Mehta Dental Practice

Marble Alley Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 6 December 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

Marble Alley Dental Practice is a general dental practice situated in the Warwickshire town of Studley.

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

The practice has three dentists all of whom are family, a dental hygienist, dental nurse and trainee dental nurse supported by a practice manager and receptionist. They are currently seeking to employ a further dental nurse and trainee dental nurse.

The practice has expanded to involve the building next door to the original premises. At the time of the inspection most of the building work was complete, however plans were in place to address further areas of the premises over the coming year.

The principal dentist is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

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

Summary of findings

56 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 mostly clutter free.
- Comments from patients indicated that the staff were kind and caring and were skilled at putting nervous patients at ease.
- Due to the demand in the local area a routine new patient appointment could be offered at the practice in two months following the initial enquiry.
- The practice had policies in place to assist in the smooth running of the service.
- The practice used national guidance in the care and treatment of patients.
- The practice met the national guidance in decontamination of dental instruments however the illuminated magnifier used to identify if any visible contaminants remained following cleaning was not entirely fot for purpose. This was replaced following the inspection.
- Risk assessments were in place to identify, monitor and mitigate risks arising from carrying out the regulated activities. Although the sharps risk assessment lacked detail and was replaced following the inspection.
- Clinical audit was used as a tool to highlight areas where improvements could be made.
- Patients commented that options for treatment were explained to them in detail and this was in evidence in the dental care records we were shown.
- Staff demonstrated good knowledge and procedures in the process of consent.

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

- Review arrangements for monitoring the availability of equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review staff awareness of Gillick competency and ensure all staff are aware of their responsibilities.
- Review the practice's sharps procedures giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 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.

The practice had medicines and equipment to manage medical emergencies, although the oxygen was out of date. This was replaced following the inspection. Missing or old emergency equipment was also replaced following the inspection.

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

The practice had not effectively assessed the risk of sharps on the premises; however this was addressed immediately following the inspection.

Fire risk assessments completed by an external contractor had not highlighted any areas for improvement.

Equipment had been serviced and tested in line with manufacturers' instructions and national 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, and included screening for gum disease.

The practice demonstrated good knowledge and systems in the process of consent, and this was evidenced by the dental care records. In discussions around children giving consent it was clear that although the principle was understood staff were less clear on how to apply this in practise.

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 endeavored to see all emergency patients on the day they contacted the practice.

No action ✓

Summary of findings

The practice offered evening appointments once a week with a dentist and dental hygienist to accommodate these patients with commitments during normal working hours. The practice afforded wheelchair access to a ground floor surgery, although at the time of the inspection there was no access to a ground floor toilet.	
Are services well-led? We found that this practice was providing well-led care in accordance with the relevant regulations. Polices were available to assist in the smooth running of the service. These had all been reviewed in the year before our visit. The practice used clinical audit as a tool to highlight areas where improvements could be made. Staff had annual appraisals where their training needs were addressed and a personal development plan drawn up to reflect it.	**No action**

Marble Alley 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 6 December 2016. 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.

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 significant incidents although they had recently changed the way that incidents were recorded. We saw one incident reported on the new template and this gave details of the investigation and prompted staff to indicate the outcome and what learning could be taken away to prevent reoccurrence. This demonstrated 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.

Prior to the new template being introduced accidents were recorded solely in an accident book and examples of these relating to sharps injuries lacked detail in regard to actions and outcomes. We discussed this with the principal dentist and the practice manager who informed us that all accidents and incidents would be recorded on the new template as well as using the accident book going forward.

The practice kept a log of all accidents and incidents so that trends could be easily identified, and a policy in reporting incidents had been reviewed in September 2016 and was available for staff to reference.

The practice received communication from the Medicines and Healthcare products Regulatory Agency (MHRA). These were e-mailed to the practice manager who showed them to the principal dentist in order to ascertain their clinical relevance. Relevant alerts were then cascaded to the rest of the 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. The practice manager demonstrated clear knowledge and understanding in this area.

Reliable safety systems and processes (including safeguarding)

The practice had a policy in place regarding safeguarding vulnerable adults and child protection. This was dated December 2015, and the practice tracker indicated that this was due for review alongside staff revision on the subject during December 2016.

