Basudev Enterprise Ltd

# Bedford Dental Practice

## Inspection Report

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## Overall summary

We carried out an announced comprehensive inspection on 12 January 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**

Bedford Dental Practice is a general dental practice situated in the Riverfield area of Bedford. It provides treatment under the NHS or privately, and as well as a full range of general dentistry also offers tooth whitening and short-term orthodontics (a term used to describe quick orthodontic treatments that usually only affect the front teeth. These types of systems can use transparent trays instead of conventional braces to effect simple tooth movements).

The practice is situated on the ground floor of a purpose built building with a car park and disabled access.

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.

We received feedback on the service from 13 patients, either by way of them filling in a CQC comment card or in person. They were overwhelmingly positive about the service offered, and made particular reference to the friendliness of the whole team, and how they were made to feel at ease by the staff.

**Our key findings were:**

# Summary of findings

- Staff demonstrated a good knowledge of how to raise a safeguarding concern, and the situation in which that may be required.
- 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 exceeded.
- The provider had emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- The practice had monthly team meetings to discuss the running of the practice, any complaints and learning opportunities.
- 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.
- The practice kept comprehensive dental care records and regularly audited the quality of the records to ensure that they were suitably detailed.
- Feedback from patients described the practice as friendly and caring. Several patients commented on how well the staff dealt with the challenges of treating young children.

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

- Review 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 the requirements of the Mental Capacity Act (MCA) 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.
- Consider more robust scheduling of particular cleaning tasks in the practice to ensure that all aspects are being carried out appropriately.

# 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 was found to have systems in place for decontamination of dental instruments which exceeding the essential requirements of The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' published by the Department of Health.

The practice used a system of safety sharps, and disposable matrix bands to lessen the risk of inoculation injury to staff.

Staff demonstrated a good understanding of the situations in which they may have to raise a safeguarding concern against a vulnerable adult or child. This was underpinned by a detailed policy and ease of access to contact numbers for reporting concerns.

Regular servicing of equipment was demonstrated to ensure it functions effectively.

Emergency equipment was kept in accordance with the guidelines from the Resuscitation Council UK, with the exception of a self-inflating bag and Yankauer suction tip. Following our visit, these were both acquired.

**Are services effective?**

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

The practice used oral screening tools to identify oral disease.

Staff we spoke with had a good understanding of the process of consent including the situations in which a child under the age of 16 could consent for themselves (Gillick competence).

The practice kept comprehensive dental care records and regularly audited the quality of the records to ensure that they were suitably detailed.

Feedback we received from patients highlighted the oral health discussions that had taken place with the dentists, and also advice given pertaining to oral health in babies.

**Are services caring?**

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

Feedback from patients was overwhelmingly positive with several patients commenting on how friendly the staff were and how good they were with children.

Patient care records were kept securely on password protected computers, and staff were able to describe how confidentiality was maintained.

**Are services responsive to people's needs?**

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

The practice was open into the evening four days a week and alternate Saturday mornings which gave flexibility to the working population, or those with regular commitments during normal working hours.

The practice had carried out a disability discrimination audit to ensure its services were available to all of the population.

# Summary of findings

The practice had a page on social media which served to engage with members of the population in a format which appealed to them, and also to let patients know of any changes to the practice.

**Are services well-led?**

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

The practice carried out monthly team meetings with learning topics and opportunities for staff to bring up concerns as well as daily team briefings to discuss any particular challenges of the day.

The practice used regular clinical audit to highlight and improve areas of practice.

Staff were encouraged to report concerns and had several avenues by which they could raise a concern either in person or anonymously.

# Bedford 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.

The inspection was carried out on 12 January 2016. The inspection was led by a CQC inspector and a dental specialist advisor

We informed NHS England area team that we were inspecting the practice; however we did not receive any information of concern from them.

During our inspection we interviewed members of staff regarding their practise, policies and procedures. We spoke with people using the service and their relatives, observed the workings of the practice and reviewed their documentation.

