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Abbots Langley Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 19 April 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

Abbots Langley Dental Practice is situated on the first floor of a commercial building in the centre of the Hertfordshire village of Abbots Langley. The practice is accessed via an external staircase to the side of the building.

The practice provides mostly private dental treatment including fillings, crowns and bridges as well as dentures and root canal treatments to adults and children. In addition the practice provides domiciliary care to individual patients and approximately 58 residential and nursing care homes in the local area. Domiciliary care involves a dentist and nurse visiting the premises of the patients and providing simple dental treatments and check-ups in their own home.

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

We received feedback on the service from 101 patients who filled out a comment card that we provided to the premises two weeks in advance of our visit. In addition

Summary of findings

we spoke with care homes that the practice provided domiciliary services to. The feedback we received was wholly positive, with many patients commenting on the friendliness of the team, and the ease at which they were able to allay the fears of nervous patients.

Our key findings were:

- Patients commented that they were treated with dignity and respect, they felt listened to, and their options for treatment were always explained to them
- The practice met the essential standards in infection control and cleanliness documented in the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05).
- Medicines and equipment for use in medical emergencies were in line with current national guidance.
- The practice had policies in place to aid the smooth running of the service, these were readily available for staff to reference, and in some cases were displayed in staff areas of the practice.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- Certain clinical risk assessments, such as fire risk assessment, and Legionella risk assessment either had not been completed, or had been completed with limited detail. Following our inspection arrangements were made for these to be carried out by external contractors specialised in these areas.

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

- Review the need for a Legionella risk assessment and implement the required actions including the monitoring and recording of water temperatures, giving due regard to the guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance
- Review the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking the X-ray and quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.
- Review the practice's protocols for completion of dental records giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Review the availability of an interpreting service for patients who do not speak English as their first language.
- Review the frequency of infection control audits in line with published national guidance.

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.

Medicines and equipment for use in a medical emergency were in line with national guidelines and three kits were available so that they could be taken out for domiciliary visits.

Decontamination procedures were carried out in line with the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' published by the Department of Health, however a Legionella risk assessment had not been completed by a competent person.

The practice completed appropriate pre-employment checks on all new staff, ensuring that they were employing fit and proper persons.

X-ray equipment was serviced and tested in line with manufacturer's guidance, although dentists were not always recording a written justification for taking the X-ray in the dental care records.

Are services effective?

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

The practice demonstrated a commitment to oral health promotion. Leaflets were available to patients, and a television displayed a positive oral health message.

Staff were appropriately registered in their roles, and had access to ongoing training and support.

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

Clinicians demonstrated a good understanding on the Mental Capacity Act 2005, and its role in establishing consent in patients who may lack the capacity to consent for themselves.

Are services caring?

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

Patients were treated with dignity and respect and nervous patients were made to feel at ease. Parents commented that children were involved in their care.

Residential and nursing care homes that received domiciliary visits commented that staff were always friendly and took the time to engage with the patients.

Patients' details and dental care records were kept securely on the premises and staff demonstrating a good understanding of the importance of data protection.

Are services responsive to people's needs?

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

The practice had arrangements in place to ensure patients who could not access the services at this practice (due to being on the first floor) were seen.

We found that adequate time was allowed for appointments to assess and discuss patient's individual needs.

Summary of findings

Emergency appointments were set aside on a daily basis so that patients could be assured of seeing a dentist at short notice if in pain.

Are services well-led?

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

The principal dentist took responsibility for the day to day running of the service and retained oversight of the governance procedures.

Clinical audit was carried out regularly, although the time intervals between audits were not always in line with published guidance.

Staff had annual appraisals to highlight their learning needs and discuss future training.

Abbots Langley 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 19 April 2016. 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 eight members of staff during the inspection.

We also reviewed the information we held about the practice and found there were no areas of concern.

