

Mr Kamal John

Thorley Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 5 July 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

Thorley Dental Practice is a general dental practice situated in the Thorley district of Bishop's Stortford, Hertfordshire. The premises are within a retail development, and have ample parking available in front of the practice.

The practice provides treatment on a private basis to adults and children. The premises consist of two treatment rooms, and waiting area/ reception area and a separate X-ray room.

The practice did not have a dedicated decontamination facility; cleaning and sterilisation of dental instruments was taking place in the treatment rooms. We saw builders' plans for alteration to the premises that allowed for construction of a decontamination room. We were told that work would commence in the coming months.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

The practice was first registered with the Care Quality Commission (CQC) in February 2012.

We received positive feedback from eight patients about the services provided. This was through CQC comment cards left at the practice prior to the inspection.

Summary of findings

Our key findings were

- The practice was visibly clean and clutter free.
- Patients reported positive experiences at the practice and commented that they were treated with care and professionalism.
- The practice could normally arrange a routine appointment within a week and emergency appointments mostly on the same day.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- The practice did not have all the emergency equipment recommended by the Resuscitation Council UK for use in a medical emergency, although this was all purchased shortly following our inspection.
- The clinicians used nationally recognised guidelines in the care and treatment of patients.

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

- 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 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.
- Review the practice's infection control procedures and protocols giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.
- Review the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking the X-ray and quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000, and review the use of rectangular collimation on the intra-oral X-ray machine to reduce the effective dose of radiation to the patient.
- Review the protocol for completing accurate, complete and detailed records relating to employment of staff. This includes making appropriate notes of verbal reference taken and ensuring recruitment checks, including references, are suitably obtained and recorded.

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 kept emergency medicines in line with the recommendations of the British National Formulary for use in medical emergencies. Emergency equipment that was missing was purchased following the inspection.

Equipment including the autoclaves and X-ray machines were serviced in line with manufacturers' instructions.

Changes were immediately made to the decontamination process to meet the requirements of the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices,' published by the Department of Health.

No action



Are services effective?

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

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

A clear process for obtaining full, valid and educated consent to treatment was described. Conversations with patients were detailed in the dental care records.

Referrals were made to other services when treatment was not available or too complex to be completed at the practice.

No action



Are services caring?

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

Patients commented that the staff at the practice were kind and friendly and that they were always treated with care and professionalism.

Staff described how patient information was kept private, and the practice responded to concerns regarding conversations being overheard within the premises.

No action



Are services responsive to people's needs?

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

New patients could usually be seen at the practice within a week of contacting, emergency patients were normally seen the same day.

Ample parking was available outside the practice which would assist those with restricted mobility accessing the premises.

Complaints to the practice had been investigated, and dealt with in a timely way and in line with the practice's 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 policies and procedures to aid the smooth running of the practice although these were sometimes undated.

Staff felt comfortable to raise any concerns with the principal dentist, and confident that their opinion would be valued.

The practice afforded wheelchair access to a treatment room.

No action



Thorley 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 5 July 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Before the inspection we asked the practice 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 four members of staff during the inspection.

We reviewed the practice's policies, procedures and other documents. We received feedback from eight patients about the dental service.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had a system in place to report, investigate and learn from incidents. No incidents had been reported in the year preceding our visit. From discussions with staff it was apparent that only serious incidents would be logged in this way. Following our inspection the practice implemented a new template for recording incidents. This stipulated that anything of note or out of the ordinary should be recorded and investigated to reduce the probability of reoccurrence.

The practice had a separate accident book. The last entry was made in July 2014 and demonstrated that the practice followed its protocol for dealing with a sharps injury.

The practice received alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). These detailed any recalls or alerts with medical equipment and medicines. These were emailed to the principal dentist who passed on any relevant alerts to staff.

The practice were aware of their responsibility in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). They had a policy in place dated January 2016, and this detailed how to make a report and in what circumstances a report should be made. RIDDOR is managed by the Health and Safety Executive, although since 2015 any RIDDORs related to healthcare have been passed to the Care Quality Commission (CQC).

Reliable safety systems and processes (including safeguarding)

The practice had systems and policies in place regarding safeguarding vulnerable adults and child protection. Policies were readily available in hard copy form although they were undated. The policy explained the types of abuse that staff may see, and how to raise a concern. The policy had contact numbers available where staff could seek advice if required; these were also displayed on the wall in a staff area.

Staff had all undertaken training in safeguarding and were confident in how to respond to a safeguarding concern should the situation arise.

