Northern Orthodontic Services Limited

Fylde Dental Clinic

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 14 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

Fylde Dental Clinic was established in 2009 by a clinical dental technician to provide a private denture service to patients. The clinic registered with the Care Quality Commission (CQC) in 2014 when a dentist was employed to provide a private general dental treatment service to patients of all ages. The dentist provides this service every Tuesday. The dentist and the clinical dental technician work independently of each other but confer on treatments when it is in the best interest of the patient. Two dental nurses are employed at the clinic. The clinic is open to patients from 8.30 – 4.30 Monday to Thursday.

The clinical dental technician 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 reviewed feedback from 15 patients as part of the inspection. Patients were very positive about the staff and standard of care provided at the practice. Patients commented that they felt involved in all aspects of their care and found the staff to be helpful, respectful, friendly and were treated in a clean and tidy environment.

Our key findings were:

- The practice was well organised, visibly clean and free from clutter.
- An infection prevention and control policy was in place. We saw the sterilisation procedures followed recommended guidance.

Summary of findings

- Systems were in place for recording accidents and significant events
- The practice had a safeguarding policy and staff were aware on how to escalate safeguarding issues for children and adults should the need arise.
- Staff received annual medical emergency training.
- The dentist provided treatment in accordance with current professional guidelines.
- Patient feedback was regularly sought and analysed.
- Patients could access urgent care when required.
- A complaints process was in place but the practice had never received a complaint.
- Consent from patients was sought before treatment started.

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

- Review the practice's patient safety incident management policy to ensure it clarifies the types of incidents that could occur at the practice and those that constitute a significant event.
- Review the availability of a legionella risk assessment carried out by a competent person giving due regard to the guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices.
- Review the protocol for undertaking accurate, complete and detailed records relating to employment of staff. This includes making appropriate notes of verbal reference taken and ensuring recruitment checks, including references, are suitably obtained and recorded.
- Review the system for identifying and disposing of out-of-date stock.
- Review the process for carrying out the daily automatic control test on the autoclave.
- Review the approach to and monitoring arrangements for staff training, including safeguarding training, to ensure it meets mandatory training needs and the Continuing Professional Development needs of staff.

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?

No action

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

The practice had forms for recording and reporting accidents and significant events. A policy was not in place to outline the types of patient safety incidents that could occur at the practice and those that constituted a significant event.

Staff we spoke with were knowledgeable about safeguarding systems for adults and children.

Recruitment processes were in place but the full range of employment checks had not been obtained for all staff. A recruitment policy was not in place for the practice.

Relevant risk assessments were in place for the practice.

A Legionella risk assessment had been completed internally. It was brief and the practice said they would consider obtaining a further assessment carried out by a competent person.

Sterilisation and decontamination processes were effective. They were carried out in a dedicated decontamination room. We noted the automatic control test was not carried out on the autoclave. This was highlighted on the day and we were told this would be carried out.

Medicines and equipment were stored appropriately for medical emergencies. We noted some items were missing from the emergency resuscitation kit, including a self-inflating bag. We saw evidence this was ordered on the day.

We noted some antibiotics were out of date. There was no evidence to suggest these had been provided to patients. These antibiotics were disposed of on the day of inspection and we were told a robust process would be adopted to ensure out of date medication was disposed of effectively.

Are services effective?

No action

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

Dental professionals referred to resources such as the National Institute for Health and Care Excellence (NICE) guidelines and the Delivering Better Oral Health toolkit (DBOH) to ensure their treatment followed current recommendations.

Staff obtained consent, effectively managed patients of varying age groups and made referrals to other services in an appropriate and recognised manner.

Staff who were registered with the General Dental Council (GDC) met the requirements of their professional registration by carrying out regular training and continuing professional development (CPD). An effective system was not in place to clarify the training staff had undertaken.

Are services caring?

No action

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

Summary of findings

Patients were very positive about the staff, practice and treatment received. We left CQC comment cards for patients to complete two weeks prior to the inspection. There were 15 responses all of which were very positive, with patients stating they felt listened to and received the best treatment at that practice.

Dental care records were kept securely on computer systems which were password protected and backed up at regular intervals.

We observed patients being treated with respect and dignity during our inspection and privacy and confidentiality were maintained for patients using the service. We also observed staff to be welcoming and caring towards patients.

Are services responsive to people's needs?

No action ✓

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

The practice was able to provide urgent dental care and all emergency patients were seen on the day they contacted the practice.

Patients had access to telephone interpreter services if required and the practice provided a range of facilities for different disabilities including a lowered reception area and a ground floor surgery.

