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# The Hub

## Inspection Report

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## Overall summary

We carried out an announced comprehensive inspection on 3 May 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**

The Hub is a private dental practice situated in the centre of Milton Keynes. It occupies a commercial unit and offers a variety of specialist treatments as well as general dentistry. These include dental implants (metal posts that are place surgically into the jaw in order to support false teeth, or an individual tooth) and treatment under conscious sedation (treatments where a sedative medicine is given to relax the patient whilst maintaining verbal contact at all time).

The practice was first registered with the Care Quality Commission in April 2011.

The practice is open 7 days a week: 7.30 am to 7.30 pm from Monday to Friday, 7.30 am to 5.30 pm on Saturday and 9.00 am to 5.30 pm on Sundays and Bank Holidays.

Outside normal working hours patients are directed to call the principal dentist on his mobile phone. The number of which is available on the practice website, and patient information leaflet, as well as being displayed on the front door of the practice.

The practice has three dedicated treatment rooms, and a fourth multi-purpose room that was used for decontamination, taking X-rays and consultations.

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

# Summary of findings

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

We received positive feedback from 28 patients through comment cards that were placed in the practice for the two weeks preceding our visit.

**Our key findings were:**

- The practice was open 7 days a week 365 days of the year so patients were able to access the service and emergency care any day, including Christmas Day.
- Patients commented that staff were friendly and helpful, and put nervous patients at ease.
- The practice had medicines and equipment in order to treat medical emergencies in line with published guidance.
- Infection control procedures were carried out in accordance with published guidance, and audited six monthly to ensure they remained effective.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- All staff had undertaken training in safeguarding and the mental capacity act, staff had a good understanding of how to raise a safeguarding concern, and when they would do so.

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

- Review the practice's system for the recording, investigating and reviewing of incidents or significant events with a view to preventing further occurrences and, ensuring that improvements are made as a result.
- Review the practice's recruitment policy and procedures and consider if the recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.
- Review the practice's protocols for medicines management and ensure all medicines are stored appropriately.
- Review the training, learning and development needs of individual staff members and have an effective process established for the on-going assessment of all staff.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Are services safe?**

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

Staff had received medical emergencies training and had a good understanding of what medicines might be required for specific emergencies.

Essential standards in infection control as detailed in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' published by the Department of Health, were being met.

The practice demonstrated compliance with the Ionising Radiation Regulations (IRR) 1999, and the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000, in the safe use of X-rays for medical purposes.

The practice had made some recent improvements to their system of pre-employment checks, but could not demonstrate that references had been requested and received for some staff.

**Are services effective?**

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

Clinicians were using nationally recognised guidance in the care and treatment of patients.

Trained staff were all appropriately registered with the General Dental Council and had no conditions on their practice.

A thorough screening process was carried out for patients including assessment of their gum health and soft tissues.

**Are services caring?**

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

Patients' confidentiality was maintained by way of a computerised appointments system and dental care records which were password protected.

Patients commented that staff were friendly and professional, and we observed patients being treated with kindness and dignity.

**Are services responsive to people's needs?**

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

The practice was open every day, and offered early morning and evening appointments thereby ensuring that patients could be seen at a convenient time to them.

The practice offered conscious sedation (these are techniques in which the use of a medicine or medicines produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation).

Complaints to the service had been investigated, and apologies issued to patients in a timely manner.

**Are services well-led?**

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

The practice had a number of polices in place to assist in the smooth running of the practice.

# Summary of findings

The principal dentist carried out a comprehensive programme of training for all the staff.

Clinical audits were used to highlight areas that could be improved, and staff received feedback in order to improve their practice.

# The Hub

**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 3 May 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Before the inspection we asked the practice for information to be sent, this included the complaints the practice had received in the last 12 months; their latest statement of purpose; the details of the staff members, their qualifications and proof of registration with their professional bodies.

During the inspection we spoke with three dentists, five dental nurses and the practice manager. We reviewed policies, procedures and other documents. We received feedback from 28 patients about the dental service.

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 had limited systems in place to report, investigate and learn from incidents. They did not keep an incident log, however they did report accidents in an accident book. The most recent accident noted was in September 2015 and involved a minor injury to a member of staff. The incident was investigated and appropriate actions taken.

Although the practice did not log specific incidents they did explain that incidents were relayed to staff in the form of a memo. We saw examples of these that had been shown to all staff and signed to confirm they understood the contents.

The practice received alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). These detailed any recalls or alerts with medical equipment and medicines. These were emailed to the principal dentist who passed on any relevant alerts in the form of a memo.

