Dr. Sylvia Bentley

Long Buckby Dental

Inspection Report

7 High Street
Long Buckby
Northampton
Northamptonshire
NN6 7RE
Tel: 01327843843
Website: www.longbuckbydental.com

Date of inspection visit: 23 March 2016
Date of publication: 09/05/2016

Overall summary

We carried out an announced comprehensive inspection on 23 March 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

Long Buckby Dental is an NHS and private dental practice in Long Buckby in Northamptonshire. The practice offers general dentistry including fillings, dentures, crowns and bridges to adults and children. It is situated on the ground and first floor of a grade two listed building in the centre of Long Buckby.

The practice employs two dentists, a qualified dental nurse and a receptionist. The practice building has a reception area, waiting room and treatment room on the ground floor, and a second treatment room, office, toilet and decontamination room on the first floor. The stairs to access the first floor are steep and narrow.

The practice was registered with the Care Quality Commission (CQC) in April 2011.

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.

We received positive feedback from 44 patients about the services provided. This was through CQC comment cards left at the practice prior to the inspection.

Our key findings were:

Summary of findings

- Patients of the practice commented that staff were friendly and helpful and that treatment was always explained to them in full.
- Essential standards in decontamination as outlined in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' published by the Department of Health were being met.
- Governance arrangements were in place for the smooth running for the practice, including the use of clinical audit to highlight areas that could be improved.
- Medicines and equipment were in place to treat emergencies in line with current national guidelines; however some of the equipment was out of date. This was replaced immediately following the inspection.
- A full oral screening was carried out on patients who attended the practice, this included assessment of gum health and soft tissues of the mouth and face.
- Equipment was maintained in line with the manufacturers' instructions.
- Use of X-ray equipment on the premises was in line with current legislation.

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

- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as Public Health England (PHE).
- Review the process of checking expiry dates on recommended 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 storage of historic dental care records to ensure they are stored securely.
- Review the practice's recruitment policy and procedures to ensure character references for new staff as well as proof of identification are requested and recorded suitably.
- Review the practice's audit protocols of various aspects of the service, such as radiography and dental care records at regular intervals to help improve the quality of service. Practice should also check all audits have documented learning points and the resulting improvements can be demonstrated.
- Review the availability of an interpreter service for patients who do not speak English as their first language.

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 were in accordance with recognised national guidance, and processes were regularly audited to ensure standards remained high.

Staff had undergone safeguarding training and were aware of the situations they might need to raise a concern. Useful contact numbers for advice or to report a concern to were available for staff to access.

X-ray equipment was serviced and tested in accordance with regulations and manufacturer's instructions. Staff were up to date with training requirements for taking X-rays and monitored the quality of the X-rays taken.

Are services effective?

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

A comprehensive medical history was taken for each patient and updated at every appointment. This meant staff would be kept up to date with any changes that may impact on treatment.

Staff used recognised national guidance to aid in the care and treatment of patients.

Referrals were made to appropriate clinicians for treatment not offered at the practice. The practice implemented a log of all referrals following our inspection so that referrals could be chased up and timeliness of an appointment improved for the patient.

Are services caring?

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

We received positive feedback for 44 patients of the service. They commented that treatment options were always explained to them, and staff were reassuring when treating children and nervous patients.

Current patient care records were kept securely on the premises, although some historic records were kept in an unlocked cupboard. These were immediately moved to a secure location.

Are services responsive to people's needs?

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

The practice offered evening appointments twice a week to meet the needs of those patients who had commitments during normal working hours.

The practice had undertaken a disability discrimination audit to establish where access could be improved for those with restricted mobility or wheelchair users.

The practice offered emergency appointments daily, and patients commented that they could always be seen if they were in pain.

Are services well-led?

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

Summary of findings

The practice had undertaken a series of risk assessments and audits to ensure the safety of staff, patients and visitors to the practice.

