Redbourn Dental Practice Limited

Redbourn Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 8 March 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Redbourn Dental Practice is situated over three floors of a converted building on the High Street of Redbourn, a village near to St Albans in Hertfordshire. The practice was registered with the Care Quality Commission (CQC) in July 2011. The practice provides regulated dental services to patients from Redbourn and the surrounding area. The practice provides mostly private dental treatment. Services provided include general dentistry, dental hygiene, crowns and bridges, and root canal treatment.

The principal dentist is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. 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 positive feedback from 49 patients about the services provided. This was through CQC comment cards left at the practice prior to the inspection and by speaking with patients in the practice.

Our key findings were:

- Staff treated patients with care and compassion; patients commented that if nervous they were made to feel at ease.

Summary of findings

- 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).
- Treatment options were identified, explored and discussed with patients.
- Staff demonstrated a good knowledge of how to raise a safeguarding concern, and the situation in which that may be required.
- Patients' confidentiality was maintained.
- The practice had policies in place to maintain the smooth running of the service.
- Dentists used nationally recognised guidance to aid in the care and treatment of patients.
- Governance protocols to ensure the continuing improvement of the service were not as robust as they could be. Certain required clinical audit and risk assessments had not been completed such as the quality of radiographs, and a legionella risk assessment.

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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 incidents or significant events with a view to preventing further occurrences and ensuring that improvements are made as a result.
- Review availability and storage of medicines and equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), the British National Formulary and the General Dental Council (GDC) standards for the dental team.
- 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
- 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
- Establish whether the practice is in compliance with its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IR(ME)R) 2000 and 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.
- Review the practice's governance protocols and procedures regarding completing clinical audit of various aspects of the service, and ensuring staff are up to date with their mandatory training and their Continuing Professional Development. Practice should also check all audits and risk assessments have documented learning points and action plans.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice met the essential requirements 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.

The practice carried equipment and medicines for use in a medical emergency. These met with the recommendations of the British National Formulary and the Resuscitation Council UK, with the exception of an automated external defibrillator. The practice did not have one, but there were four located close to the practice and staff were aware of their whereabouts.

Staff had a good understanding of the signs of abuse, the situations that they would raise a safeguarding concern, and how they would do this.

Are services effective?

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

Comprehensive medical history forms were completed by the patients prior to their appointments, this included information on smoking and alcohol intake which may affect oral health.

Dentists followed recognised national guidance for the care and treatment of patients, such as the National Institute for Health and Care Excellence, and the Faculty of General Dental Practice.

Clinicians kept accurate and comprehensive records which detailed discussions with patients regarding their options for treatment.

Are services caring?

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

Patient feedback that we received both on the day of our inspection, and from comment cards that had been completed showed that patients were very happy with the service they received. Patients said staff were friendly and professional.

Patient care records were kept securely in locked cabinets, and staff were able to describe how confidentiality was maintained.

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 carried out a disability discrimination audit to ensure its services were available to all of the population.

Out of hours arrangements were in place for both NHS and private patients and were detailed on the practice's answerphone.

Patients were sent a text reminder of their appointment.

Are services well-led?

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

Summary of findings

The practice had polices in place to support the smooth running of the service, these were available in hard copy form for staff to reference.

The practice sought and acted upon feedback from patients, by way of the NHS friends and family scheme and their own patient satisfaction questionnaire.

Governance procedures for ensuring continuing improvement of the service were not as robust as they could be. Clinical audits for highlighting areas that could be improved were not always carried out within recommended timescales, and did not always have documented learning points.

Redbourn 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 8 March 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Before the inspection we asked the 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 five 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 two dentists, and two dental nurses and a receptionist. We reviewed policies, procedures and other documents. We received feedback from 49 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 systems in place to report and learn from incidents although these were not entirely robust. The practice had polices in place regarding the reporting of serious incidents to the CQC and the principal dentist was aware of his responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). The practice also had an accident book; there had not been an entry in the last 12 months.

The practice did not, however have a system in place to report, investigate and learn from incidents which may not be serious enough to report to the CQC or Health and Safety Executive. The practice principal told us that he would discuss any incidents with staff to prevent reoccurrence, and following our inspection they would implement a formal reporting regime for this.

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

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 in the office. In addition to the policies the practice had a flow chart informing staff how to raise a safeguarding concern, and a list of relevant contact numbers including that of the named nurse specialist in child safeguarding for the local area.

Staff had undertaken training appropriate to their role, and the principal dentist had undertaken a course on being the safeguarding lead for the practice. Staff we spoke with were able to describe when and how they would raise a safeguarding concern.