During the inspection we spoke with three dentists, and two dental nurses, a hygienist and two receptionists. We reviewed policies, procedures and other documents. We received feedback from 101 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 a system in place to report and investigate incidents. The practice kept a file with an incident log so that any trends could be easily identified. A template was available to record incidents which prompted staff to indicate the investigation and outcome. The practice had not had a significant incident within the last year.

The practice had an accident book to detail minor injuries to staff and patients. This had two entries in the last year. We spoke to the practice principal about what steps would be taken to prevent reoccurrence in the event of a significant incident. We were told that a discussion would be held with all staff either individually or in small groups to ensure that the learning was embedded.

The practice received communication from the Medicines and Healthcare products Regulatory Agency (MHRA). These were e-mailed to the practice and the principal dentist shared relevant alerts with the staff.

The principal dentist was aware of his responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). 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 in the decontamination room at the heart of the practice.

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 April 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

We discussed the use of rubber dam with dentists 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 wherever possible rubber dam was used by the dentists at the practice.

Medical emergencies

The practice carried equipment and medicines for use in a medical emergency. Staff we spoke with were clear on where the medicines could be found, and which medicines would be required for a range of emergencies. Staff had undertaken basic life support training in December 2015.

The British National Formulary lists the medicines that it recommends all dental practices keep available. The practice had three sets of these available, one to be kept in the practice, and two to be taken out on domiciliary visits. These were all in order and in date.

The Resuscitation Council UK list equipment that dental practices should carry in the event of a medical emergency including an automated external defibrillator (AED). The practice had three AEDs, one to be kept at the practice and the other two to be taken out on domiciliary visits. They were regularly checked to ensure they were in working order and the pads were in date. All other emergency equipment was in line with the recommendations of the Resuscitation Council UK.

Whenever the practice provided domiciliary visits the dentist took a full kit of medicines, equipment, oxygen and an AED with them so that patients who received this service could be assured that in the event of a medical emergency the patients would receive the same care as if they had attended the practice themselves.

Staff recruitment

The practice had a recruitment policy in place which detailed the pre-employment checks that would be carried out prior to a staff member joining the service.

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 found the practice had carried out DBS checks on its entire staff and had repeated them at appropriate intervals so that they could remain assured of employing fit and proper persons. We found that appropriate pre-employment checks had been carried out and records kept of the staff we checked.

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 (which had been reviewed in January 2016) was available for staff to reference. This included details on first aiders, electrical safety, radiation and waste disposal.

A general practice risk assessment had been carried out in January 2016 which listed actions that should be taken, however these had not been dated to indicate that they had been carried out.

The practice had a health and safety law poster on display in the decontamination room. Employers are required by law (Health and Safety at Work Act 1974) to either display the Health and Safety Executive (HSE) poster or to provide each employee with the equivalent leaflet.

The practice had a fire risk assessment which had been carried out by the principal dentist. This highlighted areas of concern, but lacked some detail. We discussed this with the principal dentist who decided to arrange an assessment with an external contractor.

We spoke to the staff about how they would respond in the event of a fire. They were able to describe to procedures for evacuating the building and congregating at the external muster point.

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

A sharps risk assessment had been carried out to ascertain what measures could be taken to reduce the risk of injury from sharps. The practice had trialled a system of safety needles that allowed a plastic tube to be drawn up over the needle and locked into place after use, however after a period of time the clinicians preferred to return to the traditional needles. The practice then provided needle blocks to allow for safer removal of the needle from the syringe.

In addition they used 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. These measures were in line with the recommendations of the guidance Health and Safety (Sharp Instruments in Healthcare) 2013.

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 which had been reviewed in January 2016. This included the process by which instruments were cleaned, inspected, sterilised and packaged ready for use again, also a policy on hand hygiene, clinical waste disposal and personal protective equipment.

The treatment rooms were visibly clean, and most were uncluttered; however one treatment room had a lot of equipment and paperwork on the surfaces around where the dentist worked. This could make it difficult for the area to be effectively cleansed after each patient. We raised our concern with the principal dentist, who assured us this would be rectified.

