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Peartree Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 7 March 2017 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Peartree Dental Practice is a general dental practice close to the centre of Welwyn Garden City in Hertfordshire.

The practice has two treatment rooms and offers general dental treatment to adults and children funded by the NHS or privately. The practice offers dental implants privately. A dental implant is a metal post that is placed surgically into the jaw bone; one or more can be used to support a tooth or teeth.

The practice now has one principal dentist, two associate dentists and one locum dental hygienist, supported by three qualified dental nurses and a practice manager. Reception duties are covered by the dental nurses and practice manager.

The practice is open from 9 am to 5.30 pm on Monday to Friday.

The practice is not fully accessible to wheelchair users. There is a downstairs treatment room where patients with limited mobility are accommodated. The toilet facilities are not wheelchair accessible, and although there is a ramp to the front door there is still a lip at the threshold that wheelchair users would have to negotiate to gain access.

The practice owner 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.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience. We received feedback from 20 patients. These provided a positive view of the services the practice provides. Patients commented on the quality of care, the polite and friendly nature of staff and the cleanliness of the practice.

Our key findings were:

- The practice was visibly clean and clutter free.
- Comments from patients indicated that the staff were kind and caring and were skilled at putting nervous patients at ease.
- The practice met the standards set out in national guidance regarding infection control.
- A routine appointment could be secured within a couple of weeks and emergency appointments would be arranged where possible on the day they contacted the service.
- The practice had policies in place to assist in the smooth running of the service.
- The practice had medicines and equipment to treat medical emergencies.
- Dentists at the practice used national guidance and standards in the care and treatment of patients.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- Governance arrangements were in place for the smooth running of the service.
- Appropriate pre-employment checks were being carried out to ensure the service employed fit and proper persons.
- The practice was not logging prescriptions pads in line with national guidance.
- The practice was not including all required information on labels when dispensing medicines.
- The clinicians were not always using rubber dam when completing root canal treatment.

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

- Review the practice protocols regarding records of prescription forms with reference to the NHS guidance on security of prescription forms August 2013.
- Review the labelling of medicines that are dispensed giving due regard to schedule 26 of the Human Medicines Regulations 2012.
- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society.

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.

Infection control standards met those outlined in national guidance.

The practice was carrying out appropriate pre-employment checks on staff, including disclosure and barring service checks to ensure they employed fit and proper persons, although verbal references were not always recorded.

X-rays taken on the premises were carried out in line with current regulation.

Equipment was serviced in line with manufacturers' requirements.

Prescription pads were kept securely; however the practice were not logging the serial numbers in line with NHS Protect guidance.

No action



Are services effective?

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

The dentists used nationally recognised guidance in the care and treatment of patients.

A comprehensive screening of patients was carried out at check-up appointments including assessing risks associated with gum health, cancer and decay.

Staff demonstrated a good understanding of the Mental Capacity Act and Gillick competence and their relevance in establishing consent.

No action



Are services caring?

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

Comments from patients were overwhelmingly positive about the care and treatment they received.

Patients were involved in the decisions around their treatment and care.

Written treatment plans were given to patients for them to be able to consider their options.

No action



Are services responsive to people's needs?

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

The practice made every effort to see emergency patients on the day they contacted the practice.

Staff made every effort to assist patients with restricted mobility, although the layout of the premises presented challenges in this regard.

No action



Summary of findings

Complaints to the practice were dealt with in a timely manner and in line with the practice policy.

Are services well-led?

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

The practice had a series of policies to aid in the smooth running of the practice. These were available in hard copy form for staff to access.

Staff felt supported and encouraged to approach the principal dentist with ideas or concerns.

Clinical audit was used as a tool to highlight areas where improvements could be made.

No action



Peartree 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 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 7 March 2017. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Before the inspection we asked the provider 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. We spoke with members of staff and patients during the inspection.

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 a system in place for reporting and learning from untoward incidents. A policy was in place and templates were used to record incidents, these prompted staff to investigate and feedback learning points to prevent reoccurrence. We were shown examples of significant event recording.