Are services well-led?

No action ✓

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

There was a defined management structure in place and staff said they were supported in their roles. Staff said there was an open culture at the practice and they felt confident raising any concerns.

The practice held regular informal meetings, which provided an opportunity to openly share information and discuss any concerns or issues at the practice. A formally recorded practice meeting was held once a year.

The practice had a programme of audit to monitor their performance and help improve the services offered.

The practice conducted patient satisfaction surveys twice a year and the feedback was analysed and acted upon.

Fylde Dental Clinic

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 registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection was led by a CQC inspector and supported by a second inspector.

We informed NHS England area team and Healthwatch that we were inspecting the practice; we did not receive any information of concern from them. We also reviewed information held by CQC about the practice prior to the inspection and no concerns were identified.

During the inspection, we spoke with the registered manager, the dentist and a dental nurse. We reviewed policies, protocols, certificates and other documents as part of the inspection. We also had a look around the premises and looked at the equipment.

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 accidents and managing significant events. Accidents were recorded in a book and a form was in place for recording and analysing significant events. Staff advised us that there had not been an accident or significant event since the clinic was registered with CQC in 2014. The staff we spoke with understood what needed to be reported in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 2013 (RIDDOR). They were also aware of the types of events that CQC required a notification about.

There was no recorded policy in place that outlined the types of patient safety incidents, including significant events that could occur at the practice, how they should be managed and whether any external organisations needed to be informed when an incident occurred. We highlighted this to the member of staff with the lead for policies and they said they would develop a policy to show how safety incidents, concerns and near misses were managed at the practice.

The registered manager received safety alerts issued from the Medicines and Healthcare products Regulatory Agency (MHRA). The MHRA is the UK's regulator of medicines, medical devices and blood components for transfusion, responsible for ensuring their safety, quality and effectiveness.

The practice was not receiving alerts through the Central Alerting System (CAS). We spoke to the practice manger about this they said they would arrange for these to be received. Not receiving alerts through CAS could mean the full range of safety information relevant to the practice was not being received.

Reliable safety systems and processes (including safeguarding).

We spoke with staff about the use of safer sharps in dentistry as per the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. A sharps policy was in place for the clinic. We were told that a safe sharps system was not in use. We were provided with a sharps risk assessment that was completed in January 2016. Staff advised us that only the dentist put the safety covers back on needles. Sharps bins were stored safely outside the building when they were full and awaiting collection from the waste management company.

The dentist told us they did not routinely used a rubber dam when providing root canal treatment to patients. The dentist told us they used a parachute chain to ensure the airway was protected at all times. We were told the use of rubber dam would be reviewed. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured.

We reviewed the practice's policy for adult and child safeguarding which contained contact details of the local authority child protection and adult safeguarding teams. One of the dental nurses was identified as the safeguarding lead for the clinic. They told us staff had completed safeguarding training and that this training was recorded in staff's continuing professional development files. We had limited access to the full range of information in these files so could only confirm that two members of staff (out of four staff) had completed the training. In addition, it was unclear what level of safeguarding training each of the staff had completed. The staff we spoke understood how to report a safeguarding concern. Staff advised us that there had not been a concern identified that needed to be reported.

The practice had a whistleblowing policy in place that included external contacts. Staff told us they felt confident they could raise concerns about colleagues without fear of recriminations.

Employer's liability insurance was in place for the practice. Having this insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969 and we saw the practice certificate was up to date. Professional indemnity was in place for all staff.

Medical emergencies

The practice followed the guidance from the Resuscitation Council UK and had sufficient arrangements in place to deal with medical emergencies. A medical emergency

Are services safe?

policy was in place that took into account national guidance regarding the medicines and equipment required as part of an emergency medical kit. The policy provided staff with guidance to follow in the event of a medical emergency. In February 2016 all staff received training in basic life support including the use of an Automated External Defibrillator. An AED is a portable electronic device that analyses the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.

Medicines and equipment were in place for use in a medical emergency. Staff knew where these items were located. We noted there was no self-inflating bag available on the day of inspection. This was highlighted and we saw evidence it was ordered on the day.

The medical emergency kit was checked each month to ensure medicines and equipment was available and not out-of-date. This was not in accordance with guidance from the Resuscitation Council UK. The member of staff responsible for checking the kit said they would ensure these checks took place weekly. The oxygen cylinder was checked weekly. We checked the emergency medicines and found they were of the recommended type and were all in date.

Mercury and bodily fluid spillage kits were in place in the event that staff should need to use them.