The practice had a dedicated decontamination room. The decontamination process involved placing the instruments in an ultrasonic cleaner in the individual surgeries (this

cleans by passing ultrasonic waves through a liquid). After this the instruments were transported to the decontamination room where they were placed in a washer disinfector (this is a piece of medical equipment similar to a dishwasher that cleans the instruments.

Instruments were then inspected for debris or defect under an illuminated magnifier, before being sterilised in an autoclave. Once sterile the instruments were pouched and dated.

We saw tests that were carried out on the washer disinfector and autoclave to confirm their effectiveness; these were in line with the recommendations of HTM 01-05.

The dentist who carried out the domiciliary visits explained how infection control standards are obtained in the community. This was in line with recognised practice.

All clinical staff had documented immunity against Hepatitis B. Staff 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 the risk of contracting blood borne infections.

Environmental cleaning was carried out by an external contractor. Cleaning equipment and materials conformed to the national guidelines for colour coding cleaning equipment in a healthcare setting; however they were not all stored appropriately. We raised this with the practice principal who took immediate steps to amend this.

The practice had some systems in place to reduce the risk of Legionella. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. They were sending water for analysis annually; however they did not have a risk assessment in place. This would indicate what specific measures needed to be taken to reduce the risk. Following our inspection this was immediately arranged.

Equipment and medicines

We saw that the practice had equipment to enable them to carry out a range of dental procedures. This was available in enough quantity to allow for the time it takes to complete the decontamination cycle using a washer disinfector.

Prescription pads were kept locked in the safe at the practice.

Glucagon is an emergency drug that is used to treat diabetics with low blood sugar. It needs to be stored between two and eight degrees Celsius in order to be effective until the expiry date. If stored at room temperature it is only effective for 18 months from the date the medicine was issued to the practice. We found that although this medication was being stored appropriately at room temperature, the amendment to the expiry date had not been made to account for the fact that it was not stored in the fridge. We raised this with the principal dentist who took immediate steps to rectify the situation.

The practice provided domiciliary care, and therefore required equipment boxes to take out of the practice with all the equipment that was needed. We found that all necessary equipment and materials to provide safe care in the community was available and organised in the boxes. This included a sharps container for safe transportation of used needles and appropriate signage for the car to indicate that hazardous materials were being transported.

We saw evidence that servicing and pressure vessel testing of the autoclaves and compressor was being carried out in accordance with the manufacturer's instructions.

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.

Each treatment room had an X-ray machine for taking detailed X-rays of a few teeth. In addition there was a DPT (dental panoramic tomograph) machine in a separate room for taking an X-ray of all the teeth and jaws.

The practice used a manual system for developing X-rays. This required the use of a separate dark room for this process. We saw evidence that the chemicals used for this process were disposed of appropriately.

All X-ray machines had been serviced and tested within the last two years to ensure they were in good working order, and all staff that were trained to take radiographs were up to date with required refresher training in this area.

We found that dentists were not always recording a justification, grading and report of each X-ray taken in the dental care records in line with IR(ME)R recommendations. We raised this with the principal dentist who assured us this would be implemented immediately.

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 and signed by all patients attending the practice. This was then checked verbally at subsequent appointments, however there was no consistent system in place for patients to check and re-sign the form. This meant that there was an increased risk that the dentist may not be made aware of a change to a patient's medical history that may affect their care. Immediately following our visit the principal dentist implemented a system by which the medical history form was checked and signed by the patient at every visit.

We saw evidence through the dental care records that dentists were carrying out comprehensive screening of the patients' oral condition. This included checks of the soft tissues of the mouth, gums and teeth. The dental care records we saw did not always record in enough detail the discussions between dentist and patient, however comments received from patients indicated that the options for treatment were explained to them in detail.

The dentists used current National Institute for Health and Care Excellence (NICE) guidelines to guide their practice in the areas of frequency of recall, the necessity of lower third molar (wisdom teeth) removal, and prescribing antibiotics for patients at risk of infective endocarditis (endocarditis is a serious complication that may arise after invasive dental treatments in patients who are susceptible to it).