The practice had an up to date Employers' liability insurance certificate which was due for renewal in July 2016. 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 a rubber dam was not used in all root canal treatments. The risk that were posed by not using rubber dam were somewhat mitigated by the use of motorised instruments in a dental drill.

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 June 2015.

The British National Formulary lists medicines that it recommends dental practices keep available. The practice carried all these medications with the exception of a medicine to control seizures. Following our inspection we received evidence that this had been acquired.

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 did not have an AED; however staff were aware of four AEDs in the locality of the dental practice including one in the medical centre over the road. Staff had attended the medical practice to learn how to use their AED in July 2015. Following our inspection a risk assessment had been put into place detailing the locations of the AEDs in the village.

In addition the practice did not carry oropharyngeal airways in a range of sizes. These would be required to help maintain the airway of an unconscious or semi-conscious patient. Following our inspection we received confirmation these had been ordered.

Emergency medicines were checked monthly and this was recorded; however the emergency oxygen was not checked. The practice gave us immediate assurances that this would now be checked regularly along with the other medicines and equipment.

Staff recruitment

The practice had a staff 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.

The practice had a policy to carry out DBS checks on all staff members. DBS checks and all other pre-employment checks were in place for the members of staff whose recruitment files we looked at.

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 and folder was available for staff to reference in the office. This was dated September 2015 and included information on first aid and risk management as well as a completed health and safety checklist in June 2015.

The practice had a health and safety law poster on display in the staff 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 checklist which was dated 14 December 2015. An internal fire safety log book noted regular equipment checking, as well as dates of fire drills and fire training session for staff. Staff we spoke with were able to describe the procedures for evacuating the building, and the location of the muster points. In addition the fire equipment was serviced by an external company in July 2015.

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.

The practice had in place a sharps policy and information on the safe handling of sharps. In addition a poster was displayed which gave inoculation injury advice; this included up to date contact numbers to report the injury and receive any necessary treatment.

The practice did not have a risk assessment pertaining to the use of sharps on the premises, but staff we spoke with explained that the dentists take responsibility for disposing of sharps at the point of use, and use a needle guard to reduce the risk when re-sheathing needles.

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 May 2015. This outlined the decontamination process (Decontamination is the process by which contaminated re-usable instruments are washed, rinsed, inspected, sterilised and packaged ready for use again), hand hygiene, protocols regarding the dental unit water lines and disinfecting impressions.

The practice had two dedicated decontamination rooms, one on each floor of the premises. In both rooms manual cleaning of the instruments was carried out in line with national guidance. Instruments were then rinsed and inspected for debris or defect under an illuminated magnifier.

Instruments were sterilised in an autoclave, and we saw evidence that appropriate tests were carried out to ensure the effectiveness of the sterilisation.

Instruments should then be pouched and dated with the date upon which the sterilisation would become ineffective, however the practice had a system in place whereby they would only date those instruments that are used less often and stored out of the treatment rooms. For those instruments that were returned to the treatment rooms, staff placed them in pouches, but did not date them. In order to ensure that they were used before the sterilisation became ineffective the dental nurse re-sterilised all instruments in the surgery every two weeks.

Are services safe?

The decontamination rooms did not have separate handwashing sinks, and staff were washing their hands in the sink in which they then cleaned the instruments. We raised with staff the possible impact on the cleaning process that this may have, and they immediately modified their practice to meet national guidelines.

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. Although they were provided with a list of areas to clean, they were not required to complete a checklist or schedule of work to confirm that each area had been cleaned on which date. Following our inspection a signed schedule of cleaning was implemented. Cleaning equipment and materials conformed to the national guidelines for colour coding cleaning equipment in a healthcare setting; however they were not stored appropriately. We raised this with the practice principal who took immediate steps to amend this.

We examined the practice's protocols for storing and disposing of clinical and contaminated waste. The clinical waste bin was situated outside the rear access of the practice where wheelchair users and other patients of limited mobility would gain access to the practice. The bin was not locked and was not secured to the wall or window bars. We raised this with the principal dentist who took steps to ensure the clinical bin could not easily be accessed or wheeled away.

There were limited systems in place to reduce the risk of Legionella. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The practice had a legionella management document, but no specific risk assessment had been carried out. Water testing had been carried out in April 2015 and staff were flushing and disinfecting their dental unit water lines, but mains water temperatures were not being regularly checked or logged. Following our inspection the practice arranged a comprehensive external assessment.

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.

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.