The practice were aware of their responsibility in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). They had a policy in place dated January 2016, and this detailed how to make a report and in what circumstances a report should be made. RIDDOR is managed by the Health and Safety Executive, although since 2015 any RIDDORs related to healthcare have been passed to the Care Quality Commission (CQC).

**Reliable safety systems and processes (including safeguarding)**

The practice had systems and policies in place regarding safeguarding vulnerable adults and child protection. Policies were readily available in hard copy form and relevant contact numbers were displayed on the wall behind reception, and in the toilet that was used for both staff and patients, including the contact details for the local multi-agency safeguarding hub (MASH).

Staff we spoke with had a good understanding of how and when to raise a safeguarding concern, and where they would find the relevant telephone numbers. Staff had all completed training in safeguarding vulnerable adults and child protection appropriate to their role.

The practice had an up to date employers' liability insurance certificate which was due for renewal in November 2016. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

Root canal treatment was carried out, where practicably possible, using rubber dam (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). The British Endodontic Society recommends the use of rubber dam for root canal treatment.

**Medical emergencies**

The dental practice had equipment in preparation for any medical emergencies that might occur. This included emergency medicines and oxygen as detailed in the British National Formulary. These were centrally located and we saw there was a system in place for checking and recording expiry dates of medicines, and replacing when necessary.

The equipment for use in a medical emergency was in line with the Resuscitation Council UK guidance and included an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. The AED was being checked regularly to ensure it was working correctly.

All staff had undertaken medical emergencies training including basic life support in January 2016. Staff we spoke with demonstrated a good knowledge of how to respond in a medical emergency, including which specific medicines would be required for a range of emergencies.

**Staff recruitment**

We looked at the staff recruitment files for six staff members of different grades to check that the recruitment procedures had been followed. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all staff recruitment files. This includes: proof of identity; checking the person's skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not

needed). 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.

We found that all staff had a DBS check in place, or for new staff, an application had been made. Whilst awaiting the results of the check the practice did not allow new staff to be unsupervised with a patient.

It was apparent that there had been recent improvements to the system of pre-employment checks that had been carried out; with more recently employed staff having more records of checks being carried out. For example: the principal dentist had previously requested references, but not kept a copy of them, or a record that they had been received, more recently employed staff had a record of references received.

The practice were also in the process of auditing the staff recruitment files so that they were able to recognise where records were not complete and if necessary make appropriate amendments.

Staff had undertaken an induction programme over 28 days when they joined the service; during this the staff were made aware of the practice's policies and procedures.

**Monitoring health & safety and responding to risks**

The practice had a health and safety policy which was dated January 2016, this detailed topics including fire safety, manual handling, hazardous substances and waste disposal.

A risk assessment for sharps had been carried out in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. In response to this the practice had a needle handling policy which directed all dentists to take responsibility for disposing of their sharps at the point of use. Needle blocks were available to aid the clinicians in this task.

In addition the practice had introduced a system of disposable matrix bands. These form a collar around a tooth when placing certain fillings and can be very sharp. This system mitigates the risk of removing and replacing the band, by allowing the whole instrument to be disposed of. The practice did also have conventional matrix bands available as some clinicians preferred them.

A fire risk assessment had been carried out internally in January 2016. This lacked some detail, however the fire policy was well known by the staff including the external muster point. Fire extinguishers had been replaced within the previous year, and the fire alarm was checked weekly.

The principal dentist told us that an appropriately trained person had appraised the fire arrangements at the practice, but there was no record of this.

Risk assessments regarding the use of latex rubber within the practice, pressure vessels and medical emergencies had also been carried out.

**Infection control**

The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for cleaning, sterilising and storing dental instruments and reviewed their policies and procedures.

There was an infection control policy in place at the practice (dated February 2016), and infection control audits were carried out every six months.

Decontamination is the process by which contaminated re-usable instruments are washed, rinsed, inspected, sterilised and packaged ready for use again. We observed two dental nurses carrying out the process.

Instruments were manually cleaned, rinsed and inspected under an illuminated magnifier before being sterilised in an autoclave.

The practice had two autoclaves. After sterilising the instruments were packaged and dated with the date they were processed and a use by date.

We were shown details and logs of the tests performed on a daily, weekly and monthly basis to ensure that the decontamination process was working effectively. These were in accordance with the standards set out in HTM 01-05.

There were records to demonstrate that staff had received inoculations against Hepatitis B or were in the process of receiving them. Health professionals who are likely to come into contact with blood products, or who are at increased risk of sharps injuries should receive these vaccinations to minimise the risk of contracting blood borne infections.