The process for reporting concerns was documented with a flow chart which was available to reference in the policy folder and was also displayed in the waiting room along with relevant contact numbers. All staff had received training appropriate to their roles, and staff we spoke with were able to describe how they would raise a concern should the situation arise.

The practice had an up to date Employers' liability insurance certificate which was due for renewal in April 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. On the rare occasions when it was not possible to use a rubber dam dentists described what precautions they would take to mitigate the risk.

A protocol was in place detailing the actions required in the event of a sharps injury. This directed staff to seek advice from the dentist, and directed staff to occupational health or their general practitioner for further advice and support. Although the reports of sharps injuries in the accident book did not record whether this protocol had been followed.

Following our inspection we received a revised protocol directing staff to accident and emergency if advice could not be obtained immediately from the other sources. Two members of staff had also undertaken training in blood borne viruses to ensure they were up to date with the latest guidance in this area.

The practice were not 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)

Are services safe?

Regulations 2013 require that practices switch to 'safer sharps' where it is reasonably practicable to do so. Following our inspection the practice informed us they were looking into 'safer sharps' systems.

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 with the exception of the Oxygen. The cylinder was found to be out of date and was replaced the day after the inspection. Emergency medicines were checked and logged monthly.

Equipment for use in medical emergency was available in line with the recommendations of the Resuscitation Council UK, with the exception of oro-pharyngeal airways. These should be available in a range of sizes and support the airway in an unconscious patient. They were purchased immediately following the inspection.

Other equipment for use in a medical emergency was found to be yellowing and dusty, again these were immediately replaced.

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.

All staff had undertaken training in medical emergencies. An external company provided the training to the whole practice, most recently in April 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 four members of staff and found that DBS checks had been sought for all staff, and appropriate pre-employment checks had been carried out.

A small number of documents were held at the sister practices were some staff also worked. These were provided immediately following the inspection.

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 folder which contained the health and safety policy was updated in July 2016 and was available for all staff to reference. This included topics such as accidents, fire, personal protective equipment and autoclaves.

The practice had risk assessments in place to assess, monitor and mitigate the risks within the premises these included an infection control and decontamination risk assessment completed on 2 September 2016. A whole practice risk assessment and a risk assessment pertaining to construction work taking place on site.

Fire risk assessments had been carried out by an external contractor for both buildings individually in November 2016. Neither report highlighted any immediate areas of concern. An emergency evacuation plan was dated January 2016, and staff we spoke with were able to detail their actions in the event of an evacuation, including the external muster point. Fire drills were carried out regularly, most recently in November 2016.

A sharps risk assessment was included as part of the infection control and full practice risk assessments but lacked detail in the specifics of the protocol in this service. Following the inspection the practice undertook a detailed risk assessment on this matter.

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. All staff were aware how to access and use this information.

Are services safe?

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 infection control folder which had been reviewed and updated in July 2016.This included topics such as hand hygiene, blood borne viruses, clinical waste and personal protective equipment.

The practice had appointed the principal dentist as infection control lead, and the head nurse had day to day responsibility for decontamination. The practice was visibly clean and tidy, although the upstairs treatment room was slightly cluttered. We raised this with the principal dentist who assured us they would review this.

The practice had a dedicated decontamination facility; This had two sinks for manually cleaning and then rinsing dental instruments. A hand washing sink was situated just outside the room.

An illuminated magnifier was available to inspect the dental instruments prior to sterilising them, however the magnifier was small and the light was dim which could impact on the ability to see contaminants left on the instruments. Following the inspection this was replaced.

Instruments were sterilised in an autoclave, and sterile instruments were then pouched and dated with a use by date.

Tests carried out on the process were in line with the recommendations of HTM 01-05.

Environmental cleaning was carried out daily by the practice staff and weekly by external contractors. Cleaning schedules indicated that certain areas were being cleaned less frequently than the recommendations outlined in HTM 01-05. This was addressed immediately following the inspection and new cleaning schedules implemented to ensure this change. The equipment used conformed to the national system of colour coding cleaning equipment.

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 and secured bin prior to its removal.

All clinical staff had documented immunity against Hepatitis B. Staff who are likely to come into contact with blood products, or are at increased risk of needle stick injuries should receive these vaccinations to minimise the risk of contracting blood borne infections. The practice had a log to indicate when boosters were required for specific staff members to ensure that this was carried out in a timely manner.

