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Miss K Saxby & Associates - Ampthill Dental Surgery

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 14 March 2017 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Miss K Saxby & Associates - Ampthill Dental Surgery is a general dental practice close to the centre of the town of Ampthill in Bedfordshire.

The practice has four treatment rooms and offers general dental treatment to adults and children funded by the NHS or privately.

The practice now has one principal dentist, five associate dentists and two dental hygienists supported by six qualified dental nurses and 2 receptionists.

The practice is open from 8.30 am to 5 pm on Monday to Friday.

The practice is fully accessible to wheelchair users. The treatment rooms are on the ground floor, and although there are steps from the car park to the rear entrance of the building, there is a temporary ramp available to improve access through the front door.

Summary of findings

The practice owner 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.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience. We received feedback from 50 patients. These provided a positive view of the services the practice provides. Patients commented on the quality of care, the polite and friendly nature of staff and the cleanliness of the practice.

Our key findings were:

- The practice was visibly clean and clutter free.
- Comments from patients indicated that the staff were kind and caring and were skilled at putting nervous patients at ease.
- The practice met the standards set out in national guidance regarding infection control.
- A routine appointment could be secured privately within a week and a waiting list was available for patients wanting to register for treatment on the NHS.
- Emergency appointments were available daily, and the practice offered a sit and wait service every morning for patients with urgent need.
- The practice had policies in place to assist in the smooth running of the service.
- The practice had medicines and equipment to treat medical emergencies.
- Dentists at the practice used national guidance and standards in the care and treatment of patients.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- Governance arrangements were in place for the smooth running of the service.
- Appropriate pre-employment checks were being carried out to ensure the service employed fit and proper persons.
- The clinicians were using rubber dam when completing root canal treatment.

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

- 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

Infection control standards met those outlined in national guidance.

The practice was carrying out appropriate pre-employment checks on staff, including disclosure and barring service checks to ensure they employed fit and proper persons.

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

Equipment was serviced in line with manufacturers' requirements.

No action ✓

Are services effective?

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

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

A comprehensive screening of patients was carried out at check-up appointments; however improvements could be made to the records made in the patient care records.

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

No action ✓

Are services caring?

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

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

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

Staff described appropriate measures to ensure that patients' confidential information was kept private.

No action ✓

Are services responsive to people's needs?

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

The practice made every effort to see emergency patients on the day they contacted the practice. Registered patients were made aware that they could attend without an appointment at 8.30 am if there was an urgent need and they would be seen.

Staff made every effort to assist patients with restricted mobility.

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

No action ✓

Summary of findings

Are services well-led?

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

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

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

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

No action 

Miss K Saxby & Associates - Ampthill Dental Surgery

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

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

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had a system in place for reporting and learning from untoward incidents. The practice had not recorded an incident in the year preceding our inspection. A policy was in place and templates were used to record incidents, these prompted staff to investigate and feedback learning points to prevent reoccurrence.

Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. A clear understanding of this was evident during our discussions with staff and we were shown a policy on the same which explained the practice's expectation that staff would be open and honest.

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

The practice was aware of their responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). RIDDOR is managed by the Health and Safety Executive (HSE). The principal had affixed notes on when a RDDOR report was to be made to the back of the accident book so that the information was readily available.

Reliable safety systems and processes (including safeguarding)

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

All staff had undertaken training in safeguarding and staff we spoke with were able to describe the actions they would take in response to concerns, including how to respond if they felt a vulnerable adult or child were in immediate danger.

The practice had an up to date Employers' liability insurance certificate which was due for renewal in January 2018. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

We discussed the use of rubber dam with the 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 available and used routinely.

A protocol was in place detailing the actions required in the event of a sharps injury. This directed staff to seek advice from occupational health or accident and emergency if there was a reason to be concerned. Staff were advised to discuss all such injuries with the principal dentist who explained they would get advice in all cases of injury with a contaminated sharp.

The practice had safer sharps available at the time of the inspection, but individual dentist were given the choice in whether to use them or not. Safer sharps are medical sharps that have an in built safety features to reduce the risk of accidental injury. The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 require that practices switch to 'safer sharps' where it is reasonably practicable to do so. The practice had a risk assessment in place, and dentists were solely responsible for the disposal of sharps.

Medical emergencies

The dental practice had medicines and equipment in place to manage medical emergencies. These were stored together and all staff we spoke with were aware how to access them. Emergency medicines were in date, stored appropriately, and in line with those recommended by the British National Formulary.

Medicines were stored in a locked cupboard on the wall individually. This could result in a delay getting the appropriate medicine to the patient than if they were all stored together in a portable bag. We raised this with the principal dentist who said they would consider changing the storage arrangements. Following the inspection this was implemented.

Are services safe?

