Mr Dominic Shipsey

Copperhouse Dental Surgery

Inspection Report

29 Fore Street
Hayle
Cornwall
Tel:01736 755781
Website:

Date of inspection visit: 16 March 2016
Date of publication: 16/05/2016

Overall summary

We carried out an announced comprehensive inspection on 16 March 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Copperhouse Dental Surgery is located in the coastal town of Hayle in Cornwall. The practice has level access and is situated entirely on the ground floor of a building on a main road. There are two treatment rooms, a decontamination room and a reception and waiting area.

The practice provides NHS dental services to approximately 4,000 adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers crowns and bridges.

The staff structure of the practice consists of two principal dentists, two dental nurses, and a team of receptionists.

The practice opening hours are Monday from 9.00am to 5.00pm, Monday to Friday. Outside of these hours a service is available via the 111 out of hour's service. These details are displayed at the entrance to the practice, and are visible from the outside the practice when the practice is closed.

The principal dentists are registered with the Care Quality Commission (CQC) as individuals. 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.

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

Summary of findings

Twenty eight patients provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly, professional 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.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Staff knew how to report incidents and how to record details of these so that the practice could use this information for shared learning.
- 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.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- The provider had a clear vision for the practice and staff told us they were well supported by the management team.
- Governance arrangements were in place for the smooth running of the practice.

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. 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 checked for effectiveness.

Are services effective?

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

The practice provided evidence-based care in accordance with relevant, published guidance, for example, from the General Dental Council (GDC). The practice monitored patients' oral health and gave appropriate health promotion advice. Staff explained treatment options to ensure that patients could make informed decisions about any treatment. The practice worked well with other providers and followed up on the outcomes of referrals made to other providers.

Staff engaged in continuous professional development (CPD) and were meeting all of the training requirements of the General Dental Council (GDC). New staff had received an induction and were engaged in a probationary process to review their performance and understand their training needs.

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 twenty eight written comment cards and by speaking with four 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.

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

There was a complaints policy in place; two complaints had been received in the past year.

Systems for receiving more general feedback from patients, with a view to improving the quality of the service, included a display setting out what patients had complained about and what action the practice had taken in response. For example, the practice had introduced laminated adjustable signs which advised patients whether their dentist was running on time, in response to a patient request.

The culture of the practice promoted equality of access for all. The needs of people with some visual or hearing difficulties had been considered and additional provision of information, for example, a hearing aid induction loop was available and large print information was also available. The practice was based entirely on the ground floor of the building and was wheelchair accessible.

Summary of findings

Are services well-led?

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

The practice had clinical governance and risk-management structures in place. 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 principal dentist to address any issues as they arose.

Copperhouse Dental Surgery

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.

We carried out an announced, comprehensive inspection on 16 March 2016. The inspection took place over one day and was carried out by a CQC inspector with telephone access to a dental specialist advisor.

We reviewed information received from the provider prior to the inspection. During our inspection we reviewed policy documents and spoke with four members of staff. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. A dental nurse demonstrated how they carried out decontamination procedures of dental instruments.

Twenty eight patients had provided written feedback about the service. We also spoke with four patients during our inspection. Patients were positive about the care they received from the practice. They were complimentary about the friendly, professional and caring attitude of the dental staff.

Friends and family survey feedback from January – March 2016 showed that 100% of 11 patients who responded were likely or extremely likely to recommend the service to friends and family.

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 a system in place for reporting and learning from incidents. There had been no significant events related to patients in the past year. There was a written policy most recently reviewed in October 2015 which described what types of events might need to be recorded and investigated.

We discussed the investigation of incidents with the principal dentist. They confirmed that if patients were affected by something that went wrong, they were given an apology and informed of any actions taken as a result.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any such incidents in the past 12 months.

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 well-designed safeguarding policy reviewed in January 2016 which referred to national guidance. Information about the local authority contacts for safeguarding concerns was held in a file at the reception desk. The staff we spoke with were aware of the location of this file and found it promptly. There was evidence in staff files showing that staff had been trained in safeguarding adults and children to an appropriate level.

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, we asked staff about the prevention of needle stick injuries. Following administration of a local anaesthetic to a patient, needles were not re-sheathed using the hands and a rubber needle guard was used instead which was in line with current guidelines. The staff we spoke with demonstrated a clear understanding of the practice policy and protocol with respect to handling sharps and needle stick injuries.

