

West Street Dental Practice

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Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 21 February 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

West Street Dental Practice is a general dental practice in the centre of Leighton Buzzard, Bedfordshire.

The practice has eight treatment rooms and offers NHS treatment to adults and children. Certain treatment options are available funded privately.

The practice has undergone recent expansion and has doubled in size in the last year.

The practice now has two principal dentists, five associate dentists and two foundation dentists. This means that the dentist recently qualified and is undertaking a year of mentored working where they receive support from their in practice trainers as well as attending training days. Both the principal dentists acted as trainers for the foundation dentists.

The practice employs four dental hygienists, eight qualified dental nurses and four receptionists.

The practice is open from 8.30 am to 7.30 pm on Monday, Tuesday, Wednesday and Thursday. 8.30 am to 5.30 pm on a Friday and 9 am to 1 pm on a Saturday.

The practice is fully accessible to wheelchair users; with a disabled parking space, ramp to the front door, ground floor treatment rooms and an accessible toilet.

One of the principal dentists is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like

Summary of findings

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 33 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 within a couple of weeks and emergency appointments would be arranged on the day they contacted the service.

- 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.

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

- Review the practice protocols regarding records of prescription forms with reference to the NHS guidance on security of prescription forms August 2013.

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.

Prescription pads were kept securely; however the practice were not logging the serial numbers in line with NHS Protect guidance.

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 including assessing risks associated with gum health, cancer and decay.

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.

Written treatment plans were given to patients for them to be able to consider their options.

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.

Evening appointments were available with a dentist on weeknights and a Saturday morning ensuring flexibility for patients who may have commitments during normal working hours.

Staff made every effort to assist patients with restricted mobility. The premises were accessible to wheelchair users.

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 on the shared computer drive or in hard copy form for staff to access.

Staff felt supported and encouraged to approach the management team with ideas or concerns.

Clinical audit was used as a tool to highlight areas where improvements could be made, although the audits were not always practice wide, and so the results were not reflective of the practice as a whole.

No action



West Street 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 21 February 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, although they had not recorded an incident in the year preceding our visit. A policy was in place which had been reviewed in October 2016. A template was available to record incidents and this prompted staff to investigate and risk assess the incident.

We discussed the protocol for dealing with incidents with the principal dentist. They described a process by which a thorough investigation would be carried out and fed back to the appropriate people. They also noted that apologies and explanations be issued to any patients involved in an incident.

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.

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 actioning any alerts and disseminating relevant information to staff.

The practice were 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 practice had a folder which contained RIDDOR forms and information on how and when to make a report.

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 wall in the waiting area.

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 service had appointed two safeguarding leads, both of whom had received further training in the area. Staff were aware of who the safeguarding leads were.

The practice had an up to date Employers' liability insurance certificate which was due for renewal in July 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

We discussed the use of rubber dam with the dentist 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 being used routinely by the dentists.

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 in the event of an injury with a contaminated sharp.

The practice were transitioning to using 'safer sharps' at the time of the inspection. These 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.

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.

Equipment for use in medical emergency was available in line with the recommendations of the Resuscitation Council UK with the exception of a child size oxygen mask. These were purchased immediately following the inspection.

Are services safe?

The practice had 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 October 2016.

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 seven members of staff. DBS checks had been sought for all staff and all other pre-employment checks had been completed in line with regulation.

We were shown an induction pack designed for new dental nurses to the service. This included the processes in infection control and decontamination of dental instruments as well as the segregation of waste and protocols in opening and closing the treatment rooms.

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 updated in October 2016 and was available for all staff to reference either on the shared computer drive or in hard copy. This included topics such as accidents, personal protective equipment, radiation and autoclaves.

A full practice risk assessment was completed 2016 and assessed risks arising from pressure systems, slip, trips and falls, electrical safety and fire.

A sharps risk assessment indicated that dentists were solely responsible for dealing with medical sharps.

An internal fire risk assessment had been completed most recently in October 2016; in addition to this the practice undertook weekly fire alarm tests, six monthly fire drills and monthly emergency lighting checks. Staff we spoke with were able to describe the actions they would take in the event of a fire and identify the external muster point. Information for patients was displayed in the waiting area.