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 systems in place to report and learn from significant events. A significant events policy detailed how incidents should be recorded. A template was available for all staff to use, which detailed the incident, what steps were taken and what lessons could be learned. There had not been a significant incident reported within the last year.

The practice kept an accident book and were aware of their responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). The practice manager was able to explain how such a report would be made.

Although some of the reports in the accident book had not been logged as significant events, we were able to see that appropriate actions were taken, and opportunities were taken to learn lessons from these events. The minutes from staff meetings indicated that these incidents were discussed with the team to prevent reoccurrence.

The practice had a duty of candour policy which detailed the practice's expectation of openness and transparency towards patients and between staff members in the event of an incident.

The practice received alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) these were e-mailed to the principal dentist who disseminated relevant alerts to the staff at practice meetings, or by posting them on the notice board in the staff room.

**Reliable safety systems and processes (including safeguarding)**

The practice had policies and procedures in place for child protection and safeguarding vulnerable adults. These included an action flow chart demonstrating how to escalate a concern and lists of relevant contact details should a concern need to be raised. These were available to staff in the policies folder and on the notice board in the staff room.

All staff had undertaken training in safeguarding appropriate to their role, and staff we spoke with had a clear understanding of the situations in which they may need to raise a safeguarding concern and how they would undertake this. All staff we spoke with were able to identify the designated safeguarding lead for the practice.

The practice had an up to date Employers' liability insurance certificate due to expire 15/5/2016. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

The practice used a system of safety sharps. These allow a plastic tube to be drawn up over the needle and locked into place after use. This resulted in a far lesser risk of needle stick injury to staff. In addition the practice used disposable matrix bands. These are thin metal strips that are positioned around the tooth during placement of certain fillings, they can be very sharp and so the use of disposable bands mitigates the risk involved in changing the bands. These measures were in accordance with the Health and Safety (Sharp Instruments in Healthcare) 2013 guidance.

The practice used rubber dam when carrying out root canal treatment. 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; it 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.

**Medical emergencies**

The practice carried emergency equipment and medicines to deal with any medical emergencies that may arise. The emergency medicines were checked and found to be present in accordance with the British National Formulary (BNF) guidelines, including Oxygen.

The practice had equipment available to treat patients in the event of a medical emergency. This included an automated external defibrillator (portable electronic devices that automatically diagnose life threatening irregularities of the heart and deliver an electrical shock to attempt to restore a normal heart rhythm).

Other medical equipment was available in accordance with the Resuscitation Council UK guidance, with the exception of a self-inflating bag and a yankauer suction tip. A self-inflating bag would be used in the event of a patient stopping breathing and acts to ventilate a patient until an

# Are services safe?

ambulance arrives. A yankauer suction tip could be used in conjunction with the suction unit in the treatment room, or the portable suction unit to clear vomit or secretions from the airway. Following our inspection both of these pieces of equipment have been acquired by the practice.

We saw records that showed the equipment and medicines were being checked regularly to ensure that they were appropriate for use if the need arose.

All staff had undertaken medical emergencies training with an external trainer being invited to the practice annually to carry out this training.

Staff we spoke with had a good understanding of how to treat different medical emergencies.

**Staff recruitment**

We looked at the staff recruitment files for four 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, and where necessary a Disclosure and Barring Service (DBS) check was in place. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

We found that the practice had a policy to carry out a DBS check on all staff, and when these were pending a risk assessment had been carried out to ensure that these staff members worked with supervision.

We found all other records regarding staff recruitment were in order.

**Monitoring health & safety and responding to risks**

The practice had robust systems in place to monitor and manage risks to patients, staff and visitors to the practice.

A health and safety policy was in place at the practice. This was dated December 2015 and was available for staff to reference in a folder in the staff room. The topics covered by the policy included manual handling, accident reporting and fire safety.

All staff had undertaken fire training and staff we spoke with were able to describe the procedure involved in an evacuation, and the muster point for staff and visitors.

