics Horsham

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 15 March 2017 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.

During the inspection, we spoke with the clinical lead, practice manager, dental nurses and receptionists and reviewed policies, procedures and other documents.

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 practice reported that there were no incidents during 2016 that required investigation.

The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA). We saw evidence that a recent alert from June 2016 pertaining to anticoagulant drug therapy had been stored in the separate safety alert file. 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 with a dental nurse 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 provided by the practice, no local anaesthetic was used in the practice. The orthodontists were responsible for ensuring safe recapping using a special rubber needle guard. Orthodontists and orthodontic therapists were responsible for the disposal of wires and other sharps used in orthodontic treatment. A practice protocol was in place should a sharps injury occur. The systems and processes we observed were in line with the current EU directive on the use of safer sharps.

The practice manager was responsible for fire safety with other staff acting as fire wardens 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 were maintained on a regular basis.

The clinical lead at this location 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 treatment area 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 medical 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 medical 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 clinical staff had current registration with the General Dental Council (GDC), 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.

Are services safe?

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 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. We saw that 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. All of these policies were regularly updated. 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 September 2016 and January 2017 confirmed compliance with HTM 01 05 guidelines.

We saw that the treatment rooms and adjacent areas, waiting area, reception and toilet were clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment areas. 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 rooms were inspected and these were clean, ordered and free from clutter. Each

treatment room and the decontamination area had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

The dental nurse we spoke with described to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the treatment rooms 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 practice had a separate decontamination room where sterilisation and packaging of processed instruments took place. The dental nurse we spoke with 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 disinfectant for the initial cleaning process, following inspection with an illuminated magnifier the instruments were placed in an autoclave (a device for sterilising dental and medical instruments). When the 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 autoclave used in the decontamination process were working effectively. It was observed that the log 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 as part of the validation of the washer disinfectant were carried out in accordance with current guidelines, the results of which were recorded on appropriate log sheets.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacterium 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 November 2015. The recommended procedures contained in the report

Are services safe?

were carried out and logged appropriately. We saw evidence the water quality testing was carried out by the practice. These measures ensured that patients' and staff were protected from the risk of infection due to Legionella.

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. Waste consignment notices were available for inspection. Patients' could be assured that they were protected from the risk of infection from contaminated dental waste. Environment cleaning was carried out by an external cleaning company according to cleaning plans developed by the practice. These cleaning plans were available for inspection which were completed by the company each day.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the three autoclaves had been serviced and calibrated in 2016. The practices' X-ray machine had been serviced and calibrated as specified under current national regulations in August 2016. Portable appliance testing (PAT) had been

carried out in September 2016. We observed that the practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid 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 pack for the X-ray set along with the annual and three yearly maintenance logs and a copy of the local rules.

The file included a copy of the radiological audits which 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 IR(ME)R 2000 Regulations.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We spoke with the lead clinician about the care provided at the practice; they carried out consultations, assessments and treatment in line with recognised general professional guidelines and the guidance provided by the British Orthodontic Society (BOS). They 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 a detailed 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 orthodontic therapists 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 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 lead dental nurse responsible for carrying out PAR scoring explained that the practice was achieving a high level of improved outcomes for patients.

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, following the first treatment session a staff member including dental nurses 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 details of dental hygiene products suitable for maintaining their orthodontic braces; these were available for sale in reception. Underpinning these instructions was a range of leaflets explaining how patients could maintain good oral health during their orthodontic treatment.

Staffing

The practice had four orthodontists providing orthodontic care and were supported by three orthodontic therapists, four dental nurses, a practice manager, administrative staff and two receptionists. We observed a friendly and professional atmosphere at the practice. The staff appeared to be a very effective and a cohesive team.

We saw 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.

Working with other services

The practice was a specialist referral practice for orthodontics for practices across the Surrey area. Referring practices were required to complete a bespoke referral form developed by NHS commissioners for NHS patients to

Are services effective?

(for example, treatment is effective)

access services. The clinical lead explained how they would work with other services if patients required other specialist input such as that from consultant restorative and maxillo-facial services as part of the patient's orthodontic treatment.

Consent to care and treatment

We spoke with the clinical lead 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.

The clinical lead was 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 clinical lead 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.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patients' clinical records were stored electronically. Computers were password protected and regularly backed up to secure storage with any paper records stored in a lockable 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 CQC comment cards so patients could tell us about their experience of the practice. We collected 12 completed CQC patient comment cards. 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 the NHS 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 clinical lead 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 discussed. This included information recorded on the standard orthodontic NHS treatment planning forms where applicable. To facilitate patient involvement in the decision making process the practice engaged the use of 'treatment co-ordinator's'. Following the initial consultation and assessment with the clinician patients were then given the opportunity to discuss the treatment plan with the co-ordinator to ensure that the patient fully understood the proposed treatment. This meeting afforded the patient with a further opportunity to ask questions and clarify any issue prior to the commencement of the course of treatment.

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 patients. We saw that the practice waiting area displayed a wide variety of information including the practice patient information leaflet and leaflets about the services the practice offered, results of the family and friends test, how to make a complaint.

The patient information leaflet explained opening hours, emergency 'out of hours' contact details and arrangements and how to make a complaint. The practice website also contained useful information to patients such as details about different types of orthodontic treatments 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 orthodontist. 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, had a disability and the level of complexity of treatment.

Tackling inequity and promoting equality

Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. They told us they generally they did not need a translation service for languages because they did not have many patients that attended the practice where they could not speak or understand English. The practice manager told us if there was a need for this they would use a telephone translation line.

We asked staff how they would support patients, for example that may have learning difficulties. The clinical lead and the practice manager discussed with us that some patients that attended the practice were on the autistic spectrum. The practice manager told us they responded positively to these patients by accommodating their needs where appropriate. There was an example given where the

patient did not like being in a busy waiting room around other people. The practice offered the consultation room in this case which was a quiet room away from the waiting area. Another example given was where a patient only liked sitting on a particular colour chair and so the practice would ensure this was provided. Staff told us they were confident they could communicate with patients using visual aids where appropriate.

We asked staff how they would support patients that had difficulty with hearing and vision. The practice manager explained how they would face the patient and speak slowly and clearly especially for someone who had hearing difficulties to allow the patient to lip read. The practice manager told us they had magnifying glasses available to help people if they had difficulty reading any information.

The practice had level access to the reception area and waiting area and a ground floor treatment room. Staff told us all patients had notes in the dental care records highlighting any special assistance required prior to scheduled appointment and they responded with every possible effort to make dental provision accessible.

Access to the service

The practice had a direct emergency number to give advice in case of a dental or orthodontic emergency when the practice was closed. This information was publicised in the practice information leaflet, practice website, on the outside of the practice 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. We saw 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 information folder in the waiting area and the practice website.

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 clinical lead 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. 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. We found that 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 audits taking place at the practice. These included 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 GDC. The clinical director 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 welcomed feedback from patients through a suggestions box located in the waiting area. The practice manager told us all comments received were positive. They told us there had been no complaints. We reviewed a report from the 'friends and family' test that was completed for a six month period. This showed that out of the 153 people that completed the test 152 would recommend the practice to friends and family. We saw evidence that the results of the feedback was analysed and discussed in team meetings.