Mr. Robert Herron

Dental Practice

Inspection Report

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Date of inspection visit: 31/01/2017
Date of publication: 20/04/2017

Overall summary

We carried out an announced comprehensive inspection on 31st January 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

Robert Herron Dental is a dental practice providing mainly private treatment for adults and a small NHS contract for exempt adults and children. The practice is based in a converted commercial property in Liphook, a village situated in south Hampshire.

The practice has one dental treatment room on the first floor and a separate decontamination room.

The practice employs one dentist, who is the practice owner and Registered Manager, one dental nurse and two reception staff.

The practice's opening hours are between 08:30 and 17:00 Monday to Thursday and between 08:30 and 13:00 on Friday. The practice is closed each weekday between 13:00 and 14:00

There are arrangements in place to ensure patients receive urgent medical assistance when the practice is closed. This is provided by an out-of-hours service or direct access to an emergency mobile phone number.

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

Summary of findings

Our key findings were:

- We found that the practice ethos was to provide patient centred dental care in a relaxed and friendly environment.
- Clinical and business leadership was provided by the principal dentist
- Staff had been trained to handle emergencies and appropriate emergency medicines and medical oxygen and other breathing aids were available in accordance with current guidelines. We did note that the practice did not have 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.
- The practice appeared clean and well maintained.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- Infection control procedures were effective and the practice followed published guidance.
- The practice had a process in place for safeguarding adults and children living in vulnerable circumstances.
- There was a process in place for the reporting and shared learning when untoward incidents occurred in the practice.
- Dentists provided dental care in accordance with current professional and National Institute for 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 both routine and urgent treatment when required.
- Staff received training appropriate to their roles and were supported in their continued professional development (CPD) by the Principal Dentist.
- Staff we spoke with felt well supported by the Principal Dentist and were committed to providing a quality service to their patients.
- Information from 32 completed Care Quality Commission (CQC) comment cards gave us a positive picture of a friendly, caring, professional and high quality service.

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

- Provide an annual statement in relation to infection prevention control required under The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance is prepared.
- Review the availability of hearing loops for patients who wear hearing aids.
- Review availability of equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare Products Regulatory Agency (MHRA).
- Review the suite of practice policies ensuring that policies are updated on a more regular basis.
- Reintroduce a system of patient satisfaction surveys to capture patient feedback about the quality of services provided by the practice.
- Risk assess the lack of an automated external defibrillator (AED) and consider purchasing one.

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?

No action

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

The practice had arrangements in place for essential areas such as infection prevention, clinical waste control and dental radiography (X-rays). We found all the equipment used in the dental practice was well maintained.

Staff had been trained to handle emergencies and appropriate emergency medicines and oxygen and other breathing aids were available in accordance with current guidelines. We did note that the practice did not have an automated external defibrillator (AED).

We found there were very few incidents and accidents reported by the practice, they took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents.

Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

Are services effective?

No action

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.

Are services caring?

No action

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

We obtained the views of 32 patients prior to our inspection. These provided a positive view of the service the practice provided.

All 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.

Are services responsive to people's needs?

No action

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 these into account in how the practice was run.

Summary of findings

Patients could access both routine and urgent treatment when required.

The practice provided patients with access to telephone interpreter services when required.

The practice was on the first floor of the premises and was not accessible to patients with physical impairments. In these circumstances the practice referred these patients to two other practices nearby.

Are services well-led?

No action

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

Although the principal dentist provided effective clinical dentistry leading to good patient outcomes, there were some shortfalls in the clinical governance systems and processes underpinning the clinical care such as practice policies that required regular updating

Staff had an open approach to their work and shared a commitment to continually improving the service they provided. There was a no blame culture in the practice.

We saw that several clinical audits were undertaken by the practice including audits in infection control and dental radiography. We did note the comment cards reflected a high degree of patient satisfaction of the care provided by the dentist and their staff, the practice had not carried out a formal satisfaction survey of patients recently.

Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council (GDC).

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

Dental Practice

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 registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an announced, comprehensive inspection on 31st January 2017. Our inspection was carried out by a lead inspector and a dental specialist adviser.

During our inspection visit, we reviewed policy documents and staff training and recruitment records. We obtained the views of two members of staff.

We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the systems that supported the patient dental care records. We obtained the views of 32 patients prior to our inspection.

Patients gave positive feedback about their experience 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

We noted that the practice had in place systems to support RIDDOR 2013 (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.