The principal dentist maintained oversight of important aspects of quality assurance. Training of staff, servicing of equipment and implementing action plans from risk assessments and clinical audits that had been carried out.

Policies and protocols were in place to support the smooth running of the service. These included health and safety, infection control, child protection and safeguarding vulnerable adults.

Long Buckby Dental

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an announced, comprehensive inspection on 23 March 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Before the inspection we asked the 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 three members of staff during the inspection.

During the inspection we spoke with two dentists, and a dental nurse. We reviewed policies, procedures and other documents. We received feedback from 44 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 record, investigate and learn from significant incidents, although they had not recorded an incident within the last year. Significant incidents were discussed at practice meetings to prevent reoccurrence.

The practice did not have a system in place to receive alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). These detail any recalls or alerts with medical equipment and medicines. Following our inspection the practice signed up to receive these alerts by e-mail.

The practice had a prescribing policy in which it documented the process for reporting an adverse reaction to a medicine via the yellow card system, which collates information received from around the country.

The practice had a policy in relation the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). This detailed what occurrences would have to reported to the Health and Safety Executive as well as the detail of how to make a report, and how to obtain further advice if required.

Reliable safety systems and processes (including safeguarding)

The practice had a policy regarding safeguarding of vulnerable adults and children which had been reviewed in April 2015. This included relevant contact numbers to escalate a safeguarding concern, types of abuse and signs of abuse that may be witnessed.

The principal dentist was the named safeguarding lead and staff were able to describe the actions they would take if they suspected abuse. All staff had undergone safeguarding training appropriate to their role.

We asked the dentist how they treated the use of instruments used during root canal treatment. They explained that these instruments were single use only, although they were able to be sterilised and re-used on the same patient. We saw evidence that root canal instruments had been cleaned, sterilised and stored appropriately with the patients' details on them so they could not be used for another patient.

Root canal treatment was carried out, where practicably possible, using rubber dam (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). The British Endodontic Society recommends the use of rubber dam for root canal treatment.

The practice had an up to date Employers' liability insurance certificate. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

The practice used a system of safety needles that allowed a plastic tube to be drawn up over the needle and locked into place after use. This system reduced the risk of needle stick injury and is in line with the recommendations of the guidance Health and Safety (Sharp Instruments in Healthcare) 2013. In addition they used disposable matrix bands. These form a collar around a tooth when placing certain fillings and can be very sharp. This system mitigates the risk of removing and replacing the band, by allowing the whole instrument to be disposed.

Medical emergencies

The practice had emergency medicines and equipment for use in a medical emergency. This included 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.

The practice had emergency medicines in line with those recommended in the British National Formulary. These were within their expiry dates. The practice also kept oxygen which was being regularly checked.

The Resuscitation Council UK list emergency equipment that dental practices should have for use in medical emergencies. The practice kept all of the recommended equipment, however the expiry dates on the equipment was not being checked and the syringe and oropharyngeal airways were out of date. We raised this with the principal dentist who immediately replaced the out of date equipment, and put a system in place to check the expiry dates in the future.

Staff had all undergone medical emergencies training last year, however this was now due. Staff we spoke with had a good understanding of how to react in a medical

emergency and what medicines or equipment may be required for specific emergencies. This was underpinned with posters displayed in both treatment rooms which outlined how to treat each medical emergency.

Staff recruitment

We looked at the staff recruitment files for three staff members to check that the recruitment procedures had been followed. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all staff recruitment files. This includes: proof of identity; checking the prospective staff members' skills and qualifications; that they are registered with professional bodies where relevant; 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 found that the recruitment procedures had been followed in accordance with schedule 3 of the Health and Social Care Act with the exception of proof of identity and references. Following the inspection these were updated.

DBS checks were present for all members of staff, but these were not always specific for this service, although they were for a similar service. A risk assessment was put in place following our inspection and a new DBS applied for if necessary.