Equipment for use in medical emergency was available in line with the recommendations of the Resuscitation Council UK including an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.

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

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

Staff recruitment

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all recruitment files. This includes: proof of identity; checking the prospective staff members' skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed). DBS checks identify whether a person had a criminal record or was on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

We reviewed the staff recruitment files for five members of staff. DBS checks had been sought for all staff and all other pre-employment checks had been completed in line with regulation.

The practice had a four week induction programme in place to introduce new members of staff to the workings of the practice, and safety procedures.

Monitoring health & safety and responding to risks

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

A full practice risk assessment was completed in March 2017 covering hazards such as Blood and saliva, waste and general hazards within the premises.

A sharps risk assessment was completed as part of the general health and safety risk assessment and indicated that dentists were solely responsible for dealing with medical sharps as well as covering the dental nurses training in the sharps protocol.

A fire risk assessment had been completed internally. In addition to this weekly checks were carried out on the escape routes and alarm system, although these were last recorded in December 2016. Staff we spoke with were able to describe the actions they would take in the event of a fire and identify the external assembly point. Staff had training in fire safety in August 2016. Information for patients was displayed in the waiting area.

Following our inspection logging of the weekly fire checks commenced immediately and arrangements were made for a fire risk assessment by an external contractor on 22 March 2017.

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

The practice had a business continuity plan in place which detailed the actions to take should the premises be unusable due to unforeseen circumstances. This include an arrangement for emergency patients to be seen at a nearby practice.

Infection control

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

The practice had an infection control policy in place; this was dated June 2016 and included topics such as hand hygiene, blood borne viruses, decontamination and personal protective equipment.

The practice was visibly clean and clutter free.

The practice did not have a dedicated decontamination facility, although plans were being drawn up to convert an unused treatment room for this purpose. At the time of the

inspection cleaning of instruments either manually or using an ultrasonic bath was being carried out in the individual treatment rooms, then instruments were transported to a room which housed the autoclaves for sterilising. Instruments were then transported back to the treatment rooms for pouching and dating. We saw that the practice had transport boxes in place and appropriately labelled for each stage of this process.

We observed staff manually cleaning instruments and noted that their technique was in line with that recommended by HTM 01-05.

Appropriate testing of the autoclaves took place, in line with the recommendations of HTM 01-05. The ultrasonic cleaners were tested weekly and monthly in line with national guidance and their practice policy, however annual servicing had not been carried out. We discussed this with the principal dentist who made immediate arrangements to have this carried out, and reverted to manually cleaning of all instruments in the interim.

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

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

We noted an area that was difficult to clean due to damage; a tear in the dental chair in one of the treatment rooms would make cleaning the chair effectively difficult. This had been recognised by the infection control audit and arrangements made to replace it. In addition we saw areas where the flooring was not completely sealed to the wall; the practice arranged sealing to be carried out following the inspection.

The practice had a risk assessment regarding Legionella. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The assessment had been carried out by an external company in February 2017.

Monthly water temperatures were checked to ensure they remained outside the range in which Legionella proliferation would be more likely. The practice also completed quarterly dip slides which measure the amount of bacteria in the water. These checks did not raise any cause for concern.

Equipment and medicines

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

Portable appliance testing had been carried out and was not due again until May 2017. The fire extinguishers had been serviced in March 2016.

The compressors and autoclaves had been serviced and tested in line with manufacturers' instructions in November 2016. The ultrasonic baths had not been serviced by an engineer, although regular testing on their efficiency was being completed. Following the inspection arrangements were made to have these serviced and validated.

The machine that develops the X-rays had been services in January 2017 and gas appliances had been certified in July 2016.

Prescription pads were secured on the premises, and logged in line with the guidance from NHS Protect.

Radiography (X-rays)

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

The practice had four intra-oral X-ray machines that was able to take an X-ray of one or a few teeth at time and one panoramic X-ray machine that can take an X-ray of the whole jaws.

Rectangular collimation on intra-oral X-ray machines limits the beam size to that of the size of the X-ray film. In doing so it reduces the actual and effective dose of radiation to patients. We saw that one machine had a collimator, and these were retro-fitted to the other units following the inspection.

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

We saw from the dental care plans we were shown that clinicians were not always noting the justification for taking an X-ray, the quality grade or a report of the findings.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

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

A comprehensive medical history form was completed by patients when they first attended. Subsequently dentists checked verbally whether there were any changes, which was then updated on the computer system. Following the inspection the practice made further improvements by introducing a protocol to ensure that the medical history is repeated and signed by the patients at the start of every new course of treatment

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

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

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

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

Health promotion & prevention

Some dental care records we were shown indicated that an assessment was made of patient's oral health and risk factors, this was used by dentists to introduce a discussion on oral health and prevention of disease.