# Are services safe?

We examined the practice's protocols for storing and disposing of clinical and contaminated waste. The practice stored contaminated waste in an external clinical bin, which was locked and secured. We saw waste consignment notices indicating appropriate disposal of amalgam, sharps and clinical waste.

The practice staff took responsibility for cleaning the practice, and the equipment used for this conformed to the national guidelines for colour coding. This ensured that cleaning equipment used in the clinical areas was separate from those used in sanitary areas. During our visit we recognised that the mops were not stored in accordance with the guidance, however this was immediately rectified.

The practice had systems in place to reduce the risk of Legionella. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. A risk assessment had been carried out by an external assessor in January 2016. The practice were checking water temperatures and logging that this had been completed, but only by way of a tick box, rather than recording the actual temperature. In addition they sent water samples for testing annually to ensure there had been no growth of bacteria.

**Equipment and medicines**

We saw that the practice had equipment to enable them to carry out the full range of dental procedures that they offered. This included specific equipment for the placement of implants, gowns for surgical procedures, and sterile fluid for use in the surgical drill unit.

The practice offered patients the opportunity to have treatment under conscious sedation - (these are techniques in which the use of a medicine or medicines produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation). The practice had a visiting medical practitioner who administered the sedation and monitored the patient throughout the process, as well as discharging them afterwards.

The practice was meeting the standards set out in the guidelines published by the Standing Dental Advisory Committee: conscious sedation in the provision of dental care. Report of an expert group on sedation for dentistry, Department of Health 2003. However they did not have a plan in place to fully achieve the standard outlined in the 2015 guidance.

Glucagon is an emergency medicine which is given to diabetics in the event of a hypoglycaemic attack (low blood sugar). It needs to be stored within two to eight degrees Celsius in order to be valid until the expiry date, but could be stored outside the refrigerator at a temperature not exceeding 25 degrees Celsius for 18 months provided that the expiry date is not exceeded. We found that the medicine was kept in a designated fridge the temperature of which was being checked, but not recorded. When we checked the fridge temperature during our inspection it was over eight degrees Celsius. We raised this with the practice manager who took immediate steps to rectify the situation and ensure that the medicine would be effective if needed.

Records showed that equipment at the practice was maintained and serviced in line with manufacturer's guidelines and instructions. Pressure vessel testing had been carried out on the autoclaves and compressor within the last year to ensure they functioned safely. Portable appliance testing had been carried out on all electrical equipment in January 2016.

The practice dispensed antibiotics. These were kept securely on the premises. Logs were kept of the antibiotics dispensed, and invoices for the antibiotics detailed the batch numbers as they were delivered to the practice. This was underpinned by the safe use and storage of medicines policy which was reviewed in January 2016.

**Radiography (X-rays)**

The practice demonstrated compliance with the Ionising Radiation Regulations (IRR) 1999, and the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.

The practice had two intra-oral X-ray machines in treatment rooms, which took small X-rays of one or a few teeth at once. They had a dental panoramic tomograph (DPT) machine which takes an X-ray of the whole jaw. The practice used digital X-rays, which meant the image was available to view almost immediately, and used a smaller effective dose of radiation.

In addition the practice had a cone beam computered tomography machine (CBCT). This takes three dimensional

images of an area of the jaw, and can be used to identify whether there is an appropriate amount of bone present to place an implant, or see where a nerve runs in relation to the roots of a tooth. Two of the clinicians had undertaken specific training on CBCT.

The practice kept a radiation protection file which detailed the responsible people involved in taking X-rays as well as appropriate testing and servicing of each X-ray machine. Staff who took X-rays were up to date with required training as detailed by IR(ME)R, and regular clinical audits had been carried out to ensure the quality of X-rays taken.

In this way the practice strived to ensure that the dose of radiation to the patients was as low as reasonably possible.

# Are services effective?

(for example, treatment is effective)

## Our findings

**Monitoring and improving outcomes for patients**

During the course of our inspection patient care was discussed with the dentists and we saw patient care records to illustrate our discussions.

A comprehensive medical history form was given to patients to complete at their first visit. This was then scanned onto their computerised record and they were asked to check and sign on an electronic signature pad. The forms were then checked and re-signed annually.

Dental care records showed that the dentists regularly checked gum health by use of the basic periodontal examination (BPE). This is a simple screening tool that indicates the level of treatment need in regard to gum health. Scores over a certain amount would trigger further, more detailed testing and treatment.

Screening of the soft tissues inside the mouth, as well as the lips, face and neck was carried out to look for any signs that could indicate serious pathology.

We saw that dentists made a record of why an X-ray was required, as well as grading that X-ray for quality and reporting on what the X-ray showed. This was in line with the requirements of the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.