The practice had an up to date employers' liability insurance certificate which was due for renewal in December 2016. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

We discussed with clinicians whether a rubber dam was routinely used in root canal treatments (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). We found that although the practice had provision to use a rubber dam, it was not used universally. Dentists were able to describe the steps they would take to mitigate the risk in not using one. The British Endodontic Society recommends the use of rubber dam for root canal treatment.

Medical emergencies

The practice carried emergency medicines in line with those detailed in the British National Formulary (BNF). However, although the practice carried adrenaline, in the form of a pre-filled syringe, it was only enough to administer one dose. The BNF states that in the event of a severe allergic reaction adrenaline may need to be administered every few minutes. Following our inspection we have received evidence that more adrenaline has been ordered to cover such an eventuality.

The practice kept oxygen for use in an emergency; however when we inspected it the only plastic tubing available was discoloured and not covered. In addition no oxygen masks were available to administer the oxygen. The oxygen cylinder was dated November 2011. Following our inspection the oxygen cylinder as well as the tubing was replaced the practice took out a service contract for the oxygen cylinder to prevent this occurrence in the future. Oxygen masks for adults and children were purchased.

The practice did not carry all the equipment recommended by the Resuscitation Council UK for use in medical emergencies. The practice did not have an automated external defibrillator (AED). An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. Oropharyngeal airways used to

Are services safe?

support the airway in an unconscious or semi-conscious patient were out of date, and the self-inflating bag used to ventilate a patient in the event that they stopped breathing was found to be dirty.

Immediately following the inspection all missing equipment was purchased, and met national guidance.

Most staff had a record of having completed medical emergencies training, and training had been arranged for the whole practice shortly following our inspection. Staff we spoke with were able to describe the medicines required to treat different medical emergencies.

Staff recruitment

We looked at the staff recruitment files for six staff members of different grades 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 person's 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 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.

We found that although all clinical staff had a DBS check the practice had not performed a risk assessment or DBS check for reception staff. Following the inspection a DBS check was arranged for reception staff, and a risk assessment put into place in the interim.

Contracts for staff were not kept on the premises, and these were sent following the inspection. References for new staff if sought were not recorded. Following our inspection the practice implemented a new recruitment policy which specified that two references are recorded for each new starter.

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 staff to reference dated January 2015. This included information

on manual handling, electrical safety and substances hazardous to health. A health and safety compliance audit dated April 2016 detailed some actions to be ongoing, but no areas of concern were deemed immediate.

A fire risk assessment had been carried out by an external company in April 2016. This listed some actions to consider, but again none were time scaled in the 'immediate' category. Staff we spoke with were able to describe their response in the event of a fire, including the external muster point following evacuation of the premises.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was 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 policy detailing how sharps were to be handled, this included a risk assessment. On discussion with clinicians there had been no move to 'safer sharps' as detailed in the Health and Safety (Sharps Instruments in Healthcare) Regulation 2013. Following our inspection the practice purchased a system of safety needle and disposable matrix bands to trial in practice.

Information was displayed in each treatment room which detailed the actions to take following an inoculation (sharps) injury, and records indicated that these actions had been carried out following sharps injury.

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.

There was an infection control policy in place at the practice (dated February 2016), and infection control audits were carried out every six months.

Decontamination is the process by which contaminated re-usable instruments are washed, rinsed, inspected, sterilised and packaged ready for use again. We observed a dental nurse carrying out the process in the treatment room.

Are services safe?

Instruments were manually cleaned, rinsed and inspected under an illuminated magnifier before being sterilised in an autoclave. There were some aspects of the process of manual cleaning which were not in line with HTM 01-05; the dental nurse did not put on any personal protective equipment prior to cleaning the instruments (apron, mask or eye protection).

The instruments were cleaned under running water, rather than immersed in a solution. This meant that contaminated material could become airborne, and the temperature of the water could not be assured (the water temperature should be under 45 degrees Celsius to ensure the effective removal of protein contaminants). The practice used a separate bowl to rinse the instruments, however this was very small, and made effective rinsing difficult.

During the inspection phase of the process the dental nurse demonstrated use of the light on the illuminated magnifier to examine the instruments, but not the magnifying glass. This could limit the ability to recognise any residual debris on the instruments.

Following the inspection the practice introduced a new manual cleaning policy which detailed the process as outlined in HTM 01-05, and time was taken with the dental nurses to ensure that this became embedded immediately.

Instruments were sterilised in an autoclave and placed in pouches upon which a use by date was written. The autoclave was tested daily to ensure its effectiveness.

The practice had 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 were checking the mains water temperatures, flushing and disinfecting the water lines. This was in line with the external risk assessments that had been carried out in April 2016 to determine the level of risk. The principal dentist had also undertaken training in Legionella in July 2016.