All new staff undertook a role specific induction programme that covered their first four weeks at the practice. In addition to learning the protocols for working in the practice, this also included a comprehensive introduction to the practice policies, and was followed up with a review session with the principal dentist on completion of the induction.

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 in place which was signed by all staff in June 2015. This included information on electrical safety, fire safety, manual handling, and personal protective equipment. A comprehensive health and safety risk assessment was completed in June 2015, which had highlighted 16 actions to be carried out. Each of these had been given a timeframe for completion and had all been completed within that timeframe.

A fire risk assessment had also been completed in September 2015; again the action plan had target dates for actions to be completed. We also saw evidence that evacuation drills were being carried out, fire extinguishers and the fire alarm were tested weekly and the fire extinguishers had been serviced. There was an appointed fire marshal that completed a monthly checklist. All staff had completed fire safety training in August 2015.

There were several risk assessments that had been completed in the last year that had not generated action plans because the external assessors had deemed that no action was required. These included waste disposal, use of the X-ray equipment, storage of oxygen, slips/trips and falls, floors, stairways and passageways and pregnant workers.

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

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, and infection control audits were carried out every six months. Action plans had documented changed that could be made; they were time limited and signed when completed.

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

Instruments were manually cleaned, or cleaned in an ultrasonic cleaner (this as a piece of equipment that is

designed to clean instruments by passing ultrasonic waves through a solution). Instruments were inspected under an illuminated magnifier before being sterilised in the autoclave.

Following sterilisation the instruments were placed in pouches and marked with the date they were sterilised and the date upon which the sterilisation would become ineffective.

We were shown details and logs of the tests performed on a daily, weekly and monthly basis to ensure that the decontamination process was working effectively. These were in accordance with the standards set out in HTM 01-05.

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. A risk assessment had been carried out by an external assessor in January 2015 and an interim health check in February 2016. These had highlighted actions to reduce the risk of Legionella contamination. We observed that these actions had been implemented by the practice. In addition the practice carried out appropriate flushing and disinfecting of the dental unit water lines.

We examined the practice's protocols for storing and disposing of clinical and contaminated waste. The practice stored contaminated waste and sharps bins securely on the premises. We saw waste consignment notices indicating appropriate disposal of amalgam, sharps, clinical waste and gypsum models.

The practice contacted an external cleaning company to undertake the environmental cleaning of the practice. They conformed to the national standards for colour coding cleaning equipment, and we saw cleaning schedules which indicated which colour was used for which area. Monthly cleaning audits had been carried out, and action plans drawn up.

Equipment and medicines

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

Records showed that equipment at the practice was maintained and serviced in line with manufacturer's guidelines and instructions. Pressure vessel testing had been carried out on the autoclaves and compressor within the last year to ensure they functioned safely. The principal dentist kept a written schedule indicating when equipment servicing was due, this was on the wall in the office, so they could easily retain oversight of the servicing and be assured that equipment was functioning within specified parameters.

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. We found that the medicine was kept in a designated fridge the temperature of which was being recorded daily, however the practice was not using a thermometer that indicated the fridge temperature range. Following our inspection the practice changed the storage arrangements for this medicine and amended the expiry date to account for the fact that the temperature of the cold storage could not be assured.

Radiography (X-rays)

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

The practice had intra-oral X-ray machines in each treatment room, which took small X-rays of one or a few teeth at once. The practice used digital X-rays, which mean the image is available to view almost immediately, and use a smaller effective dose of radiation to get an image.

The practice kept a radiation protection file which detailed the responsible people involved in taking X-rays as well as appropriate testing and servicing of each X-ray machine. Staff who took X-rays were up to date with required training as detailed by IR(ME)R, and regular clinical audits had been carried out by the principal dentist for the X-rays that they took. Clinical audit of X-rays taken by the associate dentist were overdue. Following our inspection we received evidence that an audit was completed.

