Distal Point Limited

Hitchin Dental

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 26 January 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

Hitchin Dental is a mixed NHS and private practice situated in the town centre of Hitchin, a market town in Hertfordshire.

The practice has 11 treatment rooms spread over two floors in a converted building. There is a waiting room on each floor, an X-ray room and an office in the main part of the building, with a conference room and staff room accessible via an external door in another area of the building.

The practice offers a full range of general dental procedures for adults and children.

The practice owner 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.

Prior to the inspection we left comment cards at the practice for patients and visitors to the practice to feedback about their experience. We also spoke to patients as part of our inspection. In total 27 people provided feedback about the service. The comments received were highly positive and pointed to the staffs' friendly and professional manner, and how patients feel they are listened to, and their needs met.

Summary of findings

Our key findings were:

- Patients commented that they were treated with care and compassion and that their options for treatment were explained to them.
- The practice met the essential standards in infection control as set out in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' Published by the Department of Health.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained
- The provider kept emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- The practice had implemented a scheme of comprehensive training to prepare trainee dental nurses for the national examination in dental nursing.
- We identified the following example of notable practice that merits sharing during our inspection of Hitchin Dental: The practice was committed to the promotion of oral health particularly in children the practice blocks routine appointments in the half term holidays so that priority can be given to children needing to access dental care.
- Clinical audit that was completed to highlight areas in the practice that could be improved did not always have documented action plans or learning points to facilitate the improvement.
- We identified the following example of notable practice that merits sharing during our inspection of Hitchin Dental:The practice had implemented a comprehensive training programme for dental nurses.

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

- Review the practice's sharps procedures giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 with particular reference to the use of safer sharps across the practice.
- Review audit protocols to document learning points that are shared with all relevant staff and ensure that the resulting improvements can be demonstrated as part of the audit process.
- Review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.

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 demonstrated a comprehensive system of recording, investigating and learning form significant incidents.

Staff had received training in safeguarding appropriate to their role, and were able to describe situations that may cause them to raise a safeguarding concern, and how they would undertake this.

Infection control standards met the essential guidance described in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' Published by the Department of Health.

Standards for taking X-rays met the Ionising Radiation Regulations 1999 and the Ionising Radiation (Medical Exposure) Regulations 2000.

Are services effective?

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

A comprehensive medical history form was completed and signed by the patients at every check- up appointment, and then confirmed verbally by the dentist at every appointment.

Staff demonstrated a thorough understanding and application of the 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 used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Dental care records were found to be detailed, accurate and demonstrated regular screening for oral disease.

Are services caring?

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

Staff at the practice were able to describe how confidentiality was maintained at the practice.

Patient feedback indicated that staff were friendly and professional. Treatment options and costs were explained to patients before treatment started.

Are services responsive to people's needs?

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

The practice provided appointments early in the morning (8.00 am) and late in the evenings (7.30 pm) as well as Saturday mornings. This made it easy for patients who had commitments during working hours to see the dentist.

We identified the following example of notable practice that merits sharing during our inspection of Hitchin Dental: The practice blocks routine appointments in the half term holidays so that priority can be given to children needing to access dental care. The practice encouraged families to bring children in, and gave oral hygiene instruction as well as check-ups.

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 held weekly role specific staff meetings to prioritise communication and cover relevant concerns and learning.

We identified the following example of notable practice that merits sharing during our inspection of Hitchin Dental: The practice had implemented a comprehensive training programme for dental nurses to prepare them for the national examination in dental nursing.

The practice had undertaken clinical audit, but sometimes failed to document learning points or initiate action plans to improve the service.

Hitchin Dental

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.

The inspection was carried out on 26 January 2016 by a lead CQC inspector, a second CQC inspector and a dental specialist advisor.

We informed the NHS England area team that we were inspecting the practice; however they had no concerns raised within the last year. We also requested details from the provider in advance of the inspection. This included their latest statement of purpose describing their values and objectives and a record of patient complaints received in the last 12 months.