The dentists used current National Institute for Health and Care Excellence (NICE) guidelines to assess each patient's risks and needs and to determine how frequently to recall them. They also used NICE guidance to aid their practice regarding antibiotic prophylaxis for patients at risk of infective endocarditis (a serious complication that may arise after invasive dental treatments in patients who are susceptible to it), and removal of lower third molar (wisdom) teeth.

We saw separate written care records detailing the provision of sedation. This included a pre-sedation checklist and consent form. Also a medical assessment of the patient by the sedationist, a blood pressure check and continuous monitoring of the pulse and oxygen saturation level throughout the procedure.

**Health promotion & prevention**

The medical history form that patients completed detailed the patients' nicotine and alcohol use. We saw evidence through the dental care records that smoking cessation advice and dietary advice had been given to patients as part of their comprehensive check-up. The practice also prescribed high fluoride toothpaste for patients with a high risk of dental decay.

The practice had a policy on promoting dental health, this detailed ways in which the clinicians could engage patients in their oral health, for example: by inviting patients to show the clinicians how they brushed their teeth.

There was literature available in the waiting area for patients to read and take away, this included a leaflet on diabetes and oral health, and another detailing how you should care for your child's teeth.

**Staffing**

The practice was staffed by nine dentists, a specialist orthodontist, a dental hygienist, two qualified dental nurses, eight trainee dental nurses and a practice manager.

Prior to our visit we checked the registrations of the dental care professionals and found that they all had up to date registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians, orthodontic therapists and dental technicians.

Staff told us they had good access to ongoing training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the GDC. The practice had signed up to an online training programme to facilitate this. Clinical staff were up to date with their recommended CPD as detailed by the GDC including medical emergencies, infection control and safeguarding.

Some of the dental team were undergoing further specialist training in various specialities including in dental implants, and cosmetic dentistry.

Regarding the provision of conscious sedation we saw records indicating that the sedationist had undergone appropriate training and continuous professional development in the provision of sedation. They had also completed immediate life support training which taught, not only cardio-pulmonary resuscitation, but also how to recognise and treat a deteriorating patient in order to prevent cardio-pulmonary arrest.

# Are services effective?

## (for example, treatment is effective)

The dentists and dental nurses in the practice had received in house training on sedation to enable them to assist.

The practice had not reviewed staff training requirements in conscious sedation as set out in The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015.

**Working with other services**

The practice made referrals to other dental professionals when it was unable to provide the treatment themselves. The practice kept a log of all referrals made and would follow these up if a reply had not been received. Urgent referrals were emailed to save time, and also followed up with a telephone call to confirm receipt.

Patients were all given a copy of their referral letter for their own records.

The practice accepted referrals for cone beam computered tomographs (three dimensional scans of the jaw). The practice had a preformed template for referring clinicians to use which drew reference to the IR(ME)R regulations, and required confirmation that the referring clinician was suitably qualified and able to interpret the images requested.

**Consent to care and treatment**

Clinicians we spoke with detailed how they were able to ensure they had received full, valid and informed consent for treatment from the patients. The practice had a series of detailed information leaflets about various treatments, these were available for patients to take away. In addition each treatment had its own individual consent form. The cost was included in the consent form and patients could take a copy away to consider before signing to indicate their consent.

We saw evidence in dental care records that discussions about treatment options had taken place.

The Mental Capacity Act 2005 (MCA) provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Staff had all undertaken training in the MCA and demonstrated an understanding of the MCA and how it applied in considering whether or not patients had the capacity to consent to dental treatment.

Staff we spoke with had a good understanding of the situation which a child under the age of 16 could legally consent for themselves. This is termed Gillick competence and relies on the assessment of a child's understanding of the procedure and the consequences of having/not having the treatment.

# Are services caring?

## Our findings

**Respect, dignity, compassion & empathy**

Staff we spoke with explained how patients' confidentiality was maintained in the practice. The dental care records were computerised and password protected, and we saw that computers on the reception desk were positioned below the level of the counter so that they could not be overlooked by someone stood at the desk. This was underpinned by policies on patient confidentiality and data security.

We observed patients to the practice being treated in a friendly and kind manner, and comments we received from patients indicated that staff were professional and skilled at putting nervous patients at ease.

**Involvement in decisions about care and treatment**

Dental care records indicated that discussions regarding treatment options were held with patients, and comments we received from patients indicated that staff gave clear and detailed information including the risks and benefits of a treatment and the costs involved.

An individual written treatment plan was given to all patients which detailed the treatment and the costs, and information leaflets were available to patients to take away.