The practice followed other national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments in line with guidance from 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 had an oxygen cylinder, and other related items, such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. An automated external defibrillator (AED) was situated in reception. This was available for the dental practice to use; the staff were aware of its location and how to use it. (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 practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. 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 location of the emergency equipment.

Staff recruitment

The staff structure of the practice consisted of a principal dentist, a second dentist, three dental nurses and a receptionist.

Many of the staff had been in post for a number of years. One member of staff had been recruited within the past six months. There was a recruitment policy in place which stated that all relevant checks would be carried out to confirm that any person being recruited was suitable for the role. This included the use of an application form, interview, review of employment history, evidence of relevant qualifications, the checking of references and a check of registration with the General Dental Council. We reviewed two of the staff recruitment files and saw that records had been kept in relation to these checks.

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 saw evidence

Are services safe?

that all members of staff had a DBS check. (The DBS checks 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

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety policy in place, reviewed in January 2016. The practice had considered the risk of fire, had clearly marked exits and an evacuation plan. There were also fire extinguishers situated in the reception area.

There were 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. COSHH products were securely stored.

The practice had a system in place for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS).

There were informal arrangements to refer patients to other practices in the local area, should the premises become unfit for use.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. There was an infection control policy reviewed in November 2015 which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. We saw that hand washing training had taken place frequently and this was recorded in the in staff recruitment files we examined.

We observed that the premises appeared clean, tidy and clutter free. Clear zoning demarked clean from dirty areas in all of the treatment rooms. Hand-washing facilities were available, including wall-mounted liquid soap, hand gels and paper towels in each of the treatment rooms, decontamination room and staff toilet. Hand-washing protocols were also displayed appropriately in various areas of the practice.

We asked the dental nurse to describe to us the end-to-end process of infection control procedures at the practice. The protocols described demonstrated that 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)'.

The dental nurse explained the decontamination of the general treatment room environment following the treatment of a patient. Staff described the process they followed to ensure that the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines. Environmental cleaning was carried out in accordance with the national colour coding scheme by the cleaning staff employed to work throughout the building.

We checked the contents of the drawers in one of the treatment rooms. These were well stocked, clean, ordered and free from clutter. All of the instruments were pouched. It was obvious which items were for single use and these items were clearly new. Each treatment room had the appropriate personal protective equipment, such as gloves and aprons, available for staff and patient use.

The practice used a decontamination room for instrument processing. 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. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

Instruments were manually cleaned in the treatment room prior to transportation in a red lidded container to the dirty zone of the decontamination room. Items were inspected under an illuminated magnifier and then placed in an autoclave (steriliser). When instruments had been sterilised, they were pouched and stored appropriately, in a green lidded box, until required. Pouches were dated with a date of sterilisation and an expiry date in accordance with HTM 01-05.

Are services safe?

The practice carried out checks of the autoclave to assure themselves that is was working effectively. Periodic checks included the automatic control test and steam penetration test. A log book was used to record the essential daily validation checks of the sterilisation cycles.

The segregation and storage of dental 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. The practice used a contractor to remove dental waste from the practice. Waste was stored in a separate, locked location within the practice prior to collection by the contractor. Waste consignment notices were available for inspection.

Staff files showed that staff regularly attended training courses in infection control. Clinical staff were also 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. (People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections.)

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). The practice manager described the method they used which was in line with current HTM 01-05 guidelines. A Legionella risk assessment had been carried out by an external contractor in 2016. The practice was following recommendations to reduce the risk of Legionella, for example, through the regular testing of the water temperatures. A record had been kept of the outcome of these checks on a monthly basis.

The practice had carried out a practice-wide infection control audit in November 2015. This had identified some areas for improvement, which had been implemented. For example, the clear labelling of all clinical waste had been put in place. We noted that the previous audit had taken place in November 2013. We reminded the principal dentist of the recommendation to carry out these audits on a six-monthly basis.

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, fire equipment and X-ray equipment had all been inspected and serviced. Certificates for pressure equipment had been issued in accordance with the Pressure Systems Safety Regulations 2000. Portable appliance testing (PAT) had been completed in accordance with current guidance in February 2016. PAT is the name of a process during which electrical appliances are routinely checked for safety every two years as a minimum.