During the inspection we toured the premises; spoke with the registered manager, The clinical lead dentist, five further dentists, two dental nurses, one receptionist and patients. We reviewed a range of practice policies and practice protocols and other records relating to the management of the 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 comprehensive systems in place to learn from significant events. Forms were available to fill in on the computer and evidence was seen that incidents were investigated thoroughly; apologies were issues to the patient where appropriate. In addition outcomes and actions were documented to reduce the chance of re-occurrence and incidents were discussed in the weekly staff meetings. Minutes from the meetings indicated the learning points from these incidents.

The practice kept an accident book and were aware of their responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). The clinical lead was able to explain how such a report would be made.

The practice received alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) these were received by the practice manager who disseminated relevant alerts to the staff at practice meetings.

Reliable safety systems and processes (including safeguarding)

The practice had robust policies and procedures in place for safeguarding vulnerable adults and child protection. The practice had a policy available on the shared computer drive; this detailed the situations in which a safeguarding concern would be raised, and the process in raising such a concern. There was also a useful contact list with numbers including the name of the safeguarding nurse in the area and the name of the safeguarding general practitioner. These were also displayed on the wall of the staff room.

Staff we spoke with were able to name the safeguarding lead for the practice, and describe how they would raise a concern.

Training was carried out on safeguarding in a rolling programme; staff members were contacted by e-mail to renew their safeguarding training and online courses provided to achieve this.

The practice was trialling a system of safety sharps. Needle systems were available that allowed a plastic tube to be drawn up over the needle and locked into place after use. This would result in a far lesser risk of needle stick injury to staff. In addition the practice had disposable matrix bands available. A matrix band is a thin metal strip that is positioned around the tooth during placement of certain fillings, they can be very sharp and so the use of disposable bands mitigates the risk involved in changing the bands. These measures were in accordance with the Health and Safety (Sharp Instruments in Healthcare) 2013 guidance, but were not being employed throughout the whole practice.

The British Endodontic Society recommends the use of rubber dam for root canal treatment. We discussed this with dentists and practice staff and were shown the relevant entry in specific dental care records. We found that a rubber dam was routinely used in root canal treatments. 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; it prevents the patient from inhaling or swallowing debris or small instruments.

A dentist we spoke with told us that in some cases patients refused the use of the rubber dam. The dentist described what alternative precautions were taken to protect the patient's airway during the treatment when a rubber dam was not used. This included ligatures wrapped around the files so that they could be retrieved easily. It was explained how the patient was informed of the increased risk should they refuse rubber dam for treatment.

Medical emergencies

The practice carried medical equipment and medicines to deal with medical emergencies that may arise. The practice carried two sets of the emergency equipment and medicines one for each floor of the building. We found that medicines were being kept and stored in accordance with the British National Formulary guidance.

Oxygen was being kept in two locations in the building for use in a medical emergency. This was being checked daily to ensure it worked, but the expiry dates were not being routinely checked. We raised this with the registered manager and steps were taken to immediately rectify this.

The practice had an automated external defibrillator (portable electronic devices that automatically diagnose life threatening irregularities of the heart and deliver an electrical shock to attempt to restore a normal heart rhythm). This was check regularly to ensure its readiness for use in the event of an emergency.

Are services safe?

Practice staff underwent medical emergencies training annually, and staff we spoke with were able to describe how they would respond to a variety of medical emergencies.

The dental nursing staff described how they would undergo scenario training monthly to practice their management of medical emergencies.

Staff recruitment

We looked at the staff recruitment files for five staff members to check that the recruitment procedures had been followed. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all staff recruitment files. This includes: proof of identity; checking the prospective staff members' skills and qualifications; that they are registered with professional bodies where relevant, and where necessary a Disclosure and Barring Service (DBS) check was in place. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The practice policy on staff recruitment detailed that DBS checks would not be carried out for all dental nurses and administrative staff, however risk assessments were in place where a DBS check had not been carried out, which detailed a perceived level of risk, and how the risk was mitigated. These were kept at head office and were forwarded to us after our visit.

The staff recruitment procedures met the standards set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Monitoring health & safety and responding to risks

The practice had robust systems in place to monitor and manage risks to patients, staff and visitors to the practice.

The practice had a health and safety policy in place which had been reviewed on 28 July 2015. An external contractor had carried out a health and safety risk assessment on 30 April 2015. The practice covered these areas of health and safety as part of the practice induction process.