We discussed with the Principal Dentist the action they would take if a significant incident occurred, they detailed a process that involved a discussion and feedback with any patient that might be involved. This indicated an understanding of their duty of candour. Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Records showed that no such accidents occurred during 2016. Although the Principal Dentist explained that they received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA), the practice did not maintain a record of such incidents. The Principal Dentist could tell us about recent alerts that were relevant to dentistry.

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. The practice used a system whereby needles were not manually re-sheathed using the hands following administration of a local anaesthetic to a patient. The practice used the 'scoop' method during the recapping of a used needle following administration of dental local anaesthetics to prevent needle stick injuries from occurring. The principal dentist was 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.

We asked the staff how they treated the use of instruments used during root canal treatment. They explained that these instruments were single patient use only. The practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam. They explained that root canal treatment was carried out where practically possible using a rubber dam. 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 and protect the airway. Rubber dams should be used when endodontic treatment is being provided.

The practice had systems and processes in place should members of staff encounter a child or adult safeguarding issue. A policy and protocol 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 staff had received appropriate safeguarding training for both vulnerable adults and children. Information was available 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 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 oxygen we saw were all in date and stored in a central location known to all staff.

We did note that the practice did not have an automated external defibrillator (AED). There was no risk assessment in place to assess the risk to patients of not having one.

The practice held training sessions each year for the whole team so that they could maintain their competence in dealing with medical emergencies.

Staff recruitment

The principal dentist and dental nurse had current registration with the General Dental Council (GDC), the dental professionals' regulatory body.The practice had a

Are services safe?

recruitment policy which, although requiring updating, was in line with current recommendations and we saw evidence in staff files that it had been implemented 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.

We looked at three staff recruitment files and records confirmed they had been recruited in accordance with the practice's recruitment policy.

The systems and processes we saw were in line with the information required by regulations. Staff recruitment records were stored securely to protect the confidentiality of staff personal information.

We saw that all staff had received appropriate checks from the Disclosure and Baring Service (DBS). These are checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice maintained a comprehensive system of policies and risk assessments which included radiation, fire safety, general health and safety and those pertaining to all the equipment used in the practice. We found some of these required updating as most policies and risk assessments hadn't been updated since 2015.

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 including an infection control policy. 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 and control in dental practices) Essential Quality Requirements for infection control was being met. It was observed that audit of infection control processes carried out in 2016 confirmed compliance with HTM 01-05 guidelines.

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

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

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 general treatment room environment following the treatment of a patient. They demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

The practice had a separate decontamination room for instrument cleaning, sterilisation and the packaging of processed instruments. 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 combination of an ultra-sonic cleaning bath and manual scrubbing 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 sterilised, 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 complete and up to date. The practice used the foil test as evidence of validation of the ultra-sonic cleaning bath.

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 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.

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 April 2012 and then reviewed by the practice regularly thereafter. The recommended procedures contained in the report were carried out and logged appropriately. These measures ensured that patients and staff were protected from the risk of infection due to Legionella.

We saw that general environmental cleaning was carried out in accordance with a cleaning plan developed by the practice. Cleaning materials and equipment were stored in accordance with current national guidelines.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclave had been serviced and calibrated in April 2016. The practice's X-ray machine had been serviced and calibrated as specified under current national regulations in October 2015. Portable appliance testing (PAT) had been carried out in January 2017.

The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored securely.

The practice dispensed their own medicines as part of a patients' dental treatment for certain procedures. These medicines were a range of antibiotics, the dispensing procedures were in accordance with current secondary dispensing guidelines and medicines were stored in accordance with manufacturer's instructions.

We observed that the practice had equipment to deal with minor first aid problems such as minor eye problems and other minor injuries.

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 (IR(ME)R). 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 three-yearly maintenance log and a copy of the local rules. The local rules must contain the name of the appointed Radiation Protection Advisor, the identification and description of each controlled area and a summary of the arrangements for restriction access. Additionally, they must summarise the working instructions, any contingency arrangements and the dose investigation level.

We were shown that a radiological audit had been 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 the 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 that the dentist had received training for radiological knowledge under IR(ME)R 2000 Regulations.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentist carried out consultations, assessments and treatment in line with recognised general professional guidelines. They 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 oral hygiene instruction 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 that were shown to us by the dentist demonstrated 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.

Health promotion & prevention

The practice was focused on the prevention of dental disease and the maintenance of good oral health. The dentist explained that children at high risk of tooth decay were identified and were offered fluoride varnish applications 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). This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'.

Dental care records we observed demonstrated that the dentist had given 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.

Staffing

We observed a friendly atmosphere at the practice. All clinical staff had current registration with their professional body, the GDC.