Health promotion & prevention

The practice demonstrated a commitment to health promotion. Medical history forms completed by patients detailed whether they smoked or drank alcohol, this information could be used to introduce a discussion on oral health. The practice displayed posters in the waiting area detailing local contact numbers of stop smoking services.

In addition leaflets were available for patients to look at or take away on topics including preventative care and oral hygiene, dental care for mother and baby, and children's teeth. A television in the waiting area also showed positive health messages.

Posters were displayed in the waiting areas which showed the amount of sugar in well-known drinks, and hidden sugars in food. These were very impactful, and delivered a clear oral health message.

The practice demonstrated a knowledge and application of guidance issued in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' (DBOH) 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.

Staffing

The practice had four dentists, two dental hygienists, two qualified dental nurses, one trainee dental nurse, and two receptionists.

Prior to our visit we checked the registration of the clinical staff with the General Dental Council (GDC) and found that they were all appropriately registered with no conditions on their practice. The GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians orthodontic therapists and dental technicians.

We asked about staff going into the community on domiciliary visits and were informed that they always went in teams of a dental nurse with a dentist. This was necessary to ensure that appropriate infection control could be carried out, as well as the ability for staff to respond to a medical emergency.

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 General Dental Council (GDC). Clinical staff was up to date with their recommended CPD as detailed by the GDC including medical emergencies and radiography.

Working with other services

The practice both received referrals in respect of their domiciliary service, and sent referrals to other services when necessary.

We saw a template that was used in the treatment room to refer patients to hospital if they had a suspected oral cancer. These were comprehensive, and would be faxed to the hospital to ensure timeliness in making the referral.

Are services effective?

(for example, treatment is effective)

We saw examples of referral letters sent to other services, and found that the referrals made were both appropriate and detailed. However the practice was not tracking referrals made, and therefore there was a risk of an increased wait for the patient if the referral was lost in transit.

Consent to care and treatment

We spoke with clinicians regarding how they obtained full, valid and educated consent for treatment. Dentists explained that they always indicated all the options for treatment as well as the risks and benefits of each treatment option. This was corroborated through the comments we received from patients. However details of these discussions were not always recorded in the patients dental care record.

The practice had a series of consent forms for specific treatments which were signed by patients to indicate understanding and consent.

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. Because the practice provided domiciliary services to residential and nursing care homes in the area they dealt regularly with patients whose capacity to consent for themselves was failing.

Staff demonstrated an excellent understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment. They explained to us how capacity was assessed, and where the patient lacked capacity how a best interests decision would be arrived at. This involved contact with family, carers and the patient's general practitioner to establish what course of action was in the best interests of the patient.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Information that we received through patient comment cards indicated that the patients were always treated in a kind and friendly manner. They found reception staff to be helpful and polite and commented that clinical staff were able to reassure them and put them at ease.

We observed staff throughout our visit and witnessed them interacting with patients in a polite and professional way. We also saw staff being discreet on the telephone so that the privacy of the caller was maintained.

Comments from some of the care homes that the domiciliary team visit indicated that the dentist and nurse always treated patients with respect and dignity, and their privacy was maintained. They commented that treatment was explained in detail and they would phone after the treatment was complete to confirm all was well.

We saw how patients' private information was kept confidential. Appointment books on the reception desk were kept below the level of the counter, and so could not be easily overlooked by a patient standing at the desk. In addition reception staff explained how paper notes were always filed promptly, and kept in secure filing cabinets. This was underpinned by confidentiality and data protection policies which were available for staff to reference.

In addition the waiting areas in the practice were positioned away from the reception desk meaning that patients could not overhear discussions at the desk or on the phone.

Involvement in decisions about care and treatment

Patients were given a written plan for their treatment so that they were able to consider their options. This included the costs of treatment. Several patients commented that options and treatment were always explained to them fully as well as the costs involved.