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 was kept electronically on the shared computer drive, with back up files on separate laptop computers accessible in the building.

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 neighbouring 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 available as part of the policy folder and shared computer drive which had been reviewed and updated in October 2016. This included topics such as hand hygiene, blood borne viruses, clinical waste and personal protective equipment. In addition an annual statement in infection control had been completed in October 2016.

The practice was visibly clean and clutter free.

The practice had two dedicated decontamination facilities. The decontamination rooms had two sinks for manually cleaning and then rinsing dental instruments. We observed staff manually cleaning instruments and noted that their technique was in line with that recommended by HTM 01-05 with the exception that they were rinsing the cleaned

Are services safe?

instruments under running water. This could result in an aerosol of contaminated material. We raised this with the principal dentist who addressed it immediately with all staff, and arranged for it to be covered in the staff meeting.

Instruments were inspected under an illuminated magnifier prior to sterilisation in one of four autoclaves and then pouched and stamped with the date they were sterilised.

Appropriate testing of the autoclaves took place, in line with the recommendations of HTM 01-05.

We noted that local anaesthetic cartridges were stored in drawers in the surgeries, but not in the blister packs in which they were provided. This carried the risk of contamination from aerosols within the treatment rooms.

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; however the clinical bin was not secured to prevent it been wheeled away. Following the inspection we were sent photographic evidence that this was now secured.

The practice had a cleaning company 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 assistants chair in one of the treatment room would make cleaning the chair effectively difficult.

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, the member of staff that was responsible for completing these checks had received training in Legionella in November 2016. The practice also completed dip slides which measure the amount of bacteria in the water. These had only just been implemented at the time of the inspection and each treatment room had passes the test.

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 in February 2017. The fire extinguishers and emergency lighting had been serviced in November 2016.

The compressors and autoclaves had all been serviced and tested in line with manufacturers' instructions.

Prescription pads were secured on the premises, but not logged in line with the guidance from NHS Protect. A log was commenced following the inspection.

The practice used bleach for use in root canal treatment. This was appropriately risk assessed as part of the COSHH documentation, and the practice described appropriate dilution of this product and appropriate use clinically.

A glucagon injection kit is used to treat episodes of severe hypoglycaemia which is defined as having low blood glucose levels that requires assistance from another person to treat. It should be stored at a temperature of 2–8°C (in a refrigerator). If stored in the refrigerator the shelf life from the manufacturer is 36 months. It can be stored outside the refrigerator at a temperature not exceeding 25°C for 18 months provided that the expiry date is not exceeded.

Although the practice kept this medicine in the refrigerator they were not monitoring the temperature range and therefore could not be assured of its effectiveness. Following the inspection the practice purchased a new kit and amended the expiry date to account for it being kept out of the refrigerator.

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 six intra-oral X-ray machines that were able to take an X-ray of one or a few teeth at time.

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 rectangular collimators were in use by clinicians.

Are services safe?

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.

All staff that took X-rays were up to date with training as directed by the General Dental Council and IRMER.

We saw from the dental care plans we were shown that clinicians were routinely noting the justification for taking an X-ray as well as the quality grade and 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 annually, and updated verbally at each attendance. 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

Dental care records we saw indicated that an assessment was made of patient's oral health and risk factors. Medical history forms that patients were asked to fill in included information on nicotine use; 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 DH 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.

Patients had access to oral care leaflets in the waiting room including; how to care for your child's teeth and the importance of interdental cleaning.

Staffing

The practice was staffed by nine dentists, four dental hygienists and eight qualified dental nurses supported by four 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.

We spoke with a foundation dentist and with principal dentists regarding their role as trainers. The foundation dentist felt well supported by the principals and the practice as a whole.

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 fast track email to the hospital which was then followed up by a phone call from the practice to ensure it had been received.

The practice kept a log of referrals made which was checked monthly, any referrals to which an answer had not

Are services effective?