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. We found that the medicine was kept in a designated fridge however the temperature of the fridge was not being checked. Therefore the practice could not be sure that this medicine would be effective in the case of a medical emergency. We raised the concern with the principal dentist who took immediate steps to ensure it was stored appropriately, and modified the expiry date to account for the fact that the temperature of cold storage could not be assured.

Prescription pads were kept securely, and issued to the dentist as required.

Radiography (X-rays)

The practice had systems in place to ensure the safe use of radiographs although these were not entirely robust. The practice had four X-ray machines, three in the surgeries to take small pictures of individual or a few teeth, and a dental panoramic tomograph machine which took an image of the jaws and teeth together. These had all been tested and maintained in line with manufacturers' instructions and the Ionising Radiation Regulations 1999 (IRR 99).

A further requirement of the IRR 99 is that a document called the 'local rules' is available for each X-ray machine. This should have information including the appointed people responsible for the safe operation on the X-ray equipment, those clinicians that are qualified to take X-rays, and should define the controlled areas, where special procedures are needed to restrict significant exposure. The practice did not have this information in the format of a local rules document. Following our inspection of the practice this was put into place.

The Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) state that a written justification for taking an X-ray should be recorded along with the grade of the quality of the X-ray and a report on the findings of the X-rays. We found that not all the dentists at the practice were making these records. In addition IR(ME)R requires that the quality of radiographs is audited annually to

Are services safe?

ensure that patients are not subjected to unnecessary radiation. The practice had not undertaken such an audit since 2011. Following our visit the practice has undertaken an audit of X-ray quality.

Dentists were up to date with their required training in radiography.

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 for every patient at the practice, this included questions regarding social use of alcohol and nicotine or nicotine containing products, which may affect oral health and specific questions regarding medicines that may affect bone healing following a tooth extraction. The form was updated and signed by the patient every six months, and checked verbally by the dentist at each visit.

Records showed assessment of the periodontal tissues (the gums and soft tissues of the mouth) had been undertaken. These had been recorded using the basic periodontal examination (BPE) screening tool. BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to patients' gums. Higher figures would trigger further investigation, referral to a dental hygienist, or to an external specialist.

The dentists demonstrated a thorough understanding of the national guidance available to aid in the care and treatment of patients. Including the National Institute for Health and Care Excellence and the Faculty of General Dental Practitioners.

Health promotion & prevention

The practice promoted good oral health as part of their overall philosophy of care. A dental therapist was employed at the practice part time (a dental therapist is a registered dental professional who provides preventative and restorative dental care, usually for children and adolescents). Before referring children to the therapist the dentist gave the children diet sheets to complete. This meant that the dental therapist would be able to discuss the relationship between diet and their oral health using examples of their own diet.

We found a thorough application of guidance issued in the DH publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Medical history forms requested information regarding smoking habits, and discussions with the dentists were documented in the dental care records regarding smoking cessation and alcohol intake. Information leaflets were available for the dentists to provide to the patients, and in the waiting room. These included leaflets on tooth brushing, smoking, oral health for children, and a patients' guide to good oral health.

In February 2015 staff had completed in house training on oral hygiene and patient education; this included the benefits of using visual aids, brochures and information sheets to engage patients in their oral health.

Staffing

The practice had four dentists, four dental nurses and four dental hygienists, one of which was also a dental therapist. Prior to the inspection we checked the registrations of all dental care professionals with the General Dental Council (GDC) register. We found all staff were up to date with their professional registration with the GDC.

One of the dental nurses was trained in the application of fluoride to prevent decay in children's' teeth. They worked alongside the dental therapist in this capacity.

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). The GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians and dental technicians.

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

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment. They made appropriate referrals to orthodontic services, community dental services, and hospital.

Are services effective?

(for example, treatment is effective)

Urgent referrals made to hospital for suspicious lesions were faxed to the hospital. The hospital would then fax confirmation of receipt, in this way the practice could be assured that the referral was made in a timely manner.

Consent to care and treatment

The practice demonstrated a thorough understanding of the processes involved in obtaining full, valid consent for treating adults. Staff informed us that patients were always involved in discussions about their care, and the options, risks and costs of treatment always explained fully. This was evidenced through dental care records that were shown to us, and also from the feedback that we received from patients.

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 an understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment. This included understanding that capacity should be assumed even if the patient has a condition which may affect their mental capacity, the legal documents that may give the right to consent to a family member and when it may be necessary to make decisions in a patient's best interests.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Staff we spoke with explained how they ensured information about people using the service was kept confidential. The appointments system was held electronically and password protected. Dental care records were stored in locked cabinets. This was underpinned by the practice's confidentiality policy and data protection policy.