Staff recruitment

We looked at the recruitment records for all staff working at the practice to ensure they had been recruited appropriately. The immunisation status and a Disclosure and Barring Service (DBS) check was in place for each member of staff, including the members of staff recruited by the registered provider. We saw evidence that a member of staff had a DBS check that had been undertaken by another dental practice. We highlighted this to the registered manager at the time of the inspection. A DBS check helps employers to make safer recruitment decisions and can prevent unsuitable people from working with vulnerable groups, including children.

The records showed some recruitment checks were not available in accordance with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These included recorded references and photographic identification. We highlighted this to the registered manager at the time of the inspection.

Monitoring health & safety and responding to risks

A health and safety statement and policy was in place for the practice, along with a risk management policy. They had been reviewed within the last 12 months. A health and safety poster was displayed highlighting who was the health and safety officer for the practice. The health and safety officer advised us they carried out monthly checks of the premises to ensure it was safe and determine whether any maintenance was required.

A fire risk assessment of the premises had been undertaken in January 2016. We saw that a fire evacuation procedure was in place. Records demonstrated that staff had participated in fire drills. We noted the last fire drill took place on 6 October 2016. Measures were in place to check the fire alarm system and firefighting equipment.

We looked at the Control of Substances Hazardous to Health (COSHH) file. COSHH files are kept to ensure providers contain information on the risks from hazardous substances in the dental practice. The dedicated health and safety officer was responsible for ensuring the COSHH file was up-to-date. The practice had safety data sheets for the products used in dentistry. These are information sheets about each hazardous product, including handling, storage and emergency measures in case of an accident. There were no data sheets in place for environmental cleaning products used at the practice. Specific risk assessments related to the practice had not been put in place for any of the products used. The health and safety officer confirmed they revised the COSHH file when there were any changes to the products used. A record was not maintained of each time the file was reviewed or revised.

Infection control

A member of staff was identified as the lead for infection prevention and control (IPC) and we observed from their training records that they had completed training to ensure they were skilled for this lead role.

Due to the space restrictions a dedicated decontamination room was not available in the premises. Instead, instruments were sterilised in a dedicated room in the dental laboratory across the road. The practice had put in place a robust transport protocol to ensure instruments were transported safely. Extra heavy duty containers were used to transport instruments.

Are services safe?

We observed one of the dental nurses carrying out a decontamination cycle in the dedicated decontamination room; this involved the cleaning, sterilising, packing and storing of dental instruments. This process was in accordance with the Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices. Produced by the Department of Health, this guidance details the recommended procedures for sterilising and packaging instruments. A daily automatic control test was not carried out on the autoclave. We discussed this with the dental nurse and were told this would be recorded and documented going forward.

We looked at the decontamination and treatment rooms. The rooms were clean, drawers and cupboards were clutter free with adequate dental materials. There were hand washing facilities, liquid soap and paper towel dispensers in each of the treatment rooms, decontamination room and toilets.

A Legionella risk assessment had been carried by the IPC lead for the practice. We observed it was brief and lacking in detail. We discussed with the IPC lead the importance of having a comprehensive Legionella risk assessment and to consider whether an external specialist company would be better positioned to undertake this assessment.

The dental unit water lines were maintained to prevent the growth and spread of Legionella bacteria. Legionella is a term for particular bacteria which can contaminate water systems in buildings. Staff described the method used and this was in line with current HTM 01-05 guidelines. The temperatures of the water outlets were checked each month to ensure water was within the correct temperature parameters.

The practice stored clinical waste securely and an appropriate contractor was used to remove it from site. Waste consignment notices were available for the inspection and the registered manager confirmed that all types of waste, including sharps, amalgam and gypsum was collected on a regular basis.

Nurses were responsible for the routine cleaning of the premises. A cleaning protocol and checklist was in place. There was insufficient floor cleaning equipment and what was available was not stored in accordance with national guidance. We highlighted this to staff at the time of the inspection.

IPC audits had been completed by the IPC lead every six months. We looked at two of the audits and observed the criteria did not align with the recommended Infection Prevention Society (IPS) audit criteria. We discussed the IPS audit with the IPC lead highlighting the benefits of its use; provision of a compliance percentage score and generation of an action plan. They told us they had recently started to complete the IPS audit. During the inspection they completed this audit and were successful in gaining a compliance score and generating an action plan. They said they would use this approach to IPC audit going forward.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. We saw evidence of up-to-date examinations and servicing of equipment, such as the X-ray equipment, autoclave and the compressor. Portable electrical appliances were tested on 16 July 2014 to ensure they were safe to use. This test was next due in 2017.