The expiry dates of medicines, oxygen and equipment were monitored using weekly and monthly check sheets to support staff to replace out-of-date drugs and equipment promptly. Dental care products requiring refrigeration, such as adhesives used for bridge work, were stored in a fridge in line with the manufacturer's guidance. The practice monitored the temperature of the fridge daily to ensure that these items were stored at the correct temperature.

Radiography (X-rays)

There was a radiation protection file, which was in the process of being completed at the time of the inspection, in line with the Ionising Radiation Regulations (IRR) 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor as well as the documentation pertaining to the maintenance of the X-ray equipment. We saw that the X-ray equipment had been serviced in January 2016.

We saw evidence that the principal dentist had completed radiation training.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Both of the dentists carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. The principal dentist described to us how they carried out their assessment. The assessment began with the patient completing a medical history update covering any health conditions, medicines being taken and any allergies suffered. 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.

The patient's dental care record was updated with the proposed treatment after discussing options with the patient. The dentist used intra-oral photographs of patients' mouths to aid discussions about the condition of the teeth and gums. Treatment plans were available upon request, and always provided for more complex treatments. Information about the costs involved were recorded in the written plans for complex treatments, such as implants. Patients were referred to the practice information leaflet, or website for cost information on routine treatments. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

We checked a sample of dental care records to confirm the findings. These showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums were noted using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). These were carried out, where appropriate, during a dental health assessment.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. The principal dentist told us they discussed oral health with their patients, for example, around effective tooth brushing. They were aware of the need to discuss a general preventive agenda with their patients. They told us they held discussion with their patients, where appropriate, around smoking cessation, sensible alcohol use and diet. The principal dentist also carried out examinations to check for the early signs of oral cancer.

We observed that there were health promotion materials displayed in the reception area. 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 checked the 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, infection control and X-ray training.

There was a written induction programme for new staff to follow and evidence in the staff files that this had been used at the time of their employment.

Many of the staff employed had worked at the practice for a number of years. One member of staff had been recruited within the last six months. They told us there had been a comprehensive induction course which included training on safeguarding, health and safety, infection control and information governance.

Working with other services

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients.

The principal dentist and reception staff explained how they worked with other services, when required. The dentist was able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. For example, the practice made referrals to other specialists for implants and more complicated extractions.

We reviewed the systems for referring patients to specialist consultants in secondary care. 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. The receptionist kept a log book noting the dates when referrals were made, when the appointment

Are services effective?

(for example, treatment is effective)

had been completed and further actions required for follow up. They contacted other providers to check on the progress of their patients and kept the principal dentist informed about the outcomes.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. We spoke to the principal dentist about their understanding of consent issues. They explained that individual treatment options, risks, benefits and costs were discussed with each patient. Patients were asked to sign formal written consent forms for specific treatments.

All of the staff were aware of the Mental Capacity Act 2005. (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). Staff had completed formal training in relation to the MCA in 2016. The principal dentist could describe scenarios for how they would manage a patient who lacked the capacity to consent to dental treatment. They noted that they would involve the patient's family, along with social workers and other professionals involved in the care of the patient, to ensure that the best interests of the patient were met.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The 28 comments cards we received, and the four patients we spoke with, all made positive remarks about the staff's caring, professional and helpful attitude. Patients indicated that they felt comfortable and relaxed with their dentist and that they were made to feel at ease during consultations and treatments. We also observed staff were welcoming and helpful when patients arrived for their appointment or made enquiries over the phone.

Staff were aware of the importance of protecting patients' privacy and dignity. The treatment room was situated away from the main waiting area and we saw that the door was closed at all times when patients were having treatment. Conversations between patients and the dentist could not be heard from outside the rooms, which protected patient's privacy.

Staff understood the importance of data protection and confidentiality and had received training in information governance. Patients' dental care records were stored in a paper format in locked filing cabinets. There were also electronic records for X-rays and charting. Computers were password protected and regularly backed up.

Involvement in decisions about care and treatment

The practice displayed information in a practice information leaflet available in the reception area, which gave details of NHS dental charges or fees.

We spoke with both of the dentists, two dental nurses and the receptionist on the day of our inspection. All of the staff told us they worked towards providing clear explanations about treatment and prevention strategies. We saw evidence in the records that the dentist recorded the information they had provided to patients about their treatment and the options open to them.