We spoke with staff about their uniforms. All staff had a tunic top which was dedicated uniform, but not a whole outfit of uniform including shoes. We raised this with the principal dentist who implemented a new uniform policy to ensure that there was no further risk of cross contamination from uniforms.

The practice had a waste contractor in place to dispose of hazardous waste. A clinical waste bin was available at the rear of the premises to store the waste prior to collection. Although the clinical bin was locked, it was not secured to prevent its removal. Following the inspection the practice secured the bin.

There were records to demonstrate that staff had received inoculations against Hepatitis B or were in the process of receiving them. Health professionals who are likely to come into contact with blood products, or who are at increased risk of sharps injuries should receive these vaccinations to minimise the risk of contracting blood borne infections.

Equipment and medicines

The practice had a full range of equipment to carry out the services they offered. Records showed that equipment at the practice was maintained and serviced in line with manufacturer's guidelines and instructions.

The practice had two autoclaves, both of which had been serviced and tested in the year preceding our visit. A new compressor had been installed in June 2016. Portable appliance testing of electrical equipment had been carried out in August 2015, and fire equipment had been serviced between May and June 2016.

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, but could be stored outside the refrigerator at a temperature not exceeding 25 degrees Celsius for 18 months provided that the expiry date is not exceeded. We found that although the medicine was being kept with the other emergency medicines that expiry date had not been altered to account for it not being refrigerated. This was amended immediately following the inspection.

Apart from the emergency medicines, the practice did not keep stock of any medicines on the premises.

Radiography (X-rays)

The practice was required to demonstrate compliance with the Ionising Radiation Regulations (IRR) 1999, and the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.

Are services safe?

The practice had a separate X-ray room which had an intra-oral X-ray machine which takes X-rays of one or a few teeth, and an OPG machine (an Orthopantomogram takes a panoramic X-ray of all the teeth and jaws).

The practice kept a radiation protection file which detailed the specifics of the safe use of X-rays on the premises. Mechanical and electrical servicing of the machines had been carried out in August 2015. However the intra-oral X-ray machine did not have a rectangular collimator fitted. This reduces the effective dose of radiation to the patient by reducing the amount of scatter.

The local rules detailed those persons responsible for the safe use of X-rays, as well as displaying a schematic of the area. A risk assessment had been completed in March 2016 which detailed a dosage risk assessment.

A routine maintenance checklist had been supplied by the Radiation Protection Advisor (a medical physicist contracted by the practice) however the practice had not completed this. Following the inspection this was carried out.

Practitioners who were trained to take X-rays were up to date with the ongoing training requirements in the area, as specified by IR(ME)R.

The clinicians did not always record on the dental care record the justification, quality and report of an X-ray in line with IR(ME)R Regulations. Following our inspection the practice implemented a schedule of performing a record keeping audit which would highlight such issues in the future.

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 at each check-up appointment, and checked verbally in the treatment room at every appointment. This ensured that the dentist was kept informed of any changes to the patient's general health which may have impacted on treatment.

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

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

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

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

Health promotion & prevention

The practice was committed to health promotion. Medical history forms asked questions regarding nicotine and alcohol use, this information could then be used to introduce a discussion regarding these. Clinicians had leaflets on stopping smoking available to give to patients, and would direct them to the smoking cessation helpline for further advice.

We found that the principles of the guidance issued in the Department of Health publication 'Delivering better oral

health: an evidence-based toolkit for prevention' were being applied when providing preventive oral health care and advice to patients. This is a toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Staffing

The practice had two dentists, a dental hygienist, a qualified dental nurse, a trainee dental nurse, and two receptionists.

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

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 GDC. 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 treatment themselves.

The practice kept a document of referral guidelines which highlighted who to make referrals to, and in what clinical circumstances a referral was to be made. Most referrals were made by letter with the appropriate details and any X-rays to avoid them having to be taken again.

The practice would follow up a referral for a suspicious pathology (such as oral cancer) with a telephone call to the service to ensure it had been received and actioned in a timely manner.

Consent to care and treatment

The practice demonstrated the process of consent, both through their descriptions of the patient journey, and by showing us dental care records. These had written details of conversations had between the dentist and patient. They detailed the options outlined to the patient as well as the option chosen.

Are services effective?

(for example, treatment is effective)

Staff were able to detail the circumstances in which a child under the age of 16 may be able to give consent to treatment without involvement of a parent or legal guardian. This forms the basis of the legal precedent of Gillick competence, and relies on the child having a clear understanding of the benefits and possible consequences of choosing a course of action.