We noted that the external name plate which detailed names of the dentist working at the practice did not include their GDC registration number in accordance with GDC guidance from March 2012.

Staff we spoke with told us they felt supported by the principal dentist. They told us they felt they had acquired the necessary skills to carry out their role and were encouraged to progress.

The practice employed one dental nurse and two receptionists. There was a structured induction programme in place for new members of staff.

Working with other services

The principal dentist could refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as special care dentistry and orthodontic providers.

Consent to care and treatment

The principal dentist explained how they implemented the principles of informed consent; they had a very clear understanding of consent issues. The principal dentist explained how individual treatment options, risks, benefits and costs were discussed with each patient and then

Are services effective?

(for example, treatment is effective)

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 principal dentist 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 added 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. Staff were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The treatment room door was closed always when patients were with the dentist.

Conversations between patients and the dentist could not be heard from outside the treatment rooms which protected patients' privacy. Patients' clinical records were in a paper format with records stored in an area of the practice not accessible to unauthorised members of the public.

Staff were aware of the importance of providing patients with privacy and maintaining confidentiality.

We obtained the views of 32 patients prior to the day of our visit. These provided a positive view of the service the practice provided. All the patients commented that the dentists were good at treating them with care and concern. 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 helpful and efficient. 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.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. The principal dentist we spoke with paid attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the principal dentist recorded the information they had provided to patients about their treatment and the options open to them.

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 variety of information. These explained opening hours, emergency 'out of hours' contact details and arrangements as well as how to make a complaint, comment or suggestion. 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. The dentist decided how long a patient's appointment needed to be and considered any special circumstances such as whether a patient was very nervous, had an impairment and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice had made some reasonable adjustments to help prevent inequity for patients that experienced limited mobility or other barriers that may hamper them from accessing services. The practice could access a translation service, which they arranged if it was clear that a patient had difficulty in understanding information about their treatment. The practice was on the first floor of the premises and was not accessible to patients with physical impairments. In these circumstances the practice referred these patients to two other practices nearby. We noted that the practice did not have a hearing loop.

Access to the service

The practice's opening hours were between 08:30 and 17:00 Monday to Thursday and between 08:30 and 13:00 on Friday. The practice is closed each weekday between 13:00 and 14:00.

The practice used the NHS 111 service and a private number to give advice in case of a dental emergency when the practice was closed. This information was publicised in the practice information booklet kept in the waiting area, NHS Choices 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 complaints from patients. Staff told us the practice team viewed complaints as a learning opportunity and discussed those received to improve the quality of service provided.

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.

For example, a complaint would be acknowledged within three working days and a full response would be given in 10 days. We noted that the practice had not received any complaints in the last three years.

Information for patients about how to make a complaint was available in the practice's 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.

Are services well-led?

Our findings

Governance arrangements

The principal dentist provided effective clinical dentistry leading to good patient outcomes, there were some shortfalls in the clinical governance systems and processes underpinning the clinical care. The practice did have a clinical governance system in place that was provided by a commercial company system, but the system had not been updated for two years. We saw several practice policies that required updating. All the staff we spoke with were aware of the policies and how to access them.

Leadership, openness and transparency

Clinical and business leadership was provided by the principal dentist. 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 described a transparent culture which encouraged candour, openness and honesty. Staff said they felt comfortable about raising concerns with 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 the staff demonstrated a firm understanding of the principles of clinical governance in dentistry and were happy with the practice facilities.

Learning and improvement

We saw that several clinical audits were undertaken by the practice that included audits in infection control and dental radiography. We did note the comment cards reflected a high degree of patient satisfaction of the care provided at the dentist and their staff, the practice had not carried out a formal satisfaction survey of patients in recent times.

Staff working at the practice were supported to maintain their continuing professional development as required by the GDC Staff told us that the practice ethos was that all staff should receive appropriate training and development.

The practice ensured that all staff underwent regular mandatory training in cardio pulmonary resuscitation (CPR), infection control, child protection and adult safeguarding and dental radiography (X-rays).

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

The practice gathered feedback from patients through compliments and complaints. We saw that there was a robust complaints procedure in place, with details available for patients in the waiting area.

The practice was listed on NHS Choices website with only minimal information as supplied by the Wessex Area Team on 12th November 2010. There were no patient reviews.

The Practice had not carried out a recent patient survey it was noted from the comment cards received that the patients who responded were happy with the level of service provided by the practice.

Staff told us that the dentists were very approachable and they felt they could give their views about how things were done at the practice. Staff told us that they had regular meetings and described the meetings as good with the opportunity to discuss successes, changes and improvements.