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 March 2015. The practice had a log of actions that were completed following this assessment, and we were shown records pertaining to the checking of water temperatures monthly.

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 October 2016, and the practice had a register of all electrical appliances on the premises.

The compressor and autoclaves had both been serviced and tested in the year before the inspection and in line with manufacturers' instructions.

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.

Are services safe?

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

Rectangular collimation 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.

The required three yearly testing of the equipment was carried out in November 2016 and this included the annual service. However the practice was not logging the routine maintenance checks and could not evidence annual servicing of the units prior to this year. Following the inspection the practice implemented a system of routine checks and took steps to ensure annual servicing would be carried out in a timely manner.

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 every examination appointment, 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.

Patients had access to a number of leaflets on oral health which were displayed in the waiting room to patients to take away and read in their own time. This included leaflets on diet and how that can affect oral health, mouth cancer, smoking and gum disease.

Staffing

The practice was staffed by three dentists, a dental hygienist, a qualified dental nurse, and a trainee dental nurse, supported by a practice manager and a receptionist.

The practice was actively seeking a dental nurse to join the team at the time of the inspection, and was using a locum dental nurse agency to provide cover in the interim.

The dentists who work at this location and their two sister practices are all family, this could present issues when it comes to absence due to annual leave. The practice have addressed this by scheduling carefully so that the times when this may affect the service were minimal.

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.

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.

Routine referrals made for example for: orthodontics, minor oral surgery or conscious sedation were made by using a template or writing a letter.

Are services effective?

(for example, treatment is effective)

Referrals for suspicious lesions were made by fast track email to the hospital, which was acknowledged by the hospital. The practice also had access to a charitable organisation in oral cancer diagnosis and treatment and guidance could be sought from them within 12 hours by e-mailing a photograph of the lesion.

The practice kept a referral log so that referrals could be easily chased up if contact had not been received from the receiving organisation within a suitable timeframe.

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 a computer software programme that demonstrated treatments for patient to aid in their understanding. Information leaflets were regularly used for patients to take away and consider their options further. These discussions were recorded in the dental care records.

The practice principal assessed patients for dental implants at the practice, but sited the actual implants at a specialist practice. We were shown detailed records of the assessment process including a consent document that gave all appropriate information to patients.

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

Similarly staff demonstrated an understanding of the situation in which a child under the age of 16 could legally consent for themselves. This is termed Gillick competence and relies on an assessment of the child's understanding of the treatment and the consequences of having/ not having the treatment. Although staff we spoke with understood the principle, they were not clear on how to apply this to a practice setting. To that end they arranged staff training to take place in the month following the inspection.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Comments we received from patients indicated that they were very happy with the level of care they received from the practice. Patients commented that the staff were friendly, helpful and professional and that they dealt particularly well with nervous patients.

We spoke to staff about how patient's confidential information was kept private. We were shown that paper records were kept secured on the premises. The practice had plans in place as part of the ongoing refurbishment to separate the reception area from the waiting room so that patients at the reception desk would not be overheard. In the interim the receptionist was aware of her responsibilities regarding patient confidentiality and took steps to ensure it was maintained.

These measures were underpinned by practice policies pertaining to confidentiality, information security and information governance. All of which had been reviewed in the year preceding the inspection.

We witnessed patients being dealt with in a friendly and professional manner, both in person and over the telephone.

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. This included the costs of treatment.

Comments received from patients indicated that their conditions were explained well and they received advice and options in order to make decisions.

NHS and private price lists were displayed in the waiting area for patients' information.

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.

We asked reception staff how soon a new patient could be given a routine appointment and were told that at the time of our inspection, due to high demand in the local area, a routine appointment could be offered in two months' time. The practice made prospective patients to the practice aware of this.

The practice had a 'meet the team' noticeboard in the waiting room with photographs of the staff and biographies; there was also a community noticeboard where the community were invited to post information. This demonstrated the practice's position in the local community and their intention to serve their community.

Tackling inequity and promoting equality

Staff we spoke with expressed that they welcomed patients from all backgrounds and cultures, and all patients were treated according to their individual needs. This was underpinned by the practice's equality and diversity policy dated January 2016.

We spoke to staff about the ways in which they met the needs of patients with individual needs. We were shown a dental care record which indicated that adjustments were made to the way that treatment was delivered in order to make the experience easier to tolerate for the patient.