The price list for treatment was detailed on the patient information leaflet as well as the practice website.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting patients' needs**

As part of our inspection we conducted a tour of the practice and found the premises and facilities were appropriate for the services delivered.

We examined the appointments book and found that adequate time had been allocated for each patient for discussion and treatment. Reminders for appointments were sent out by text message, or e-mail if the patient preferred.

The practice saw many emergency patients, who were often very nervous. Staff described how they prided themselves in being able to help these patients and put them at ease. They described how they would try to identify their anxieties and make all reasonable adjustments to make them more comfortable.

If patients wanted to have conscious sedation the practice might arrange an advance appointment with the sedationist so that they could talk through their concerns and decide whether it was the right choice for them.

**Tackling inequity and promoting equality**

Staff told us they welcomed patients from diverse backgrounds and cultures, and they were all treated according to their needs.

We spoke with staff about how they met the individual needs of patients. The practice had level access and was situated solely on the ground floor, meaning that wheelchair access was possible. In addition the dental chair in one of the treatment rooms was able to swivel on its base allowing improved access around the chair.

Although the practice did not have access to an interpreting service many of the staff spoke multiple languages, and staff said they have never had the need of an interpreter beyond those languages the staff spoke.

**Access to the service**

The practice was open from 7.30 am to 7.30 pm from Monday to Friday, 7.30 am to 5.30 pm on Saturday and 9.00 am to 5.30 pm on Sundays and Bank Holidays. These opening hours made it easier for patients to access the service at a time that was convenient to them.

The practice was open every day of the year, including Christmas Day and would see emergency patients every day. Out-of-hours patients were directed to a mobile phone number held by the principal dentist. The number was displayed on the door of the practice as well as being on the practice information leaflet and the website, so patients could be assured of speaking to a dentist at arranging to be seen if necessary.

The practice made every effort to see patients making emergency appointments on the day they contacted the practice, whether they were previous patients of the practice or new patients.

**Concerns & complaints**

The practice had a complaints handling policy which was dated December 2015. This was available for staff to reference, and was also displayed in the waiting area for patients. The policy detailed how a complaint could be made to the practice, and also how to escalate the complaint beyond the practice if the patient remained dissatisfied after the practice had addressed the complaint. These organisations included the dental complaints service and the General Dental Council.

The practice kept a complaints log which allowed the practice to track any trends in the type of complaint being received. We saw evidence that complaints to the practice were investigated and apologies given to the patients in a timely manner if appropriate. Learning was fed back to the dental team to prevent their reoccurrence.

# Are services well-led?

## Our findings

**Governance arrangements**

The practice had a number of polices in place to support the smooth running of the service. This included complaints, cross infection control, whistleblowing and health and safety. These were available for staff to reference in hard copy form.

The practice held staff meetings every two weeks. These often took the form of lunch and learn sessions and involved a training aspect as well as discussing any complaints, incidents or alerts. Recent topics for discussion included consent and confidentiality. Detailed minutes of these meeting were taken so that staff who were not able to attend could understand what was discussed.

We recognised recent improvements to some of the systems in the practice, most notably regarding records of pre-employment checks, and auditing that had taken place to identify areas that needed to be addressed in the process.

**Leadership, openness and transparency**

Staff reported a culture of honesty and transparency throughout the practice. They reported that they felt comfortable to raise concerns with either the principal dentist or the practice manager and felt supported in doing so.

The practice had a whistleblowing policy in place. This directed staff on the actions to take if they felt concerned about a colleague's actions or behaviours.

**Learning and improvement**

The practice sought to continuously improve standards by use of quality assurance tools, and continual staff training.

Clinical audit that had been carried out in the last year included: an audit on antibiotic prescribing, handwashing audits, a consent and treatment planning audit, X-ray quality, and infection control.

Staff were supported in achieving the General Dental Council's requirements in continuing professional development (CPD). We saw evidence that all clinical staff were up to date with the recommended CPD requirements of the GDC.

The practice principal provided a comprehensive programme of training for the staff, in addition to which the practice had signed up to an online training portal so that staff could learn in their own time, and at their own rate.

The practice had set up a programme of yearly staff appraisals to assess their training needs; however some staff had not received an appraisal in the last year.

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

The practice provided satisfaction surveys to patients in order to see what areas of the service could be improved upon. As a direct result of such feedback the practice had changed all the waiting room chairs, so that they had arms. This helped elderly patients getting up from the chairs.

The principal dentist and practice manager welcomed feedback from staff either formally or informally, as a result of such feedback mobile trolleys for storing instruments were placed in the corridor so that staff did not have to enter a treatment room where a patient might be, to get a particular instrument.