LEH Ltd

MK Dental Spa

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 23 November 2015 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

MK Dental Spa is a predominantly private dental practice situated on the first floor of a purpose built building in the Kiln Farm area of Milton Keynes.

The practice has a range of dental specialists, and operates a referral system whereby other practices can refer their patients for specific specialist treatments, such as endodontics (root canal treatment) periodontics (gum treatment) and dental implants (where a titanium post is placed surgically into the jaw bone. It is then used to replace a tooth, or support a bridge or denture). In addition an oral surgeon with a National Health Service (NHS) contract works two days a week. Patients requiring oral surgery (tooth extractions etc.) can be referred on the NHS.

The practice is open from 8.45 am to 5.30 pm Monday, Tuesday, Thursday and Friday. 8.45 am to 6.30 pm on Wednesday and alternate Saturday mornings by appointment only.

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.

Summary of findings

25 patients provided feedback about the practice. We looked at comment cards patients had completed prior to the inspection and we also spoke with patients on the day of the inspection. Overall the information from patients was very positive. Patients were positive about their experience and they commented that they were treated with kindness and respect.

Our key findings were:

- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- Governance arrangements were in place for the smooth running of the practice; however the practice did not retain information regarding continuous professional training of individual staff. For this reason the registered manager could not be assured that all required training was up to date in accordance with the requirements of the General Dental Council.
- Robust systems were in place to ensure that patients were able to provide valid, informed and educated consent.
- The practice had good systems and adequate training in place for providing conscious sedation to patients (these are techniques in which the use of a drug or medicine or medicines produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation).

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

- Review availability and staff knowledge of equipment and medicines to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), the British National Formulary, and the General Dental Council (GDC) standards for the dental team.
- Review at appropriate intervals the training, learning and development needs of individual staff members and have an effective process established for the on-going assessment and supervision of all staff.
- 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.

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.

Staff demonstrated a good knowledge of how to raise a safeguarding concern for a child or vulnerable adult. They were able to describe the types of scenario which may cause them to raise a concern.

Medicines and equipment were in place to deal with medical emergencies, although some staff were not able to tell us where individual medicines were kept. The medicine in question is now stored with the other emergency medicines.

Recruitment checks on staff were carried out in accordance with schedule three of the Health and Social Care Act 2008.

Decontamination of dental instruments was carried out in accordance with the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' Published by the Department of Health.

Are services effective?

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

Staff had an excellent understanding of national guidelines available to aid diagnosis and treatment.

The practice had three dental nurses that had been trained in sedation; this is a requirement of the Standards for Conscious Sedation in the Provision of Dental Care 2015 guidelines produced by the Intercollegiate Advisory Committee for the Provision of Sedation in Dentistry.

Staff we spoke with had a thorough understanding and approach to gaining consent for treatment.

Are services caring?

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

Staff members demonstrated their knowledge of data protection and how to maintain confidentiality.

Feedback that we received from patients to the service described how they were always treated in a kind and friendly manner. Nervous patients reported how they were put at ease in this practice.

Are services responsive to people's needs?

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

The practice responded to patient requests to have appointments available at the weekends; the practice now opens every other Saturday with appointments available all day.

We saw evidence that complaints were thoroughly investigated, and where appropriate, apologies issued to the patients involved in a timely manner.

Are services well-led?

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

Quality assurance processes were in place at the practice to ensure continuous improvement. Clinical audit was used to identify areas where improvements to practice could be made.

Summary of findings

The practice had systems in place to involve, seek and act upon feedback from people using the service.

Continuous professional development requirements in mandatory training were not monitored by the registered manager, therefore assurances could not be given that staff had carried out their mandatory training. We have been provided evidence since our visit that a comprehensive monitoring schedule was now in place for all staff.

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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 23 November 2015 by a CQC inspector and two dental specialist advisors.

We informed Healthwatch that we were inspecting the practice; however we did not receive any information of concern from them. We also requested details from the provider in advance of the inspection. This included their latest statement of purpose describing their values and objectives and a record of patient complaints received in the last 12 months.

During the inspection we toured the premises, spoke with the principal dentist (who was the registered manager), two dentists, three dental nurses and the practice manager. We reviewed a range of practice policies and practice protocols and other records relating to the management of the 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 systems in place to learn from significant incidents. A proforma was available with actions, outcomes and learning objectives to be completed. Staff informed us that this would be fed back though staff meetings. No significant incidents had been logged in the last year.