The practice had measures in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. Practices are required to keep a detailed record of all the substances at use in the practice which may pose a risk to health. The practice found that having these paper based and in a large file was cumbersome to use and made accessing the information in a timely manner difficult. Therefore they have computerised these records so that a simple search can be carried out to find the specific details required.

A general practice risk assessment had been carried out in December 2015, along with a specific risk assessment pertaining to health and safety. The practice also had a business continuity plan in place which detailed steps to take in the event of a situation that would put the running of the business at risk. In this way the practice was taking steps to mitigate risks to staff, patients 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 seen to be carried out every six months. The action plan derived from the most recent audit highlighted that sharps boxes should be wall mounted and that carpet should be removed from the decontamination room. We found the sharps boxes wall mounted and plans underway to replace the carpet in the decontamination room.

Decontamination is the process by which dirty and contaminated instruments are bought from the treatment room, washed, inspected, sterilised and sealed in pouches ready for use again.

We observed a dental nurse carrying out the process from start to finish. The practice used an ultrasonic cleaner to

wash the instruments. This is a piece of equipment which is specifically designed to remove contaminants from dental instruments by the use of ultrasound waves passing through a liquid.

The instruments were then inspected under an illuminated magnifier to look for any visible debris or defects in the instruments, before being sterilised in an 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 staff undertook the environmental cleaning of the practice. The practice followed the national colour coding scheme for cleaning materials and equipment in dental premises. This ensured that equipment used for cleaning was specific to the area that was being cleaned. For example, equipment used to clean clinical areas was different to equipment used to clean the kitchen.

The dental nurses were responsible for cleaning down their treatment rooms at the end of the day. We found schedules in each surgery that detailed the process and signatures to indicate this had been carried out.

Reception staff were responsible for cleaning the waiting area and toilets. Staff informed us that they changed out of their uniforms and put on gloves and aprons when cleaning the toilets, schedules for cleaning the toilets were signed on the back of the toilet door. Although staff told us the waiting area was cleaned daily, there was no schedule in place confirming this. Upon discussion with the practice manager we were assured this would be implemented immediately.

Cleaning equipment was stored appropriately with the exception of one of the mop and buckets which was stored inappropriately in the patient toilet. Following the inspection we received information that this had been rectified.

All staff were involved in a weekly litter picking rota where they would be required to make sure that external areas of the practice and car parks were free from litter. Staff we spoke with described changing out of their uniforms to undertake this task.

The practice demonstrated appropriate storage and disposal of clinical waste. Waste consignment notices were seen. Clinical waste was stored appropriately prior to removal from the premises.

There were systems in place to protect staff, patients and visitors from the risk of water lines becoming contaminated with Legionella bacteria. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. An external assessment was carried out in March 2015, which detailed measures to be taken to reduce the risk. This included checking water temperatures in the building on a monthly basis, disinfecting and flushing the dental water lines. We saw record to indicate this was being carried out as described.

All clinical staff had been vaccinated against Hepatitis B (a virus that is carried in the blood and may be passed from person to person by blood on blood contact). Evidence of this was retained in the staff recruitment files.

**Equipment and medicines**

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

We saw that regular servicing and testing had been carried out on the autoclave and compressor, most recently on 28/7/2015 in line with the manufacturer's instructions. Evidence was also seen of regular servicing of the Oxygen and automated external defibrillator.

Prescription pads were kept locked away in the safe, and a log kept of prescriptions issued.

Evidence was seen in the dental care records that expiry dates and batch numbers of local anaesthetic were checked at the chairside, and logged.

**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.

# Are services safe?

All treatment rooms displayed the 'local rules' of the X-ray machine on the wall. These detailed the specifics of each machine as well as the responsible persons to contact.

The practice used exclusively digital X-rays, which are available to be viewed almost instantaneously, as well as delivering a lower effective dose of radiation to the patient.

The practice kept a radiation protection file which demonstrated that all of the X-ray machines had undergone critical examination testing in the last year (to confirm that they are working within normal parameters).