Local anaesthetics were stored appropriately and a log of batch numbers and expiry dates was in place.

The practice stored some antibiotics to dispense to patients. We saw some of the stock was out of date. There was no evidence these antibiotics had been provided to patients as there was a system in place of checking the expiry date prior to dispensing to a patient. We highlighted this to the dentist and registered manager and we were told a more robust system would be put in place to ensure all antibiotics were in date.

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 kept a detailed radiation protection file, including the names of the Radiation Protection Advisor, the Radiation Protection Supervisor and Health and Safety Executive notification. The local rules and maintenance certificates were contained in the file.

We saw all the staff were up-to-date with their continuing professional development training in respect of dental radiography. The practice was undertaking regular analysis of their X-rays through an annual audit cycle. The audits were in accordance with the National Radiological Protection Board (NRPB) guidance.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We found the dentist was following guidance and procedures for delivering dental care. A comprehensive medical history form was completed with patients and this was checked at every visit. A thorough examination was carried out to assess the dental hard and soft tissues including an oral cancer screen. The dentists also used the basic periodontal examination (BPE) to check patient's gums. This is a simple screening tool that indicates how healthy the patient's gums and bone surrounding the teeth are. The dental records we looked at informed us that patients were advised of the findings, treatment options and costs.

The dentist was familiar with the current National Institute for Health and Care Excellence (NICE) guidelines for recall intervals, wisdom teeth removal and antibiotic cover. Recalls were based upon individual risk of dental diseases.

The dentist used their clinical judgement and guidance from the Faculty of General Dental Practitioners (FGDP) to decide when X-rays were required. A justification, grade of quality and report of the X-ray taken was documented in the patient dental care records.

Health promotion & prevention

We found the practice was proactive about promoting the importance of good oral health and prevention. There was evidence in the dental records we looked at that the dental team applied the Department of Health's 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive care and advice to patients. Preventative measures included providing patients with oral hygiene advice such as tooth brushing technique, fluoride varnish applications and dietary advice. Smoking and alcohol consumption was also checked where applicable.

Staffing

Four staff worked at the practice. We looked at the continuing professional development (CPD) files for three of the staff. Because staff maintained and retained their own CPD files we did not have access to the full range of training we had been advised each member of staff had completed. Training summary forms were in place for staff but these had not been effectively completed so the practice could not demonstrate what training had been undertaken and when. Therefore we were unable to confirm the status of staff training with the exception of training in medical emergencies; all staff had completed this training within the last 12 months.

An induction policy and checklist was in place to inform new staff about the way the practice operated. We could see that an induction template had been completed when staff first joined the practice. The induction process included making new members of staff aware of the practice's policies, the location of emergency medicines and arrangements for fire evacuation procedures.

A system of self-appraisal was in place and we saw a completed self-appraisal form for one member of staff. This approach to appraisal was incomplete as it remained a self-appraisal and did not involve a review by a third party, such as a manager. This meant there was no objective evaluation of performance or opportunity to discuss training needs.

We asked about extended duties for nurses and were advised that one of the nurses had undertaken training to take impressions.

A system was in place to ensure staff maintained their required for registration with the General Dental Council (GDC).

Working with other services

The dentist confirmed they would refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. Referral letters were used to send all the relevant information to the specialist. Details included patient identification, medical history, reason for referral and X-rays if relevant. The dentist had a process in place to monitor the progress of referrals.

The practice also ensured any urgent referrals were dealt with promptly such as referring for suspicious lesions under the two-week rule. The two-week rule was initiated by NICE in 2005 to enable patients with suspected cancer lesions to be seen within two weeks.

Consent to care and treatment

A consent policy was in place for the practice. We spoke with the dentist about how they implemented the principles of informed consent. Informed consent is a

Are services effective?

(for example, treatment is effective)

patient giving permission to a dental professional for treatment with full understanding of the possible options, risks and benefits. The dentist explained how individual treatment options, risks, benefits and costs were discussed with each patient and then if appropriate documented in a written treatment plan. The patient would be provided with a copy of the plan and a copy would be retained in the patient's dental care record.

The dentist was clear about the principles of the 2005 Mental Capacity Act (MCA) and the concept of Gillick competence. The MCA is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. Gillick competence is a term used to decide whether a child (16 years or younger) is able to consent to their own medical or dental treatment, without the need for parental permission or knowledge. The child would have to show sufficient mental maturity to be deemed competent.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We provided the practice with CQC comment cards for patients to fill out two weeks prior to the inspection. There were 15 responses all of which were very positive with compliments about the staff, practice and treatment received. Patients commented they were treated with respect and dignity and that staff were sensitive to their specific needs.