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. Although staff had not had specific training in this area they were able to describe the principles involved in a 'best interests' decision to treat.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Information that we received through patient comment cards indicated that the patients were always treated in a pleasant and caring manner. They found reception staff to be helpful and friendly and commented that clinical staff were able to reassure children and put them at ease. We observed staff throughout our visit and witnessed them interacting with patients in a polite and professional way.

We spoke with staff and witnessed how confidentiality was maintained at the practice. Patient records were kept behind the reception desk, but no confidential information was visible. Staff described how they would direct patients away from the reception area to a private room in order to have a confidential conversation.

We noted that a door connecting the two treatment rooms compromised the privacy of patients in either treatment

room as they could be overheard by anyone in the other room. In addition the front door of the practice was open during our visit, and patients at the desk could be overheard by patrons of a coffee shop sitting outside. We discussed these concerns with the principal dentist who assured us that the front door of the practice would now be closed at all times, and in the upcoming renovation works they will remove the door between the treatment rooms.

Involvement in decisions about care and treatment

Patients receiving complex treatment received a written treatment plan from the practice. Comprehensive discussions took place with patients regarding treatment options; this was evidenced in the dental care records. Patients commented that the clinicians listened to them and their concerns.

Private fees for treatment were displayed in the waiting area of the practice.

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.

We examined appointments scheduling, and found that adequate time was given for each appointment to allow for assessment and discussion of patients' needs. A new patient to the practice could expect to receive a routine appointment within a week.

We spoke with reception staff who told us that patients with individual needs would be given a longer appointment to allow time for those needs to be met.

Tackling inequity and promoting equality

The practice had an equal opportunities policy which indicated the practice's intention to welcome patients of all cultures and backgrounds, and that reasonable adjustments would be made to meet the individual needs of staff and patients attending the practice.

The practice was arranged on one level allowing access for wheelchairs and those with limited mobility, although the layout did not allow wheelchair access to the toilet. Staff explained that if they were aware of a patient with limited mobility they kept an eye out for them so that they could lend assistance.

The practice benefitted from having ample parking in front of the premises which aided those with restricted mobility accessing the practice.

The practice did not have access to an interpreting service to assist patients for whom English was not their first language. There was no hearing loop to assist patients who

use hearing aids. Following the inspection a hearing loop was purchased, and the practice signed up to a telephone interpreting service so that the needs of these patients could be met.

Access to the service

The practice was open from 9 am to 5 pm Monday to Friday.

Emergency appointments were set aside daily for each clinician and the practice endeavoured to see all patients in pain on the day they contacted the practice.

Outside normal working hours patients were directed by the answerphone to contact the NHS 111 service. In addition the answerphone prompted patients to leave a message and they would be contacted as soon as the practice re-opened.

Concerns & complaints

The practice had a complaints policy. In addition to this information was displayed in the waiting room indicating how a patient could make a complaint to the practice. This poster included contact information for services to which a patient could escalate a complaint if they remained dissatisfied.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was an effective system in place which ensured a timely response.

Complaints that had been received by the practice had been dealt with evidencing a duty of candour. 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.

Are services well-led?

Our findings

Governance arrangements

The principal dentist was responsible for the day to day running of the practice, and staff were aware and encouraged to approach them with any concerns.

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, information governance and whistleblowing. The policies were not always dated, which made it difficult to ensure the information contained within was up to date and relevant. Following the inspection this was addressed.

The practice had a series of risk assessments in place to identify, assess and mitigate the risks to patients, staff and visitor to the practice.

A staff meeting had taken place in April 2016, but previous to that, not since November 2015. Communication across the small team took place informally, however staff indicated that they felt they would benefit from more staff meetings.

Leadership, openness and transparency

Staff reported an open and honest culture where they felt supported and encouraged to raise concerns. Communication across the team was constant and easy; the principal dentist was approachable and supported the staff.

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.

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 at six monthly intervals most recently in February 2016, which had generated an action plan, but had not highlighted any of the failings that we recognised in the decontamination process.

An audit of quality of X-rays taken was completed on January 2016. This looked at a sample of X-rays taken by one clinician, and the results were within the expected range. An action plan had been drawn up nonetheless to improve the quality further. A recent audit had not been carried out for the associate dentist, however they had recently returned from a protracted period of absence and a plan was in place to arrange it as soon as possible.

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 had recently implemented a programme of staff appraisals, and all dental nurses and reception staff had received an appraisal within the last year. They reported these appraisals as being very useful and a good opportunity to discuss matters arising from their work.

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

The practice gave patient questionnaires to get feedback about the service. An analysis of the patient satisfaction survey from 2015 highlighted both positive and negative comments which were used to improve the service.

Staff feedback was welcomed formally or informally, and staff were happy that they could approach the principal dentist at any time with ideas or concerns.