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. A clear understanding of this was evident during our discussions with staff and records of significant events.

The practice received communication from the Medicines and Healthcare products Regulatory Agency (MHRA). These were e-mailed to the practice manager who took responsibility for taking any necessary action and disseminating relevant information to staff.

The practice was aware of their responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). RIDDOR is managed by the Health and Safety Executive (HSE). The practice had a folder which contained RIDDOR forms and information on how and when to make a report.

Reliable safety systems and processes (including safeguarding)

The practice had a policy in place regarding safeguarding vulnerable adults and child protection which indicated the signs of abuse to look for and what actions to take if concerned. A flow chart was also available indicating the actions to take and contact numbers were displayed on the wall.

All staff had undertaken training in safeguarding and staff we spoke with were able to describe the actions they would take in response to concerns, including how to respond if they felt a vulnerable adult or child were in immediate danger. We were shown an example of where the practice manager had responded immediately and appropriately to a concern.

The practice had an up to date Employers' liability insurance certificate which was due for renewal in June 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

We discussed the use of rubber dam with the dentist in the practice. A rubber dam is a thin, rectangular sheet, usually of latex rubber. It is used in dentistry to isolate a tooth from the rest of the mouth during root canal treatment and prevents the patient from inhaling or swallowing debris or small instruments. The British Endodontic Society recommends the use of rubber dam for root canal treatment. We found that a rubber dam was available, but not used routinely.

A protocol was in place detailing the actions required in the event of a sharps injury. This directed staff to seek advice from occupational health or accident and emergency in the event of an injury with a contaminated sharp.

The practice were not using safer sharps at the time of the inspection. These are medical sharps that have an in built safety features to reduce the risk of accidental injury. The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 require that practices switch to 'safer sharps' where it is reasonably practicable to do so. The practice had a risk assessment in place, and dentists were solely responsible for the disposal of sharps. Following the inspection the practice began a trial of safer sharps.

Medical emergencies

The dental practice had medicines and equipment in place to manage medical emergencies. These were stored together and all staff we spoke with were aware how to access them. Emergency medicines were in date, stored appropriately, and in line with those recommended by the British National Formulary. Medicines were stored in individual boxes for different medical emergencies and instructions for use were kept in each box.

Equipment for use in medical emergency was available in line with the recommendations of the Resuscitation Council UK including 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.

Staff undertook basic life support training annually with an external trainer most recently in May 2016.

Are services safe?

Staff we spoke with were able to describe the whereabouts of the medical emergencies medicines and equipment and demonstrated knowledge of which medicine was required for specific medical emergencies.

Staff recruitment

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all recruitment files. This includes: proof of identity; checking the prospective staff members' 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 had a criminal record or was 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 reviewed the staff recruitment files for four members of staff. DBS checks had been sought for all staff and all other pre-employment checks had been completed in line with regulation, although verbal references were not always recorded.

The practice used a locum agency for access to staff when required. The practice had confirmation from the agency regarding the pre-employment checks they carry out on all staff, and in addition completed the routine checks for any staff member working at the practice.

Monitoring health & safety and responding to risks

The practice had systems in place to monitor and manage risks to patients, staff and visitors to the practice. A health and safety policy was updated in November 2016 and was available for all staff to reference in hard copy. This included topics such as manual handling, electrical safety and pressure vessels.

A full practice risk assessment was completed in March 2017 and previous to this a compliance audit in health and safety was completed by an external contractor in August 2016. This had generated an action plan, all of which items had been addressed within an appropriate timeframe.

A sharps risk assessment indicated that dentists were solely responsible for dealing with medical sharps.

A fire risk assessment had been completed by an external contractor in August 2016; recommendations highlighted had been implemented in an appropriate timeframe. In addition to this the practice undertook weekly fire alarm tests and monthly emergency lighting checks. Staff we spoke with were able to describe the actions they would take in the event of a fire and identify the external assembly point. Staff had training in fire safety in August 2016. Information for patients was displayed in the waiting area.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. A file of information pertaining to the hazardous substances used in the practice and actions described to minimise their risk to patients, staff and visitors.