Price lists for private and NHS charges 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

We examined appointments scheduling, and found that adequate time was given for each appointment to allow for assessment and discussion of patients' needs.

We asked reception staff how soon a new patient could be given a routine appointment and were told that at the time of our inspection this could be arranged within a day or two.

For advice or appointments out of hours, patients were directed to the NHS 111 service, which can arrange an emergency dental appointment if necessary. This information was indicated on the answerphone message.

Care homes contacted the service if they were in need of a visit. The domiciliary team were usually able to respond within a couple of days.

The patient toilet had a baby changing facility to assist the parents of young children attending the practice. In addition the waiting areas had cleansable toys for children.

Tackling inequity and promoting equality

Staff told us that the practice welcomed patients from all cultures and backgrounds. This was underpinned by the equality and diversity policy which was dated January 2016, and highlighted the practice's legal responsibility to act in accordance with the Equality Act 2010. Some staff had undertaken equality and diversity training to further improve their knowledge in this area.

We spoke to staff about how they accommodated people's individual needs, and they told us that they would assist patients with restricted mobility up and down the stairs. They had a very stable patient base, and so knew which patients needed help and would look out for them to go down and assist.

The practice did not have access to an interpreting service. However reception staff informed us that they did not have any patients at the time of the inspection that needed that service.

Access to the service

The practice was open from 8.30 am to 5.30 pm on Monday, Tuesday and Thursday. 8.30 am to 12.45 pm on a Wednesday and Friday.

The practice was situated entirely on the first floor, with external stairs to access the premises. For this reason the premises did not allow for wheelchair access, or for some patients with restricted mobility.

The practice had arrangements in place to refer to a practice nearby with ground floor access. Or in the situation where a patient could no longer attend practice they were in a position to offer domiciliary care.

Emergency appointments were set aside daily for each dentist and so patients could be assured of seeing their own dentist in a timely manner if they were in pain.

Concerns & complaints

The practice had a complaints handling policy in place. This was displayed in the waiting area for patients to reference and indicated how patients could make a formal complaint to the service if they were unhappy, and how to escalate the complaint beyond the service if they felt the complaint had not been dealt with to their satisfaction.

The practice had not received any formal complaints in the year preceding our visit.

Are services well-led?

Our findings

Governance arrangements

The principal dentist (who was the registered manager) took responsibility for the day to day running of the practice. We noted in this small team that there were clear lines of responsibility and accountability established. The principal dentist kept clear oversight of all aspects of the service and took personal responsibility for many of the ongoing governance checks.

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, confidentiality, data protection and whistleblowing. These had all been recently reviewed and updated to ensure they remained relevant.

In addition risk assessments were in place to minimise risks to staff, patients and visitors to the practice including sharps, fire safety, and health and safety. Equipment in the practice was being maintained in line with manufacturer's guidance.

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 did not have formal staff meetings. Previously they had trialled a programme of staff meetings; however they decided that given the close nature of their small team they were able to communicate important messages through the practice without the need for a formal session.

The principal dentist took responsibility for ensuring that important messages were communicated to the whole team individually if necessary.

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.

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 that could improve and highlight how those improvements could be made. We saw audits in cross infection control, quality of X-rays, domiciliary services and handling sharps. These did not always generate clear action plans, and the infection control audits were being completed annually, where national guidance recommends that they are completed every six months.

Staff felt supported in their roles and commented on the availability of training to further their careers. The practice subscribed to online training systems on behalf of all of the staff. Staff underwent regular appraisals in order to identify their training needs and wishes, and future goals were discussed and planned for.

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

The practice obtained feedback from patients from several pathways. Patient satisfaction surveys were carried out, the results of this for the previous five years was displayed in the waiting area. In addition a suggestion box in the waiting area yielded some feedback.

Staff detailed areas where patients and staff feedback had yielded changes in the practice, mostly in respect to the waiting areas, but also equipment and instruments for staff, and new chairs for the reception staff.