The receptionist detailed the ways in which they would help patients with limited mobility. The practice had wheelchair access to a ground floor treatment room and clinicians would swap rooms in order to accommodate patients in this way.

The practice planned to install a disabled access toilet as part of the current refurbishment, but at the time of the inspection this was not available. The receptionist informed prospective patients of this when they contacted the practice.

The practice had applied to get a disabled parking space allotted in front of the practice and were awaiting the result of this application at the time of the inspection.

Comments received from patients indicated that the practice strived to meet the individual needs of patients.

Access to the service

The practice was open from 9 am to 5.30 pm on Monday, Wednesday and Thursday. From 9 am to 7.30 pm on Tuesday and from 9 am to 1 pm on Friday. By offering evening appointment for a dentist and dental hygienist once a week they afforded flexibility to those patients who had commitments during normal working hours.

Emergency slots were set aside daily and the practice endeavoured to see any patient in pain on the day they contacted the service.

Out of hours arrangements were detailed on the answerphone. Patients who belonged to the private financing plan were able to contact them. NHS patients were advised to call the NHS 111 centre who would direct them appropriately.

Concerns & complaints

The practice had a complaints policy in place which was displayed in the waiting area. As well as directing patients on how to raise a complaint within the service it also gave contact details for external agencies that a complaint could be escalated to.

The practice kept a log of complaints received and had received one complaint in the year preceding our visit. We saw evidence that an investigation was undertaken and apologies issued to the patients where necessary.

A leaflet on how to make a complaint was available in the waiting room for patients to take away, and details were also included in the practice information leaflet.

Are services well-led?

Our findings

Governance arrangements

The principal dentist took responsibility for the day to day running of the practice, with support from the practice manager. Staff had been assigned lead roles in various areas of the governance. We noted clear lines of responsibility and accountability across the practice team.

The practice manager had a schedule displayed in the office this detailed when equipment testing and servicing was dues, when clinical audit was due and when policies and protocols were due to be reviewed and updated.

Practice meetings were held three monthly and the minutes of these meetings were available on the staff noticeboard. In addition a folder on the staff noticeboard invited staff to suggest topics for discussion at the next staff meeting.

The practice manager told us that they try to tie in the topics for discussion at the practice meeting with the policies that are due for renewal. For example: the Safeguarding policies were due for review in December 2016, the practice manager would then carry out this review and discuss it with the staff at the staff meeting. In this way the staff are kept up to date with any changes to policy, and revise the contents.

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 or practice manager.

The practice manager worked two days a week at this service at the time of the inspection, with the remainder of the week spent at the sister practices. The principal dentist also worked between the three sites. Communication between these and the other dentists was frequent to ensure that the management team were kept up to date.

Staff we spoke with felt supported in their roles and commented on what a nice place it was to work.

We recognised the practice's commitment to improvement and to serving the local community.

A whistleblowing policy was available (dated February 2016) which guided staff in how to raise concerns about a colleague's actions or behaviours. It detailed the practice's expectations of candour in this regard. Contact details for external agencies that staff could raise concerns to were available in the policy.

Learning and improvement

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

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. Logs of CPD were kept by the management team and included the recommended topics listed with the General Dental Council.

Staff received annual appraisals, and personal development plans were drawn up to aid their career progression and highlight any training needs.

Clinical audits were used to identify areas of practice which could be improved. Infection control audits had been carried out in November 2016 and had highlighted action points.

Audits on the quality of X-rays taken were carried out quarterly although they could be of greater educational and quality assurance value by auditing individual operators rather than the practice as a whole as this could mask a poor performing practitioner.

A record keeping audit was completed annually, most recently in October 2016. This demonstrated good analysis of the results. Other audits that had been completed in the year preceding or inspection included instrument cleanliness, waste, cleaning, governance, consent and access.

The dentist took part in peer review and regularly discussed cases in order to maintain standards.

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

The practice obtained feedback from patients from several pathways. They regularly checked feedback given through social media and NHS choices website. In addition the completed the NHS friends and family test and displayed the results in the waiting room.

Are services well-led?

The practice had a suggestion box, and also displayed a noticeboard entitled ‘you said, we did’ one example from this was a suggestion for a larger waiting area which had been incorporated into the expansion plans.