The practice had a business continuity plan in place which detailed the actions to take should the premises be unusable due to unforeseen circumstances. This included an arrangement for emergency patients to be seen at a nearby practice. The principal dentist and practice manager both kept copies of this policy off site.

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.

The practice had an infection control policy in place, this included topics such as hand hygiene, blood borne viruses, clinical waste and personal protective equipment. In addition an infection control action plan had been completed in March 2017.

The practice was visibly clean and clutter free.

The practice had a dedicated decontamination facility. The decontamination room had two sinks for manually cleaning and then rinsing dental instruments. We observed staff manually cleaning instruments and noted that their technique was in line with that recommended by HTM 01-05.

Instruments were inspected under an illuminated magnifier prior to sterilisation in the autoclave and then pouched and stamped with the date they were sterilised.

Are services safe?

Appropriate testing of the autoclaves took place, in line with the recommendations of HTM 01-05.

The practice had contracts in place for the disposal of contaminated waste and waste consignment notes were seen to confirm this. Clinical waste was stored in a locked bin prior to its removal.

The practice had a cleaner who undertook the environmental cleaning of the practice daily. We saw schedules of the cleaning to be carried out and saw that equipment for cleaning conformed to the national standard for colour coding cleaning equipment in a healthcare setting.

We noted an area that was difficult to clean due to damage; a tear in the assistants chair in one of the treatment rooms would make cleaning the chair effectively difficult.

The practice had a risk assessment regarding Legionella. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The assessment had been carried out by an external company in August 2016.

Monthly water temperatures were checked, the member of staff that was responsible for completing these checks had received training in Legionella in November 2016. The practice also completed quarterly dip slides which measure the amount of bacteria in the water.

Equipment and medicines

The practice had a full range of equipment to carry out the services they offered and in adequate number to meet the needs of the practice.

Portable appliance testing had been carried out in March 2016. The fire extinguishers had been serviced in January 2017.

The compressor and autoclave had been serviced and tested in line with manufacturers' instructions.

Prescription pads were secured on the premises, but not logged in line with the guidance from NHS Protect. A log was commenced following the inspection.

A glucagon injection kit is used to treat episodes of severe hypoglycaemia which is defined as having low blood

glucose levels that requires assistance from another person to treat. It should be stored at a temperature of 2–8°C (in a refrigerator). If stored in the refrigerator the shelf life from the manufacturer is 36 months. It can be stored outside the refrigerator at a temperature not exceeding 25°C for 18 months provided that the expiry date is not exceeded.

Although the practice kept this medicine in the refrigerator they were not monitoring the temperature range and therefore could not be assured of its effectiveness. Following the inspection the practice purchased a new kit and a thermometer that records the temperature range.

The practice dispensed antibiotics. These were stored appropriately; however insufficient details were recorded on the packaging when the medicines were dispensed. Following the inspection the practice reviewed the Medicines for Human Use Regulations 2012 and changed their protocol in dispensing to comply with this.

Radiography (X-rays)

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

The practice had one intra-oral X-ray machine that was able to take an X-ray of one or a few teeth at time, and one panoramic X-ray machine that can take an X-ray of the whole jaws. These were both situated in a designated room in the practice.

Rectangular collimation on intra-oral X-ray machines limits the beam size to that of the size of the X-ray film. In doing so it reduces the actual and effective dose of radiation to patients. We saw that rectangular collimators were in use by clinicians.

The required three yearly testing of the equipment was up to date for all the machines, and individualised local rules were present for each machine.

All staff that took X-rays were up to date with training as directed by the General Dental Council and IRMER.

We saw from the dental care plans we were shown that clinicians were routinely noting the justification for taking an X-ray as well as the quality grade and report of the findings.