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 and re-signed 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, and dentist we spoke with were aware of the local stop smoking services available to them, and had referred patients to them.

The principal dentist had also given talks in a local school to engage the children in the principles of oral health. In addition a children's oral health poster was displayed in the waiting room.

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.

Feedback we received from patients highlighted that oral health discussions had taken place with the dentists.

Staffing

The practice was staffed by two dentists (although one was on maternity leave at the time of our inspection) supported by a dental nurse and a receptionist. The practice occasionally used agency dental nurses from a local agency, who performed pre-employment checks for their staff.

Prior to our visit we checked the registrations of the dental care professionals and found that they all had up to date registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians, orthodontic therapists and dental technicians.

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, safeguarding and fire awareness training.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the treatment themselves. Referrals for oral surgery were made by secure e-mail, as were referrals for suspicious lesions.

Staff were not making a log of referrals made, and so could not be sure that patients were receiving appointments in a timely fashion. We raised this with the principal dentist who immediately implemented a system of tracking referrals.

Are services effective?

(for example, treatment is effective)

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. Patients were encouraged to consider their options in depth before returning to the practice once they had decided.

The practice did not have a system for signing a consent form once the patient had made a decision. We discussed this with the principal dentist who undertook a review of the system.

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. Although the clinicians varied in the consideration of the age at which you might consider a child suitable to assess for Gillick competence. Following our inspection the clinicians made arrangements to update their training in this area.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Measures were in place to ensure that patients' private information was kept confidential. The reception desk was separate from the waiting area, and a radio was playing in the waiting area meaning that patients stood at the desk could not be overheard by patients in the waiting room. The computer screen was placed below the height of the counter, meaning that it could not be overlooked by anyone standing at the desk.

This was underpinned by the practice privacy, dignity and confidentiality policy. This contained information regarding what would constitute 'personal information', data protection, and in what circumstances disclosures of private information could be made to a third party. All staff had read and signed this policy.

Current paper dental care records were kept in locked filing cabinets away from the patient areas of the practice; however some historic dental care records were stored in an upstairs store cupboard that did not have a lock on the door. We raised this with the practice principal that showed us where they would be moved to, which was a secure location.

Feedback from patients indicated that that staff were kind and friendly. Several comments stated that they were good with children, and were able to put nervous patients at ease.

We observed patients to the practice being welcomed in a polite and professional manner.

Involvement in decisions about care and treatment

Patients received a written treatment plan detailing the treatment and costs of treatment for them to keep.

Patients that we spoke with said that they always felt involved in the decisions made about their treatment, and dentists took the time to explain all the options available to them.

NHS fees were detailed in a poster in reception, and private fees were detailed in a leaflet in the waiting room.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

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

The practice offered evening appointments on Tuesday and Thursday until 7.30pm which gave flexibility to patients who may have commitments during normal working hours.

The practice took part in an on call rota with six other local dental practices. Patients who called the practice out of hours with an emergency were directed by the answerphone message to call a mobile number. This meant they could speak to an on call dentist at any time, who could arrange for them to be seen if necessary.

The practice had a hearing loop in the reception area to assist hearing aid users.

Tackling inequity and promoting equality

The practice welcomed patients of all cultures and backgrounds and sought to treat patients according to their individual needs.

At the time of our inspection the practice did not have any patients who required an interpreter, but the practice were aware to consider arranging one if a patient did not have English as their first language.

The practice had carried out a disability discrimination audit as part of a whole building external risk assessment in January 2015. As the building was grade two listed, there was a limited amount of alteration that could be completed to make the building accessible to those with restricted mobility and wheelchair users. The staircase was very narrow and steep, and a sign directed patients to ask for assistance if required.

Despite the difficulties the practice has ensured that access to the downstairs treatment room was possible for wheelchair users, employing a ramp to access the room over a small step.

Access to the service

The practice was open from 8.30am Monday to Friday, and then closed at 5.30pm on Monday, Wednesday and Friday, and at 7.30pm on Tuesday and Thursday.