Evidence was seen that staff were up to date with required training in radiography as detailed by IR(ME)R. Clinical audits were carried out on X-ray quality, most recently on 5/1/2016. This involved grading each X-ray produced on its quality to ensure continuous improvement of standards. In addition the practice audited records pertaining to X-rays, specifically, whether the justification for taking the X-ray was documented in the dental care records.

# 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 filled in by patients annually, and checked verbally 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.

Oral and facial soft tissues were also regularly screened to assess to changes that may indicate oral cancer or other oral conditions.

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.

The practice carried out auditing of the clinical record keeping annually, the most recent being January 2016. Action plans were seen following the audits to highlight areas where practice could improve.

**Health promotion & prevention**

The practice took its commitment to health promotion and prevention very seriously. Dental care records indicated that an assessment of patients' oral hygiene was made and oral hygiene instruction given to patients when indicated.

The practice had a television in the waiting room which displayed positive health messages to patients waiting for their appointments.

In addition the patient information folder in the waiting area had useful documents detailing how hidden sugars maybe identified in food and drinks.

We found a comprehensive application of guidance issued in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is a toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Feedback we received from patients highlighted the oral health discussions that had taken place with the dentists, and also advice given pertaining to the protection of oral health in babies.

**Staffing**

The practice was staffed by the five dentists and three hygienists supported by two qualified dental nurses, six trainee dental nurses a receptionist and a practice manager. 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 trainee dental nurses were all on a course to achieve their qualification, and were being supported by the practice and their mentors.

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 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.

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.

New staff to the practice underwent an induction process over a four week period. This detailed the working of the practice, supervision and policies and included tick sheets to sign off when the new starter was competent.

# Are services effective?

## (for example, treatment is effective)

**Working with other services**

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment. A policy was in place detailing how referrals were to be made, and giving the contact information for practitioners to whom referrals had previously been made.

We saw example of referrals made, and found them to be detailed and appropriate.

We asked the practice how they ensured the timeliness of a referral where a serious pathology (such as oral cancer) was suspected. In this situation a referral would be made by e-mail, followed up by a paper referral. We were told that the individual dentist would chase these referrals to ensure that an appointment had been received by the patient.

**Consent to care and treatment**

The practice demonstrated consent as a process rather than simply a signature. Discussions with patients were detailed in the dental care records. Written treatment plans were provided for all patients which detailed costs as well as options for treatment.

Patients we spoke with commented that they always felt involved in their treatment and were given ample opportunities to ask questions.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Most staff had not undertaken specific training in this area although the practice had made arrangements for an external trainer to come into the practice in February 2016. In addition MCA had been a recent discussion point at a team meeting.

Staff we spoke with demonstrated an understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment. This included an understanding that capacity should be assumed even if the patient had a condition which may affect their mental capacity, and when it may be necessary to make decisions in a patient's best interests.

# Are services caring?

## Our findings

**Respect, dignity, compassion & empathy**

Staff we spoke with explained how they ensured information about people using the service was kept confidential. Dental care records were held electronically and password protected, any paper records were stored in locked cabinets.

Staff at reception demonstrated that their monitors were positioned in such a way that they could not be viewed by patients standing at the desk, and were able to describe how they maintained a patient's confidentiality by making sure phone conversations were not overheard, and taking patients to another room should they wish to have a private conversation.

This was underpinned by a confidentiality policy which had been signed by all staff to confirm they had read and understood it.

Patients that we spoke with on the day and those that provided feedback through comment cards spoke positively of the service, particularly mentioning the friendliness and professionalism of the staff, and their ability to put patients at ease when attending the practice.

Several patients commented that the staff were extremely good with children, and gave oral health advice for young children.

We observed patients to the practice being welcomed in a friendly and caring 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.

Both NHS and private fees were detailed on posters 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 late evening opening four nights a week (Monday to Thursday) and was open alternate Saturday mornings which offered flexibility of appointment times to people who may have commitments during normal working hours.

The practice detailed arrangements for out of hours cover on the answerphone. For NHS patients the NHS 111 service could be utilised.