The practice received alerts from the Medicines and Healthcare products Regulatory Service (MHRA) these were e-mailed to the principal dentist who disseminated relevant alerts to the staff during regular practice meetings, and by e-mail.

The practice understood the responsibility to report drug interactions, and kept a stock of the standard 'yellow cards' to submit reports to the relevant authorities should the need arise.

Staff were aware of their responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). The principal dentist informed us of how they would make such a report.

Reliable safety systems and processes (including safeguarding)

The practice had a safeguarding vulnerable adults and children policy. The policies were dated 2013. They identified how to raise a safeguarding concern for an adult and separately for a child. Useful contact details were available, including the out of hours emergency team for vulnerable adults, and the first response number for a child.

Staff demonstrated a good understanding of the situations in which they would raise a safeguarding concern. They were able to identify the principal dentist as the safeguarding lead for the practice, and they could point to how they would go about raise a concern should the need arise. Records of staff meetings demonstrated that a safeguarding presentation was given to staff in January 2014.

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 9 June 2016. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

The practice used a system of disposing of sharps that was developed by the practice principal. Dentists took responsibility for disposing of sharps, and there was a comprehensive sharps policy in place. This was in accordance with Health and Safety (Sharp Instruments in Healthcare) 2013 guidance.

The practice had a visiting specialist endodontist (specialising in treatments to the root canals of the teeth). They were the only clinician performing root canal treatment in the practice. We were informed by staff that he used rubber dams for his root canal treatments. 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 dental practice had emergency medicines and oxygen to deal with any medical emergencies that might occur. These were located in a central location, although staff we spoke with could not always tell us immediately where a particular medicine was kept.

We found the emergency medicines to be in date and present in accordance with the British National Formulary guidance. With the exception of Glyceryl Trinitrate (GTN), which should be present in a spray form to administer under the tongue in the event of an angina attack. The practice did carry the medicine, but in tablet form. This would take longer to work in an emergency. We informed the practice principal who immediately assured us it would be replaced.

Resuscitation Council UK guidelines suggest the minimum equipment required for use in a medical emergency. This includes an Automated External Defibrillator (AED) (a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm) and oxygen which should be immediately available. This was all found to be present in accordance with the guidelines, however the practice did not have an automated blood glucose measuring device. This would be

Are services safe?

used to check if a diabetic has low blood sugar. The principal described the circumstances in which the need for this may arise and actions he would take which would mitigate the risk in not having this equipment available.

Staff regularly undertook basic life support training until this year, when the practice had decided to implement the more in depth immediate life support (ILS) course for all staff. This is a six hour training course and is a requirement of the Standards for Conscious Sedation in the Provision of Dental Care 2015 guidelines (conscious sedation is a service offered by the practice whereby a sedative medicine is given to the patient to calm and relax them to a point where they can still respond, but are more able to tolerate dental treatment. It is typically offered to nervous patients, and usually results in no memory of the treatment). The ILS course was booked for the week following the inspection.

Staff underwent regular medical scenario training as a team five or six times a year in order to remain practised, so that in the event of an emergency the staff would act with confidence.

Staff recruitment

We looked at the personnel 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 personnel 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.

Upon joining the practice staff were given an induction that involved talking though all the staff policies. All the pertinent information was given to the new member of staff on a CD. This included their contract, job description, practice ethos as well as policies including health and safety, cross infection and fire safety.

We found there were sufficient numbers of suitably qualified staff to meet the needs of the patients to the practice.

Monitoring health & safety and responding to risks

The practice had systems, processes and policies 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 included a general risk assessment that had been carried out in January 2015.

A fire risk assessment was in place, which documented staff training in this area through staff meetings and the induction process. Staff we spoke with were able to describe the fire procedures, and describe recent fire drills that had been carried out. Logs of topics discussed at staff meeting showed that training had been carried out most recently in April 2015.

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

Infection control

The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' Published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for cleaning, sterilising and storing dental instruments and reviewed their policies and procedures.

The practice had an infection control policy. This documented procedures in place pertaining to decontamination (decontamination is the process by which contaminated re-usable instruments are washed, rinsed, inspected, sterilised and packaged ready for use again), hand hygiene, spillages, single use items, and manual cleaning.

We observed two dental nurses carrying out the decontamination process. The decontamination procedure demonstrated a clear flow from the 'dirty' area to the 'clean' area as identified in HTM 01-05.