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 completed by patients when they first attended. This was completed electronically on a tablet computer. Subsequently dentists checked verbally whether there was any changes. We discussed with the principal dentist whether this could be improved to have patients re-check and sign their form again at regular intervals. This was implemented following the inspection.

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.

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.

The decision to take X-rays was guided by clinical need, and in line with the Faculty of General Dental Practitioners directive.

Health promotion & prevention

Dental care records we saw indicated that an assessment was made of patient's oral health and risk factors. Medical history forms that patients were asked to fill in included information on nicotine use; this was used by dentists to introduce a discussion on oral health and prevention of disease.

We found a good application of guidance issued in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is a toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. The practice had information leaflets for children to highlight where hidden sugars or other issues which may affect oral health.

Patients had access to oral care leaflets in the treatment rooms and oral health aids were available for demonstration purposes.

A poster indicating the negative health effects of alcohol was on display in the waiting room.

Staffing

The practice was staffed by three dentists, a dental hygienist and three qualified dental nurses supported by the practice manager.

Prior to our inspection we checked that all appropriate clinical staff were registered with the General Dental Council and did not have any conditions on their registration.

Patients could access an appointment with the dental hygienists only through the dentists. Direct access to the dental hygienist appointments was not available.

Staff told us they had good access to on-going training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for 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, dental technicians, and orthodontic therapists.

Clinical staff were up to date with their recommended CPD as detailed by the GDC including medical emergencies, infection control and safeguarding training.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the treatment themselves.

Referrals for suspicious lesions were made by fast track email to the hospital which was then followed up by a phone call from the practice to ensure it had been received.

Are services effective?

(for example, treatment is effective)

The practice did not keep a log of referrals made which would have helped keep track of referrals sent out and be able to chase up the referral in a timely manner. We were told that patients were given a timeframe when they were referred to another service, with instructions to contact the practice if they hadn't heard from the referral service within the specified timescale.

Consent to care and treatment

We spoke to clinicians about how they obtained full, educated and valid consent to treatment. Comprehensive discussions took place between clinicians and patients where the options for treatment were detailed.

Patients who were considering dental implants were sent a comprehensive document that included the risks and benefits of treatment to consider and sign.

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 demonstrated a good understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment

Similarly staff had a good understanding of the situations where a child under the age of 16 would be able to consent for themselves. This is termed Gillick competence and relies on an assessment of the competency of the child to understand the treatment options.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Comments that we received from patients indicated consistently that the care and treatment they received was of a high standard. Staff were described as helpful, friendly and professional, and comments indicated that the dentists took the time to explain fully to the patients their options and treatment.

We witnessed patients being spoken to in a polite and courteous manner, and patients indicated that staff were skilled at putting nervous patients and children at ease.

Staff told us that they would contact patients who had undergone tooth extractions or placement of implants the following day to ensure no complications had arisen.

We discussed and witnessed how patients' information was kept private. The computer at the reception desk was positioned so that it could not be overlooked by patients stood at the desk.

Reception staff explained how they took care when speaking to patients on the telephone as a potential situation where care had to be taken not to divulge private information. In addition sensitive discussions with patients in the practice were taken away from the reception desk where they could be overheard by other patients in the waiting room.

These measures were underpinned by practice policies on confidentiality and data protection. The practice meeting in February 2017 included these topics for discussion.

Involvement in decisions about care and treatment

Following examination and discussion with the clinician patients were given a treatment plan to consider.

Comments received from patients indicated that they felt listened to and dentist took the time to respond to their concerns. Options were explained to patients and advice given.

The NHS and private price lists were displayed in the waiting area.

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.

At the time of our inspection the practice was accepting new NHS patients and a new patient could expect to receive an appointment within a couple of weeks. We examined appointments scheduling and found that there was enough time allocated for assessment and discussion of the patients' needs.

For the comfort of patients there was a television in the waiting room. A notice in the waiting room also introduced the practice staff.