A dignity and privacy policy was in place for the practice along with a chaperone policy. We observed staff maintained privacy and confidentiality for patients on the day of the inspection. Practice computer screens were not overlooked in reception and treatment rooms which ensured patient's confidential information could not be viewed by others. We saw that doors of treatment rooms were closed at all times when patients were being seen. Conversations could not be heard from outside the treatment rooms which protected patient privacy.

Dental care records were stored electronically and computers were password protected to ensure secure access. Computers were backed up and passwords changed regularly in accordance with the Data Protection Act. Staff were aware of the principles of data protection and confidentiality.

Involvement in decisions about care and treatment

Review of the CQC comment cards and our observation of dental records demonstrated that patients were involved in decisions about their care. Posters outlining treatment costs were displayed in the waiting area. The practice website provided patients with information about the range of treatments that were available at the practice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Staff confirmed that if a patient made contacted seeking an urgent appointment then they would be seen that day. They advised us that the dentist kept an appointment slot free on the day they worked. We asked about the other days and were told the dentist was flexible and would come in and see a patient requiring urgent care even if they were not working.

Tackling inequity and promoting equality

Reasonable adjustments to prevent inequity to any patient group. A disability access audit had not been completed for the practice. This audit is an assessment of the practice to ensure it meets the needs of people with a disability. The premises had been adapted to support patients with limited mobility and patients who used wheelchairs or mobility scooters. The facilities were all on the ground floor. Portable ramps were available for access through the front door. There was a lowered area at the reception desk for people using mobility aids. There was an accessible toilet with handrails. Staff had access to a translation service if required.

Access to the service

Opening hours were displayed in the premises, in the practice information leaflet and on the practice website. Patient feedback indicated there was good access to routine and urgent dental care. There were clear instructions on the practice's answer machine for patients requiring urgent dental care when the practice was closed.

Concerns & complaints.

A member of staff was identified as the lead for complaints. A complaints procedure was in place which provided guidance on how to handle a complaint and provided relevant contact details for external organisations. Information for patients about how to make a complaint was displayed in the waiting areas. The practice manager confirmed that no complaints had been received about the practice since it had opened.

Are services well-led?

Our findings

Governance arrangements

One of the nurses had delegated responsibility for the day-to-day running of the practice. They were responsible for ensuring governance processes were in place and up-to-date. Governance processes included a portfolio of operational policies and procedures, risk management systems and a programme of audit. The nurse had the lead for many elements of the service including, complaints, health and safety and infection prevention and control.

A portfolio of policies was in place and they were reviewed on a regular basis. We noted some policies relevant to the service were not in place, including a recruitment policy and policy about how incidents, concerns and near misses were managed. We highlighted this at the time of the inspection. Risk management processes were in place to ensure the safety of patients and staff members. For example, we saw risk assessments relating to the environment, fire and sharps. Routine checks were in place to minimise risk.

A business continuity plan was in place, which sets out how the service would be provided if an incident occurred that impacted on its operation.

Leadership, openness and transparency

Staff told us there was an open culture within the practice that encouraged candour, openness and honesty to promote the delivery of high quality care, and to challenge poor practice. Staff said that because it was such a small team there was frequent informal communication, usually at lunchtime. They said the full staff team worked together on a Tuesday, which was an ideal day to update on any changes and share information.

A formal team meeting was held once a year and the issues discussed were recorded. We saw the minutes from the last meeting held in July 2016.

Staff were aware of who to raise issues and told us the registered manager was approachable, would listen to their concerns and act appropriately. We were told there was a no blame culture at the practice.

The staff we spoke with were aware of the need to be open, honest and apologetic to patients if anything should go wrong; this is in accordance with the principles Duty of Candour principle which states the same.

Learning and improvement

Clinical and non-clinical audits were routinely carried out as part of an audit programme. An audit is an objective assessment of an activity designed to improve an individual or organisation's operations. Audit topics included health and safety, infection prevention and control, instrument cleaning, dental records and an X-ray audit. The audits we saw had been completed within the last 12 months.

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

A process was in place to seek feedback from patients about the quality of the service. A survey was carried out every six months and the feedback was analysed. The staff member responsible for overseeing the survey provided examples of changes made as a result of the feedback. One example was taking a longer time to explain and clarify treatment and costs to patients.

Staff told us their views were sought and listened to and that they were confident to raise concerns or make suggestions to the registered manager.