(for example, treatment is effective)

been received could then be chased up in a timely manner. We discussed with the principal dentist the appropriate timeframe for chasing up referrals made, particularly as the member of staff assigned to check the referrals log did not have clinical training.

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.

The practice had specific written consent forms for certain treatments such as extractions and tooth whitening.

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. However the practice did not have a policy on the MCA. Following the inspection we received evidence that this had been implemented.

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 and children at ease.

We discussed and witnessed how patients' information was kept private. The computers at the reception desk were below the level of the counter so that they 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. In addition sensitive discussions with patients

in the practice were taken away from the reception desk where they could be overheard by other patients in the waiting room, and would take place in a private office behind the reception desk.

The practice was entirely paperless which meant that it was not possible for paper records to be left on show, or misplaced.

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 all given a copy of 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 accepting new NHS patients and a new patient could expect to receive an appointment within a couple of weeks. We examined appointments scheduling and found that there was enough time allocated for assessment and discussion of the patients' needs.

Enquiries and appointments could be requested through the website as well as on the telephone or in person at the practice.

For the comfort of patients there was a television in the waiting room.

Tackling inequity and promoting equality

The practice had an equality and diversity 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 was accessible to patient using a wheelchair with a disabled car parking space outside, a permanent ramp to the front door, ground floor treatment rooms and an accessible toilet.

The reception desk was directly opposite the front door meaning that staff could see patients approaching and would be able to go to their assistance.

Language interpreters could be arranged for patients who did not speak English as a first language.

Access to the service

The practice was open from 8.30 am to 7.30 pm on Monday, Tuesday, Wednesday and Thursday. 8.30 am to 5.30 pm on a Friday and 9 am to 1 pm on a Saturday. The availability of evening appointments and appointments on a Saturday meant that patients who had commitments during normal working hours could be accommodated.

Emergency slots were set aside daily and the practice endeavoured to offer an appointment to any emergency patient on the day they contacted.

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

Concerns & complaints

The practice had a complaints handling policy dated January 2016. Details that were displayed for patients in both the upstairs and downstairs waiting rooms.

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 dentists (one of whom was the registered manager) took responsibility for the day to day running of the practice, supported by a management team of two further senior members of staff. We noted clear lines of responsibility and accountability across the practice team.

As the principal dentists were husband and wife this meant that they would take annual leave together. In these situations the remaining members of the management team would take lead roles, and the principal dentists would remain contactable at all times.

Staff meetings were arranged every six weeks. Set agenda items to be discussed at all staff meetings included complaints, significant incidents, survey results and safety alerts. The minutes of staff meetings were signed by all present. Any staff member not able to attend would receive the minutes to read over and sign to ensure everyone was kept up to date.

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 as well as in hard copy form. Policies were noted in infection control, health and safety, complaints handling, safeguarding and whistleblowing. The password to the shared drive was changed periodically, staff we spoke with during the inspection were aware of the password.

The governance system used by the practice was computer based and contained information as well as documents and policies. The system was organised and user friendly.

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 dentists.

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 dated October 2016 and was available for staff to reference in the policy folder or on the shared computer drive.

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 in line with the recommendations of The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' published by the Department of Health. They had generated action plans for improvement.

Clinical audit on the quality of X-rays taken had been completed annually by the foundation dentists. As such it only covered four of the dentists within the practice and was not therefore reflective of the practice as a whole. We raised this with the principal dentists who assured us that this would encompass all clinicians going forward.

A record keeping audit was also completed in January 2016, again this did not cover all performers.

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 made an online training facility available to all staff to assist with training.

The management team kept oversight of the training carried out by all staff members. A spreadsheet indicated areas of mandatory training and when this had been completed so that they 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 the results of this were displayed in the waiting rooms monthly.

Patient satisfaction surveys had also been requested. In February 2017 these had revealed requests for increased availability of hygiene appointments, which the practice were looking into.

In addition suggestion boxes were available in the waiting rooms and a compliments book.

Are services well-led?

Staff were encouraged to bring ideas to the management team either informally or formally, and felt empowered to do so.