Tackling inequity and promoting equality

The practice had an equality and diversity policy which indicated the practice's intention to welcome patients of all cultures and backgrounds. This was corroborated by staff we spoke to during the inspection who expressed that they welcomed patients from all backgrounds and cultures, and all patients were treated according to their individual needs.

We spoke to staff about ways in which they assisted those with individual needs attending the practice. The practice was not easily accessible to patient using a wheelchair. There was a ramp to the front door, but beyond this a lip at the threshold would have to be negotiated for access. The practice had a downstairs treatment room, but the X-ray room was upstairs, therefore it was not possible for patients who could not manage the stairs to have an X-ray taken.

We spoke with reception staff that indicated they would assist patients with limited mobility, and make adjustments to accommodate the patient's individual needs. The practice leaflet requested that patients who

may require assistance with access make the practice team aware so that their needs could be met. The practice had completed a disability access audit to ensure that they were doing all they could within the limitations of the premises to improve access.

The practice did not have access to language interpreters to assist patients for whom English was not a first language, and did not have a hearing loop for patients who used hearing aids. These were both addressed following the inspection.

Access to the service

The practice was open from 9 am to 5.30 pm on Monday to Friday.

Emergency slots were set aside daily and the practice endeavoured to offer an appointment to any emergency patient on the day they contacted.

Out of hours arrangements were available for patients to hear on the answerphone and displayed on the front door of the practice. The arrangements in place were to contact the NHS 111 out of hour's service.

Patient who had dental implants placed were given contact details for the dentist directly out of hours.

Concerns & complaints

The practice had a complaints handling policy. Details that were displayed for patients in the waiting room.

This poster gave the contact details for agencies to whom a patient could raise a complaint external to the practice, or to escalate a complaint should they remain dissatisfied following a response from the practice.

We were shown examples of complaints made to the practice and saw that they were dealt with in a timely manner and appropriately. The outcomes of complaints were fed back to staff to reduce the chance of reoccurrence.

Are services well-led?

Our findings

Governance arrangements

The principal dentist took responsibility for the day to day running of the practice, supported by the practice manager. We noted clear lines of responsibility and accountability across the practice team.

Staff meetings were arranged monthly. Set agenda items to be discussed at all staff meetings included any update and audits as well as any significant events.

The practice had policies and procedures in place to support the management of the service, and these were readily available in hard copy form. Policies were noted in infection control, health and safety, complaints handling, safeguarding and whistleblowing. The policies were not always dated; however we were told that all the policies were updated in the last year as a new system of governance was implemented.

Leadership, openness and transparency

Staff we spoke with reported an open and honest culture across the practice and they felt fully supported to raise concerns with the principal dentist.

The practice had in place a whistleblowing policy that directed staff on how to take action against a co-worker whose actions or behaviours were of concern, including the contact details of outside agencies where a staff member could obtain independent advice. The policy was available for staff to reference in the policy folders.

Staff we spoke with felt comfortable to raise concerns should they feel the need and this was discussed at a staff meeting in September 2016.

Staff felt supported both personally and professionally by the principal dentist.

Learning and improvement

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

Clinical audits were used to identify areas of practice which could be improved. Infection control audits had been carried out, most recently in March 2017 and had generated some actions for improvement.

A clinical audit on the quality of X-rays taken had been completed in February 2017. This was a comprehensive audit of 50 X-rays per clinician which had been analysed and an action plan for improvement drawn up for each clinician.

A record keeping audit was also completed in February 2017; again this was comprehensive for all clinicians.

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 principal dentist and practice manager kept oversight of the training carried out by all staff members. Staff were asked to present all training certificates so that the practice could be assured of staff keeping up to date with their commitments to their professional body.

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

The practice sought feedback for patients and staff through various sources. They invited comment through the NHS friends and family test; the results of which were discussed at staff meetings.

In addition suggestion boxes were available in the waiting room. The practice information leaflet encouraged patients to give positive or negative feedback and explained how they could do this.

Staff were encouraged to bring ideas to the principal dentist either informally or formally, and felt empowered to do so.