The practice had a page on social media which approximately 800 of its patients were signed up to. In this way they were able to inform patients of any changes to the practice and engage with certain population groups in a format that appealed to them.

**Tackling inequity and promoting equality**

The practice had an equality, diversity and human rights policy dated 22/12/2015 which detailed the practice's intention to welcome patients of all cultures and backgrounds. This was also displayed in the waiting room.

At the time of the inspection the practice did not have any patients that required a translator, but the practice was registered with a translation service. An interpreter could be arranged to attend the practice, or speak on the phone should the need arise.

The practice had carried out a disability discrimination audit in January 2016, which was underpinned by a policy. This indicated that the practice was suitable for wheelchair users, being on the ground floor with ramp access to the front of the building, and a disabled toilet.

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. This had been reviewed 12/12/2015 and was available for all staff to reference in the staff room.

**Access to the service**

The practice was open from 9.00 am to 7.00 pm Monday, Wednesday, Thursday and Friday. 9.00 am to 8.00 pm on a Tuesday and 9.00 am to 1.00 pm on alternate Saturdays.

The practice would always try to see emergency patients on the day that they contacted, even if they could not be guaranteed to see their own dentist.

**Concerns & complaints**

The practice had a policy on complaints handling which had been reviewed in December 2015. This guided staff on how to handle complaints, and gave reference to the need to be open and honest in the handling of complaints.

Patients were directed on how they could complain by a poster in the waiting room.

We saw evidence that complaints had been thoroughly investigated and apologies issued where necessary in a timely manner.

Documented minutes of team meetings indicated that complaints were a regular topic for discussion, in order that practice continued to improve.

# Are services well-led?

## Our findings

**Governance arrangements**

The practice had recently introduced a new practice manager to the team. The principal dentist (who is the registered manager) spent time at another practice as well as this one, and so the practice manager appointment had served to clarify the lines of responsibility and accountability. Staff we spoke with were clear on who to speak with in certain situations and were happy with the recent addition to the management team.

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.

The practice had monthly staff meetings, agendas for these meeting included discussing any complaints or incidents, a training topic for discussion (such as safeguarding or needlestick injuries) and an opportunity for staff to bring up any concerns that they had.

In addition to this staff undertook a team briefing every morning to ascertain any particular challenges for the day.

The practice had policies and procedures in place to support the management of the service, and these were readily available in hard copy form. Policies were noted in infection control, health and safety, complaints handling, safeguarding children and vulnerable adults, information governance and whistleblowing. These had all been reviewed within the last year.

In addition risk assessments were in place to minimise risks to staff, patients and visitors to the practice; fire safety, and control of substances hazardous to health.

**Leadership, openness and transparency**

Staff reported a culture of honesty and transparency throughout the practice which was underpinned by a policy detailing the practice's expectations of candour.

Staff we spoke with felt comfortable to raise concerns with the management team either personally, or at a team meeting. In addition a concerns book was placed in the staff room and staff directed to make any anonymous comments in the book. No-one had commented in the book.

The practice had in place a whistleblowing policy, which had been recently discussed during a staff meeting. This gave guidance on how staff could go about raising concerns they may have about another's actions or behaviours.

**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. These included six monthly infection control audit, an annual X-ray quality audit and record keeping audit and recent audits on disability discrimination act and antibiotic prescribing. All clinical audits had clear action plans to improve the service.

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.

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

**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. There was a comments box in the reception area, and the practice also invited comments through the NHS friends and family scheme.

The noticeboard displayed a 'you said, we did' poster which detailed a couple of changes that the practice had made in response to patient requests.

Staff we spoke with highlighted areas where they had asked for changes to be made, and the principal had implemented these changes.

Firstly they had asked that an extra dental nurse be available daily to help in busy clinic and with the decontamination process. Secondly that three receptionists be employed daily as reception felt it was sometimes taking them too long to answer the phone. Both of these requests were implemented and staff we spoke with seemed happy that this was aiding the smooth and effective running of the practice.