All staff had undertaken fire training as part of their induction to the service. Staff we spoke with were able to describe the procedures involved in evacuating the building and the muster point for staff and visitors. An external fire risk assessment was carried out on 30/4/2015 and fire drills were carried out.

The practice had measures in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. Practices are required to keep a detailed record of all the substances at use in the practice which may pose a risk to health. These records were computerised so that a simple search could be carried out to find the specific details required. This was available to all staff on a disc.

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.

Decontamination is the process by which dirty and contaminated instruments are bought from the treatment room, washed, inspected, sterilised and sealed in pouches ready for use again. The practice did not have a central decontamination room; instead the decontamination process was being carried out in the individual treatment rooms.

We talked through the decontamination process with two dental nurses. Instruments were manually cleaned and inspected under an illuminated magnifier prior to being sterilised in the autoclave. We found staff were not checking the water temperature for cleaning the instruments (water temperature over 45 degrees Celsius can inhibit the effective removal of protein contaminants) however staff we spoke with were aware that the water should be cool.

Instruments were then sterilised in an autoclave, and we saw appropriate checks were carried out on the autoclave to ensure the effectiveness of the sterilisation process.

Clean instruments were then pouched, dated with the date upon which the sterilisation would become ineffective and signed by the nurse that had carried out the decontamination process so that quality could be audited.

Are services safe?

The practice carried out weekly checks on the decontamination process and cleanliness of the surgery, we saw examples of these checks, which highlighted areas for improvement and gave a time limit of a day for standards to improve.

In addition, lunchtime checks were carried out in each treatment room to ensure the room was left ready for the afternoon session to begin, the instruments from the morning had been through the decontamination process and the treatment room was clean and clutter free.

We saw waste consignment notices attesting to the appropriate disposal of clinical waste, sharps, amalgam and extracted teeth. Clinical waste was securely stored in lockable bins.

Environmental cleaning of the building was carried out by cleaners who followed a schedule of work, and signed when the work had been completed. The practice conformed to the national guidelines for colour coding cleaning equipment to ensure that certain cleaning equipment was limited to cleaning a specific area.

The practice had systems in place to reduce the risk of Legionella. This is a bacterium that can contaminate the water supply of buildings. The practice had an external assessment carried out in February 2015. This documented that the practice should be checking the hot and cold water temperature monthly. We saw evidence that this was carried out. In addition we discussed the management of dental unit water lines with the dental nurse staff and found that a comprehensive regime of flushing and disinfecting the water lines was in place.

Equipment and medicines

We saw that the practice had equipment to enable them to carry out a range of dental procedures.

Prescription pads were kept in each surgery and a log of each prescription issued kept. As part of the daily surgery checks prescription pads were checked to ensure they were stored securely.

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 the concern with the head dental nurse, who immediately amended the expiry date.

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 exclusively digital X-rays, which were available to be viewed almost instantaneously, as well as delivering a lower effective dose of radiation to the patient.

All X-ray machines had been services and tested within the last year to ensure they were working within normal parameters. We saw the results from an examination of the machines which had suggested a few minor amendments. These had been carried out promptly.

We saw evidence that clinicians were writing a justification for taking each X-ray as well as documenting the quality of the X-ray, and reporting on the findings of the X-ray in the dental care records.

In this way the practice ensured that the effective dose of radiation to the patients was kept as low as reasonably possible.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

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

A comprehensive medical history form was filled in and signed by the patients at every new check-up appointment. There were separate forms for adults and children (under 12) and the adult forms included information regarding use of nicotine products and alcohol consumed. The medical history was verbally confirmed by the dentist at every appointment.

We were told that assessment was carried out on the gum health of every patient as part of the check-up appointment. We saw evidence of this as part of the dental care records. 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. We saw that higher scores on the BPE triggered further assessment, discussion and treatment.

It was demonstrated through dental care records that dentists were keeping accurate and detailed records of appointments. It was clear that the decision to take X-rays was guided by clinical need and in line with the Faculty of General Dental Practitioners directive.

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 serious commitment to oral health promotion. Dentists we spoke with were able to discuss local stop smoking groups and other avenues that they may be able to recommend to patients who wished to stop smoking.

We saw entries in dental care records that detailed patients' oral health, discussions that had taken place with patients regarding improving oral health.