Are services safe?

Cleaning of the instruments was carried out by use of an ultrasonic cleaner. This is a piece of equipment specially designed to remove contaminants from dental instruments using ultrasonic waves through a liquid.

Once the instruments had been cleaned they were rinsed in a designated sink, and inspected under a free standing, illuminated magnifier for any residual debris or damage. They were pouched and then placed in an autoclave for sterilisation.

After sterilisation the instruments were marked with the date after which the sterilisation would become ineffective, (one year from sterilisation). Before being returned to the surgery in an appropriately marked, lidded 'clean' box.

We were shown how the practice ensured that the decontamination system was working effectively. We saw the paperwork used to record and monitor these checks.

The autoclave was tested daily by running an empty cycle every morning. A test strip was placed in the autoclave which changed colour once the autoclave reached the appropriate temperature and pressure to ensure sterilisation. In addition a daily steam penetration test was carried out daily. The autoclave had a printer that provided information on each cycle of the autoclave. These were logged and kept so that sterilisation could be assured over time. The autoclave had undergone regular servicing, most recently in October 2015.

The effectiveness of the ultrasonic cleaner was also checked regularly. Records were seen confirming that the temperature of the liquid was below 45 degrees Celsius (if the fluid was above 45 degrees Celsius that can prevent the effective removal of protein contaminants). A foil test was carried out every three months; this demonstrated that the ultrasonic was cleaning evenly. A weekly protein residue test proved that after the ultrasonic cleaning cycle the instruments were free of protein contaminants.

The practice demonstrated appropriate storage and disposal of clinical waste. Waste consignment notices were seen for clinical waste, amalgam, sharps, teeth and gypsum. This was underpinned by a policy on the disposal of clinical waste.

The staff files we checked all had documentation indicating that staff were adequately immunised against Hepatitis B.

Staff who are likely to come into contact with blood products, or are at increased risk of needle stick injuries should receive these vaccinations to minimise the risk of contracting blood borne infections.

The practice had systems in place to reduce the risk of Legionella. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The practice were checking the mains water temperatures, flushing and disinfecting the water lines. However the risk assessment that was in place was not carried out by an external assessor, and so specific risks to the individual building may not have been taken into account. Since completing the inspection we have received evidence from the practice that this has been arranged.

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

Temperature sensitive medicines were being kept in a designated medicines fridge, however the temperature of the fridge was not being checked, and so the effectiveness of the medicines up to the expiry date could not be assured.

Conscious sedation was being carried out by a visiting medical anaesthetist, and also by the oral surgeon working in the practice - (these are techniques in which the use of a medicines produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation). Certain specific equipment is necessary during this treatment, including a medicine called Flumazenil which reverses the effects of the sedative, and monitoring equipment to ensure the patients' wellbeing whilst under the effects of the sedation. These were all found to be present.

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 surgeries displayed the 'local rules' of the X-ray machine on the wall. These are specific documents to each set detailing (amongst other things) the designated Radiation Protection Advisor, and Radiation Protection Supervisor. The location of the cut-off switch for the unit, and a schematic diagram of the surgery pertaining to possible X-ray scatter, this is the tiny amount of radiation that can spread beyond the beam area.

A central radiation protection folder demonstrated regular testing and servicing of the equipment, as well as a full inventory of equipment, and a list of dental nurses that had been trained to process the X-rays.

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.

Justification for taking an X-ray was documented in the patients dental care record, as well as a report of the findings of the radiograph. The quality of the X-ray image was logged and periodically audited so that the overall quality of X-rays being taken was improving.

In this way the effective dose of radiation to the patients was as low as reasonably possible.

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.

The practice had specialist clinicians working on different days of the week, as well as general dentists, they had specialists in endodontics (root canal treatment), Periodontics (gum treatment), implantology (where a metal post is placed surgically into the jaw bone, and used to 'permanently' replace missing teeth, or support a denture in the mouth). Patients requiring any of these specialist treatments could be referred between the dentists in the practice, just as if they were being referred from an outside practice, meaning that patients could benefit from the wealth of specialist experience available.