Emergency appointments were set aside daily to accommodate those patients that needed to be seen urgently, and feedback that we received form patients indicated that when they needed to be seen urgent the practice always made arrangements for them to be seen.

With one dentist off on maternity leave at the time of our inspection, patients were waiting slightly longer for routine appointments, however the practice had taken steps to increase the hours of the other clinician so that the impact felt by patients would be reduced.

Concerns & complaints

The practice had a policy on handling patient complaints; this was reviewed in April 2015, and had been signed by all staff to confirm they understood the contents and process.

They policy was available both in the policy folder in the office for staff to reference and displayed in reception for patients to reference. The complaints policy gave details regarding how a complaint to the practice would be dealt with, and also gave contact numbers of organisations that patients could escalate the complaint to should they feel it necessary.

Complaints that had been made to the practice were dealt with promptly, and apologies issued to patients if required, in line with their policy.

Are services well-led?

Our findings

Governance arrangements

The principal dentist (who is the registered manager) took responsibility for the day to day running of the practice, although as they were on maternity leave at the time we visited the practice this responsibility had been delegated to the associate dentist. The principal dentist still frequently visited the practice and was available to support the function of the practice.

Certain staff had lead positions within the practice, such as safeguarding lead and infection control lead. All staff that we spoke with were able to identify these individuals.

Policies and protocols were in place to support the function of the service. These were organised into a small folder that contained all the up to date policies. There was then a series of larger binders that contained all the reference documents and risk assessments that guided these policies, and staff could use those if more information was required.

Risk assessments had been carried out by external contractors on a variety of areas, including health and safety, the building, legionella and fire risk. The principal dentist had collated the action plans from all the recent audits and risk assessments and had put them into one small folder, that way they were able to keep oversight of the changes that needed to be implemented and the timescales for those actions.

A comprehensive schedule of servicing for all the practice equipment was on the wall in the office ensuring that all equipment was serviced at appropriate time intervals and continued to function within normal parameters.

The practice had monthly staff meetings; minutes for these meetings were available for staff to review. Discussions at staff meetings had included any complaints or incidents, a training topic such as cross infection control and an opportunity for staff to raise any concerns that they had.

Leadership, openness and transparency

Staff reported a culture of honesty and transparency throughout the practice. Staff felt well supported by the principal dentist, and were comfortable to approach them with any issues or concerns that they had.

The practice had in place a whistleblowing policy, which had been signed by all staff. This gave guidance on how staff could go about raising concerns they may have about a colleague's actions or behaviours.

Learning and improvement

The practice sought to continuously improve standards by use of quality assurance tools, and continual staff training. This was underpinned by the practice policy on quality assurance which was displayed in the reception area for patients to see.

Clinical audits were used to identify areas of practice which could be improved. These included six monthly infection control audit, an annual X-ray quality audit. The X-ray audit was only assessing X-rays taken by one clinician. Following our inspection an interim audit had been completed for the associate dentist, and going forward a joint audit schedule was implemented. All clinical audits had clear action plans to improve the service.

The associate dentist had recently completed a specific clinical audit which had been prompted by recognition that several patients were experiencing post-operative problems. This resulted in minor changes in practice and demonstrated the practices commitment to improving the patient journey.

Staff were supported in achieving the General Dental Council's requirements in continuing professional development (CPD). We saw evidence that all clinical staff were up to date with the recommended CPD requirements of the GDC. The principal dentist kept a tracker document which highlighted the areas of recommended CPD, and logged the training that staff had undertaken in this area. In this way the principal dentist maintained oversight of the training requirements of the staff.

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

The practice had systems in place to involve, seek and act upon feedback from people using the service. The practice invited comments through the NHS friends and family scheme.

Staff told us that within this small and close-knit team communication was constant and easy, and any suggestions made would be welcomed by the principal dentist.