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

Staff were aware of ways that patients could access local stop smoking services through the pharmacist or general practitioner and would refer patients that requested it.

Free toothpaste was available for patients in the practice.

Staffing

The practice was staffed by six dentists, 2 dental hygienists and six qualified dental nurses supported by two receptionists.

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

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

Staff told us they had good access to on-going training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians, dental technicians, and orthodontic therapists.

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

Working with other services

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

Referrals for suspicious lesions were made by fax the same day, and a phone call made to confirm receipt.

The practice did not keep a log of referrals made which would have helped keep track of referrals sent out and be able to chase up the referral in a timely manner. We were

Are services effective?

(for example, treatment is effective)

told that patients were given a timeframe when they were referred to another service, with instructions to contact the practice if they hadn't heard from the referral service within the specified timescale.

Consent to care and treatment

We spoke to clinicians about how they obtained full, educated and valid consent to treatment. Comprehensive discussions took place between clinicians and patients where the options for treatment were detailed; however these discussions were not always fully documented in the patients dental care record. Comments we received from patients indicated that their options were explained to them in detail, explanations given, and time taken to answer any questions.

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Staff demonstrated a good understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment

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

Are services caring?

Our findings

Respect, dignity, compassion & empathy

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

We witnessed patients being spoken to in a polite and courteous manner, and patients indicated that staff were skilled at putting nervous patients at ease. A patient commented that they had been contacted at home after a difficult appointment to ensure they were well.

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

Reception staff explained how they took care when speaking to patients on the telephone as a potential situation where care had to be taken not to divulge private information. The waiting area was situated way from the reception desk making it less likely that a patient wold be overheard whilst stood at the reception desk.

Staff told us that computers were password protected with individual log on information, and paper records were kept out of sight and locked away at the first opportunity.

These measures were underpinned by practice policies on confidentiality and data protection.

Involvement in decisions about care and treatment

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

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

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

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

At the time of our inspection the practice was not accepting new NHS patients; however they kept a waiting list and contacted patients as they had availability. The practice was accepting patients on a private basis, and a patient could expect to receive an appointment within a week. We examined appointments scheduling and found that there was enough time allocated for assessment and discussion of the patients' needs.

Tackling inequity and promoting equality

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

We spoke to staff about ways in which they assisted those with individual needs attending the practice. The practice had ground floor treatment rooms which offered wheelchair access. There were stairs from the car park at the rear of the building, and also to the front door. The practice had a temporary ramp to allow access through the front door. In addition double hand rails on the stairs to the rear door improved access for patients with restricted mobility.

An access audit had been carried out in January 2017 to ensure that the practice were doing all they could to assist those with individual needs.

The practice could arrange language interpreters for patients who did not speak English as a first language, although they had not had need to arrange this at the time of the inspection.

Access to the service

The practice was open from 8.30 am to 5 pm on Monday to Friday.

Emergency slots were set aside daily and in addition, patients were told that they could attend the practice at 8.30 in the morning and 'sit and wait' to be seen if they had an urgent need.

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

Concerns & complaints

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

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

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

Are services well-led?

Our findings

Governance arrangements

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

Staff meetings were arranged, these could be practice wide, or specifically for the dental nurses or dentists. Minutes for these meetings were taken and available for staff to reference. Meeting that had taken place in the last year included undertaking a fire drill, use of the AED and a meeting with the dentists to discuss the results of the X-ray audit and write an action plan for improvement.

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

The principal dentist kept a diary with all the equipment maintenance schedules documented so that they could be assured that required maintenance would take place in a timely manner.

Dental care records we were shown did not always demonstrate an appropriate level of detail; this was compounded by the fact that dental care records were kept partially on the computer and partially in hard copy. We raised this with the principal dentist who showed us a record keeping audit that had been started. Data had been collected which corroborated our findings. The results of the audit had not been analysed, however the principal dentist ensured us this would be fed back to the clinicians and an action plan and re-audit completed as soon as possible.

Following the inspection the practice made changes including moving fully to a computerised patient care record and adding in automatic prompts to ensure that clinicians are recording appropriate detail.

Leadership, openness and transparency

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

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

Staff we spoke with felt comfortable to raise concerns should they feel the need.

Learning and improvement

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

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

A clinical audit on the quality of X-rays taken had been completed in July 2016; the results of this had been discussed with the dentists at their team meeting and an action plan for improvement drawn up. A re-audit was carried out in October 2016 to demonstrate improvements.

A record keeping audit had been started and highlighted some failing in the process. We were assured that the audit process would be completed to address the concerns.

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

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

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

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

Are services well-led?

In addition suggestion boxes were available in the practice, and emails were sent to patients following their first appointment at the practice asking for comment.

Staff indicated that they felt comfortable to approach the principal dentist with any feedback, concerns or ideas; either formally or informally.