Dentists we spoke with had a thorough understanding of national guidelines available to aid diagnosis and treatment. These included the National Institute of Clinical Excellence (NICE) guidelines pertaining to wisdom teeth extractions, recall intervals and antibiotic prescribing for patients at risk of infective endocarditis (a serious complication that may arise after invasive dental treatments in patients who are susceptible to it). Also the Faculty of General Dental Practitioners guidance on when X-rays were required and necessary. We found that this guidance was being followed by the dentists.

Comprehensive medical history forms were filled in and signed for new patients, then verbally updated at each visit. We discussed with the provider increasing the frequency of signed medical histories.

Health promotion & prevention

The practice promoted the maintenance of good oral health as part of their overall philosophy. There were guidance posters in the waiting area on how to check your mouth for signs of oral cancer, as well as smoking cessation leaflets.

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

Staffing

The practice demonstrated appropriate staffing levels, and skill mix to deliver the treatments offered to the patients.

The practice carried out conscious sedation (these are techniques in which the use of a medicine or medicines produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation). The practice had three dental nurses that had been trained in sedation this is a requirement of the Standards for Conscious Sedation in the Provision of Dental Care 2015 guidelines produced by the Intercollegiate Advisory Committee for the Provision of Sedation in Dentistry.

There was a staff appraisal system in place which was used to identify training and development needs. Staff told us they had found this to be a useful and worthwhile process and felt well supported by the principal dentist.

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 and dental technicians. All clinical staff were registered with the GDC.

Working with other services

As the practice had multiple dental specialists working on different days of the week, many of the patients who would normally have to be referred out of the practice to receive specialist treatment were able to have it in house. Nonetheless a written referral was made between the in house clinicians which prevented any confusion that may arise with patients seeing multiple clinicians in the same practice for different reasons, and a copy of the referral letter was sent to the patients.

Are services effective?

(for example, treatment is effective)

The practice referred patients requiring orthodontic treatment to a local practice, and any urgent referrals made to the hospital in respect of oral cancer concerns were faxed as well as posted to ensure they arrived in a timely manner.

Consent to care and treatment

Staff we spoke with had a thorough understanding and approach to gaining consent for treatment. They understood consent as a multi-stage process where treatment was rarely carried out on the first visit, and patients were encouraged to take time to consider all the options.

We saw examples of dental care records which clearly showed a robust reporting of all the options, risks and benefits outlined to patients. All patients were given a written treatment plan to take away outlining the options available, and costs involved. Information leaflets were also regularly given to patients to aid them in the decision-making process. In this way the practice could be assured of achieving valid, informed and educated consent from the patients in regard to their treatment.

Staff we spoke with had a variable understanding of the Mental Capacity Act 2005 (MCA) and its relevance in obtaining consent. The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Some staff were able to clearly describe how a patients capacity may change over time, and the processes involved in making a 'best interests' decision. However, not all staff understood the implications of the MCA so well. Not all staff had undertaken MCA training.

There was good understanding of situations in which a child (under 16 years old) may be able to consent for themselves rather than relying on a parent to consent for them. This is termed Gillick competence and depends on the child's understanding of the procedure and the consequences in having/ not having the treatment.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The provider and staff explained how they ensured information about people using the service was kept confidential. Patients' dental care records were kept electronically. They were password protected and backed up to a secure server off site. Any paper records for patients were kept securely in locked cabinets, away from the patient facing areas of the practice.

Staff members demonstrated their knowledge of data protection and how to maintain confidentiality. Staff told us patients were able to have confidential discussions about their care and treatment in the office, rather than at the reception desk.

We observed staff were helpful, discreet and respectful to patients.

Feedback that we received from patients to the service described how they were always treated in a kind and friendly manner. Nervous patients reported how they were put at ease in this practice and were comfortable to return for treatment.

Involvement in decisions about care and treatment

Patients reported to us that they felt involved in the decisions regarding their treatment. In depth conversations with patients were noted in dental care records and patients were always provided with a written treatment plan and covering letter that described the discussion that took place. Care was taken to make sure this letter was written without using dental 'jargon' or terms that may not be understood by patients.

Information on the cost of treatment was displayed in the reception area, and outlined in the individual treatment plans that were generated for each patient.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We examined appointments scheduling, and found that adequate time was given for each appointment to allow for assessment and discussion of patients' needs. We noted that the specialist oral surgeon operated a consultation appointment system. This meant that patients had the opportunity to confirm treatment and ask questions without the added pressure that imminent treatment added. It also gave them the chance to consider the options for treatment.