Monitors at the reception desk were situated below the level of the counter so they could not be overlooked by patients standing at the desk.

We observed staff treating patients with dignity and compassion, and feedback we received from patients both during our visit, and from the comment cards that were filled in prior to our visit were entirely positive about the service. Several patients commented that they chose to drive some distance to visit this practice; others noted how well the practice treats children and were able to put nervous patients at ease.

Involvement in decisions about care and treatment

The practice had an information and communication policy which had recently been signed by all staff which detailed the practice's expectation of patient involvement in decisions about their care.

Patients told us that they felt involved in the decisions about their treatment, options for treatment were always explained and costs outlined before treatment commenced.

Price lists for both NHS and private treatment were clearly displayed in the waiting room.

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.

The practice detailed arrangements for out of hours cover on the answerphone. For NHS patients a dental emergencies out of hours team were contactable. Private patients were given a mobile phone number to contact a dentist at the practice directly.

The practice offered occasional early morning appointments and Saturday appointments by prior arrangement.

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, This was underpinned by the practice's equality, dignity and human rights policy, which was available to staff in hard copy form.

The practice had carried out a disability discrimination audit in October 2014, which had been reviewed in January 2016. This had highlighted that the ground floor surgery could be accessed by wheelchair users, and there was single level access to the practice via the side entrance. This entrance had a bell so that patients with restricted mobility could attract attention and assistance.

Improvements had been made to the staircase to add hand rails on both sides to assist patients with restricted mobility. A handrail had also been added to the front entrance of the premises which had three steps.

Access to the service

The practice was open from 9 am to 5.30 pm Monday to Wednesday, 9 am to 4 pm on Thursday and 9 am to 3 pm on Friday.

Emergency appointments were set aside daily for each clinician so patients could be seen in a timely manner if in pain.

Patients were sent a text reminder that their appointment was due. Staff also made telephone calls to patients the day before their appointment to remind them that their appointment was the following day.

Concerns & complaints

There were separate complaints policies for NHS and private patients. The details provided for these was initially the same, comprising how the complaint would be managed by the practice. The policies differed regarding the other agencies to contact if the complaint was not resolved to the patients satisfaction. These were available to patients in the waiting area.

The practice had not received any formal complaints in the 12 months preceding our visit.

Are services well-led?

Our findings

Governance arrangements

There was a clear management structure at the practice, with staff having set roles and responsibilities. The registered manager was the principal dentist and discussions identified the registered manager understood their role within the registered service.

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. Staff had signed forms to state that they had read and understood the policies.

Systems in place to monitor the safety and effectiveness of the service were not as robust as they could be; a required risk assessment had not been completed, certain clinical audit had not been undertaken, and oversight of the mandatory training requirements of certain staff was not being carried out.

The practice had monthly staff meetings, the minutes of which were kept so that staff who were not able to attend could understand what was discussed.

Leadership, openness and transparency

Staff reported a culture of honesty and transparency throughout the practice which was underpinned by a policy detailing the practice's expectations of candour.

Staff we spoke with felt comfortable to raise concerns with the practice principal either personally of at a practice meeting.

The practice had in place a whistleblowing policy, which had been recently discussed during a staff meeting. This gave guidance on how staff could go about raising concerns they may have about another's actions or behaviours.

Learning and improvement

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

Some clinical audit had been carried out in the last year. An infection control audit had been carried out September 2015, and before that in July 2014, current national guidance stipulates that infection control audits are completed every six months. Neither audit had generated an action plan to highlight areas where improvements should be made. We raised this with the practice principal who immediately altered the schedule for this audit.

A record keeping audit had recently been carried out for two clinicians, which detailed some actions to improve the overall standard.

Although most X-rays taken were being graded a comprehensive audit of X-ray quality had not been carried out since 2011. Following our inspection this has been completed.

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 maintained oversight of the CPD carried out by the dental nurses, but did not have a monitoring system in place to confirm that the dentists were up to date with required training.

Staff received annual appraisals which highlighted the training needs of individual staff.

The practice had a series of in house training meetings with topics including health and safety, Mental Capacity Act and infection control. These generated a written document which could be referenced by staff to revise on the topic.

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

The practice had systems in place to involve, seek and act upon feedback from people using the service. The practice invited comments through the NHS friends and family scheme, and also through their own questionnaire. Although lots of information had been collected, it had not always been audited.

The practice had added handrails to the staircase and the entrance to the building as a result of patient feedback, and chairs in the waiting room were being replaced with a model that would be easier of patients with limited mobility to use.

Staff reported that their input was welcomed either formally or informally, and changes had been made in response to their suggestions.