The practice demonstrated a thorough knowledge and application of guidance issued in the DH 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.

Over the school half term holidays the practice prioritised seeing children and applying the principles of the DBOH toolkit to guide and improve their oral health. Children were seen by a dentist who performed a check –up and assessed their clinical need. Then all the children were seen by an oral health educator, or dental therapist who discussed prevention of dental disease.

Children were given a gift bag to take away designed to engage them in their oral health. This included diet charts, egg timers for timing tooth brushing and star charts. The length of time before children were recalled was guided by clinical need.

Staffing

The practice had 14 dentists, three dental therapists, two head dental nurses, three newly qualified dental nurses and 11 trainee dental nurses. A practice manager and 10 receptionists and a cleaner completed the team.

Some dental nurses had completed the radiography training and were able to take X-rays; there was an intention by the practice to have more nurses with extended competencies.

We spoke with the head dental nurse about the support offered to the trainee dental nurses, particularly as they outnumbered the trained dental nurses. The practice operated a comprehensive training programme for the dental nurses. In addition they were mentored day to day by the dentist they worked with, and the practice would ensure that a trained dental nurse was working in each area of the building supporting the trainees in that area.

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 orthodontic therapists and dental technicians.

Are services effective?

(for example, treatment is effective)

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

Working with other services

The practice is part of a local group of eight practices, one of which has specialists in different areas of dentistry. The practice could utilise this by referring complex treatment to dental specialists in a timely manner.

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.

Although we were told that this was followed up by a phone call to the hospital by the referring dentist to confirm receipt of the referral, this was not always confirmed by the dentists that we spoke with. This was discussed with a dentist who agreed that a more robust system could be implemented.

Consent to care and treatment

The practice demonstrated a good understanding of the processes involves in obtaining full, valid and informed consent for an adult. We were shown entries in dental care records where treatment options were discussed with patients, and references to patients being given time to consider their options.

In addition a written treatment plan with estimated costs was produced for all patients to consider before starting treatment.

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. The practice displayed guidance on the MCA in the office, however not all staff that we spoke with had a clear understanding of the process involved in making a best interests decision.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Staff we spoke with explained to us how patients' information was kept confidential. This was underpinned by an information governance policy which could be accessed by staff on the shared computer drive.

We observed that the computer screens at the reception desk were set below the level of the desk, and so could not be overlooked by anyone standing at the desk. Patients' records were computerised and password protected. The head dental nurses would check that the computer had been logged off during their lunchtime surgery checks.

We received feedback from patients that they were treated with kindness and dignity. Staff were described as professional, thorough and respectful.

Involvement in decisions about care and treatment

Patients to the service were provided with a written treatment plan and estimate of costs before treatment started. Patients we spoke with confirmed that treatment options were always explained to them, and they were given ample opportunity to ask questions about their treatment.

NHS costs were clearly displayed in the waiting areas on the ground and first floor.

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 offered late evening opening (until 7.30 pm) four days a week. They had early morning appointments available from 8.00 am Monday to Friday, and opened every Saturday morning. In this way the appointment system offered ample opportunity for access by patients who may have commitments during normal working hours.

The practice had received feedback from patients that they had difficulty getting through on the phone, and if someone did answer immediately they were often placed immediately on hold. In response to this the practice increased the number of phone lines to six, and requested that reception staff took a number to call the patient back if they couldn't be dealt with immediately, rather than being placed on hold.

During two school half term holiday weeks in a year, the practice did not book any routine adult dentistry, instead the whole practice committed themselves to seeing children. Check-ups and oral hygiene instruction were given to the children, as well as a gift bag containing colouring competitions, egg timers (for timing tooth brushing) and brushing charts.

All children that visited the practice during these weeks were entered into a prize draw to win a family holiday to a European theme park.

The last year that this was undertaken, the practice saw 3,000 children for check-ups and oral health instruction.

This commitment to oral health was also demonstrated through school visits that the practice carried out. The presentation made would be tailored to the age group of the children. The younger age groups were able to meet the practice's friendly dinosaur, to engage them in the importance of tooth brushing.

Patients commented that they appreciated receiving reminders of their appointments and recalls by text message.