The patient feedback we received via comments cards, and through speaking with patients on the day of the inspection, confirmed that 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' dental needs. The dentist decided on the length of time needed for their patient's consultation and treatment according to patient need. The feedback we received from patients indicated that they felt they had enough time with the dentist and were not rushed.

Staff told us that patients could book an appointment in good time to see the dentist. The feedback we received from patients confirmed that they could get an appointment when they needed one, and that this included good access to emergency appointments on the day that they needed to be seen.

During our inspection we looked at examples of information available to people. We saw that the practice information leaflet displayed in the waiting area contained a variety of information including opening hours and costs.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. There was an equality and diversity policy for staff to refer to. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. Reception staff showed us they had could provide written information for people who were hard of hearing and use large print documents for patients with some visual impairment.

The practice was fully wheelchair accessible. There was level access at the entrance to the premises and the practice was based entirely on the ground floor. Although there was no patient toilet facility on the premises, the practice had a formal arrangement with a nearby café which enabled patients to use its toilets (which included a toilet with disabled facilities). There was signage about this arrangement on display throughout the practice. There were also public conveniences nearby. Patients told us that this had never been a problem.

Access to the service

The practice opening hours were from 9.00am to 5.00pm, Monday to Friday. Outside of these hours a service was available via the 111 out of hour's service. These details were displayed at the entrance to the practice, and were visible from the outside the practice when the practice was closed.

We asked the principal dentist and the receptionist about access to the service in an emergency or outside of normal opening hours. They told us the answer phone message gave details about how to access out-of-hours emergency treatment.

The receptionist told us that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, were seen on the same day that they alerted the practice to their concerns. The feedback we received via comments cards confirmed that patients had good access to the dentist in the event of needing emergency treatment.

Concerns & complaints

Information about how to make a complaint was displayed in the reception area. There was a formal complaints policy describing how the practice handled formal and informal complaints from patients. There had been two complaints recorded in the past year which had been fully investigated and dealt with in line with the duty of candour.

Patients were also invited to give feedback through a suggestions box in the reception area.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements and a management structure. There were relevant policies and procedures in place. Staff were aware of these and acted in line with them.

There were arrangements for identifying, recording and managing risks through the use of risk assessment processes.

Regular meetings took place at the practice. These included a staff meeting on the first Wednesday of every month. Records showed items discussed at the March 2016 meeting included information governance, equality and diversity training and the introduction of new uniforms.

The principal dentist told us about the governance structures and protocols at the practice. A systematic process of induction and staff training was in place which ensured that staff were aware of, and were following, the governance procedures.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said that they felt comfortable about raising concerns with the principal dentist. They felt they were listened to and responded to when they did so.

We found staff to be hard working, caring towards the patients and committed to the work they did. We found the principal dentist provided effective clinical leadership to the dental team.

Staff told us they enjoyed their work and were supported by the principal dentist. They understood the systems for staff appraisal and were focused on meeting high standards by the end of their probationary period.

Learning and improvement

The principal dentist had a clear vision for the practice which included plans for improving the premises and equipment. For example, the principal dentist had plans to install a patient toilet with disabled facilities at the practice. The practice had introduced modern dental chairs with an inbuilt system to clean their water lines with peroxide on a regular basis, in line with current practice. The principal dentist carried out clinical supervision at Plymouth University Peninsular Medical School every week. This enabled them to deliver the most up to date patient care and treatment.

Dentists at the practice kept up to date with current practice and learning through six weekly attendances at a dental clinical quality standards committee.

Staff were 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 the dentist was working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the GDC.

The practice had completed clinical audits of infection control and dental care records. The most recent infection control audit had been completed in November 2015 had identified some action points, and these had been implemented. For example, the clear labelling of all clinical waste had been put in place.

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

The practice gathered feedback from patients through the use of a suggestions box in the waiting area. The practice had a laminated poster in reception which displayed patient feedback and actions taken as a result. For example, patients had suggested the introduction of a toy to entertain children whilst they waited for their appointment. This had been implemented. There was a children's bead toy, which could be cleaned easily, available in the waiting room on the day of our inspection.

Staff told us that the principal dentist was open to feedback regarding the quality of the care. The appraisal system also provided appropriate system for staff to give their feedback.