The practice offered pre-visits to nervous patients. This was where patients with a phobia of dentists were invited to the practice without charge to see the facilities, meet the staff and discuss how their individual needs could be met. In this way when they came for treatment they were more at ease with the surroundings and could be treated in a manner that helped them tolerate the treatment.

The practice responded to patient requests to have appointments available at the weekends; the practice now opens every other Saturday with appointments available all day. This improved access for the predominantly working population in this area. The practice also sent text message alerts to patients to remind them of appointments.

The waiting area had a free Wi-Fi connection, so patients could use their multimedia devices whilst waiting for their appointments.

Tackling inequity and promoting equality

We asked staff to explain how they communicated with people who had different communication needs such as those who spoke another language. Staff told us they treated everybody equally and welcomed patients from different backgrounds, cultures and religions. Staff explained to us how they were in the process of having some of the literature translated into different languages. And although they did not feel they had any patients at this time who could not speak good English, they were aware that they may need to acquire a translator should the need arise.

Despite being on the first floor, the practice had a lift, and so was accessible to people using wheelchairs. The practice also had an assisted toilet for people with restricted mobility.

The practice had an equality, diversity and human rights policy available for all staff to reference.

Access to the service

We were told how patients to the practice who are in pain would be seen on the same day. Out of hours, the practice had an on-call rotor with other local dental practices. The contact details for this were available on the answerphone and on the practice website.

Feedback we received from patients commented specifically on how the practice would see you on the day if you were in pain.

Concerns & complaints

The practice had a complaints policy which detailed to staff how a complaint should be handled. There was a complaints log where all the details were recorded and then passed to the registered manager for investigation.

We saw evidence that complaints were thoroughly investigated, and where appropriate, apologies issued to the patients involved in a timely manner.

Patients were informed how to raise a complaint from an information poster on the waiting room wall.

Are services well-led?

Our findings

Governance arrangements

The principal dentist (as the registered manager) had responsibility for the day to day running of the practice and was supported by the practice team; however he was only at the practice for two days a week. This had recently been addressed by the appointment of a practice manager. There were clear lines of responsibility and accountability; staff knew who to report to if they had any issues or concerns.

The practice had policies and procedures in place to support the management of the service, and these were readily available in hard copy form, as well as provided to all staff on a CD. These included a complaints policy, safeguarding, and infection control policies, as well as a robust policy on how to deal with needle stick injuries, and a business continuity plan to allow the continuation of the service in adverse circumstances.

Risk assessments were in place to minimise risks to staff, patients and visitors to the practice; fire safety, manual handling and Control of Substances Hazardous to Health. The principal dentist retained a schedule which documented when servicing for particular equipment was required.

Leadership, openness and transparency

Staff reported an open and transparent culture at the practice, which encouraged honesty. Specialist dentists, although only there one or two days a week, reported how integrated they felt within the practice team.

The inspection team also noted the attitude of the leadership, and all through the practice, was aspirational and keen to constantly improve the services on offer.

Learning and improvement

Quality assurance processes were in place at the practice to ensure continuous improvement. Clinical audit was used to identify areas where improvements to practice could be made. We saw evidence of infection control audits (most recently dated October 2015). As a result of this most recent audit an action plan had been drawn up which the staff read and signed to confirm they understood the changes to be made.

The quality of X-rays taken was audited yearly, and feedback given to clinicians on the outcomes. Other clinical audits we noted pertained to clinical management of lower third molars (wisdom teeth) and a record keeping audit.

Staff were supported in achieving the General Dental Council's requirements in continuing professional development (CPD) however, the practice did not hold current CPD certificates for all staff. Therefore the registered manager could not be certain that requirements of training had been met by all staff.

Following our visit we have received documents pertaining to CPD carried out by all staff, as well as evidence that a schedule has been put in place to identify any shortfalls; and enrolment of all staff on an online teaching programme so that, in the future, the practice can be assured that the staff are up to date with training and the requirements of CPD.

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, and comments form for patients to fill in. A patient satisfaction survey was undertaken within the last year.

In response to patient feedback, the practice now operated Saturday appointments on alternate weekends, and would arrange pre-visits for dental phobic patients.

Staff feedback was sought informally, though staff meetings and through the appraisal system. In response to staff requests a new surgery was in the process of being set up to accommodate the increasing oral surgery requirement. Staff also requested an additional function on the computer system for documenting tooth wear, and another function for calculating oral cancer risk. These had both been implemented.