Tackling inequity and promoting equality

Staff we spoke told us how they welcomed patients from all different backgrounds and cultures and everyone was treated with respect and compassion.

We asked about communication with patients for whom English was not a first language. Staff we spoke with explained that they had several members of staff that spoke multiple languages, and were aware that a situation may arise where they needed to access translation services, although this had not been that case to date.

The practice had carried out a disability discrimination audit on 6 April 2015. This indicated that the practice was suitable for wheelchair users, having ground floor treatment rooms with ramp access to the front of the building, and a disabled toilet.

Access to the service

Emergency appointments were set aside for each dentist every day; this ensured that patients in pain could be seen in a timely manner. Patients commented that they were able to see a dentist easily in an emergency.

Concerns & complaints

The practice demonstrated a robust system for investigating, handling, and learning from complaints to the service, this was underpinned by a comprehensive complaints policy.

Patients were guided in how to raise a complaint by a poster displayed in the waiting area.

We saw evidence that complaints were discussed across the team meetings for dentists, nurse and practice managers so that all members of staff could benefit from the learning.

Are services well-led?

Our findings

Governance arrangements

The practice had clear lines of responsibility and accountability. The registered manager was supported by a clinical lead dentist, practice manager and head nurses within the management team. This meant that there were multiple avenues for staff members to approach the management team, and regular meetings ensured that good communication across the practice and the group was a priority.

Weekly role specific practice meetings were held for the dentists, dental nurses and receptionists so that issues discussed were relevant to that workforce.

The practice had policies and procedures in place to support the management of the service, and these were readily available on the shared computer drive for the staff to reference. These included a complaints policy, safeguarding, and infection control policies, as well a robust health and safety policy, and business continuity plan to allow the continuation of the service in adverse circumstances.

Comprehensive risk assessments were in place to mitigate risks to staff, patients and visitors to the practice. These included assessments in fire risk, health and safety risk, and a general practice risk assessment.

The practice employed administrative staff at a head office location who maintained oversight of the training, indemnity and registration of the staff employed. E-mail reminders were sent to staff in advance of important documentation needing renewing.

Leadership, openness and transparency

Staff at the practice reported a culture of honesty where they were actively encouraged to raise any concerns and approach a member of the management team.

In addition a whistleblowing policy was available for staff to reference, which detailed how staff could raise a concern about a co-workers actions or behaviour.

Learning and improvement

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

The practice had its own comprehensive training pathway for trainee dental nurses, and many of the staff that started at that level had progressed through to become head nurses or practice managers.

We saw the training folders designed for the first 12 weeks in practice. These included tests on what they had learnt, testimonials from dentists they had worked with confirming competency at particular tasks.

The training was supplemented by a series of PowerPoint presentations that the trainee dental nurses could reference at any time to remind them of their learning. The training was designed to prepare the dental nurses for the national qualification in dental nursing.

The practice tried to engage school leavers to a career in dentistry, and would regularly send a head nurse from the practice to careers events to talk about a career as a dental nurse.

The head office of the group kept information on the continuing professional development of all staff, as well as their individual certificates of training being available in hard copy in the practice.

Staff we spoke with described how they received e-mail reminders that certain training needed to be completed and this was sometimes linked directly to an online course so that the training was completed in a timely manner. In this way the practice maintained oversight of the training being completed and could be assured that required training had been undertaken by all staff.

The practice undertook regular clinical audit to ensure the effectiveness of the service, and highlight any areas for improvement. Audits on infection control and quality of X-rays taken were found to be comprehensive, but did not always have written action plans, or highlighted areas for learning.

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 patients using the service. There was a comments box in the reception area, and the practice also invited comments through the NHS friends and family test.

The practice responded to patient feedback in the area of communication with the practice. It was highlighted that patients were frequently placed on hold, or struggled to get

Are services well-led?

through at all. In response to this the practice had increased the number of phone lines, had trained receptionists to take a number and call back, rather than placing callers on hold, and in addition had invested in a listening line so that interactions between the practice and patients by phone could be used as a learning tool to improve service.

Staff were actively encouraged to give feedback through the weekly staff meetings, or their annual appraisals. Staff told us a few examples of changes that had been made after a staff suggestion, notably in the training programme for the dental nurses.