North Street Dental Practice Limited

North Street Dental & Aesthetic Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 21 March 2016 to ask the practice the following key questions;

Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?
We found that this practice was providing safe care in accordance with the relevant regulations

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

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

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

Are services well-led?
We found that this practice was not providing well-led care in accordance with the relevant regulations.

Background
North Street Dental & Aesthetic Practice is a dental practice providing private treatment for both adults and children.

The practice is situated in Emsworth, a village near Chichester, West Sussex. The practice has three dental treatment rooms and a separate decontamination room used for cleaning, sterilising and packing dental instruments. The practice is based on the ground and first floor. The ground floor is accessible to wheelchair users, prams and patients with limited mobility.

The practice employs three dentists, two hygienists of whom one is a locum, three dental nurses and a receptionist. The practice opening hours are 8.30am to 5.30pm on Monday, Wednesday and Thursday and 8.30am to 2pm on Tuesday and Friday. There are arrangements in place to ensure patients receive urgent care and treatment assistance when the practice is closed.

Summary of findings

The practice owner 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.

During our inspection we reviewed 25 CQC comment cards completed by patients and obtained the view of nine patients on the day of our inspection.

The inspection was carried out by a lead inspector and a dental specialist adviser.

Our key findings were:

- Staff had been trained to handle emergencies.
- Appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The treatment rooms in use and other public areas of the practice appeared clean and maintained.
- Infection control procedures followed published guidance.
- The practice had a safeguarding lead professional with processes in place for safeguarding adults and children living in vulnerable circumstances.
- Although the practice generally followed national guidance for radiation used in dental practice, the maintenance of the X-ray sets was not carried out in accordance with current Ionising Radiation Regulations 1999, one of the three X-ray sets had not been maintained in accordance with current guidelines. We have since received evidence to confirm this has been addressed.
- Staff reported accidents and kept records of these which the practice used for shared learning.
- Dentists provided dental care in accordance with current professional and National Institute for Care Excellence (NICE) guidelines.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Patients could access treatment and urgent and emergency care when required.
- The practice did not have effective systems established to assess, monitor and mitigate the various risks arising from undertaking of the regulated activities. We have since received evidence to confirm risks relating to fire, legionella and the electrical wiring have been addressed.
- The practice reviewed and dealt with complaints according to their practice policy.
- Most staff received the training required to enable them to carry out their roles. Areas of concern included fire safety, safeguarding vulnerable adults and children and infection control training.

There were areas where the provider must:

- Ensure all relevant staff are up to date with their mandatory training and Continuing Professional Development (CPD).
- Ensure the practice recruitment policy and procedures are suitable and the recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.

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

- Review the practice protocols for managing a central log of staff training requirements and reviews.
- Consider installing a hearing loop and language interpreting facilities.
- Review the practice system for its policy management and ensure that policies have a review date to reflect changes to guidelines and government legislation.
- Consider providing the hygienist with the support of an appropriately trained member of the dental team.
- Review the protocols and procedures for the auditing of the quality of dental X-rays.

Summary of findings

- Review the induction process for new staff to ensure records are maintained to confirm effective procedures are followed.

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 were aware of the importance of identifying, investigating and learning from patient safety incidents. Most staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

The practice had arrangements in place for essential topics such as infection control, clinical waste control, management of dental emergencies at the practice and dental radiography (X-rays). We found that most of the equipment used in the dental practice was well maintained. We have since been provided with evidence to confirm the equipment requiring attention has been serviced. The practice did not have effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors. We have since received evidence to confirm the risks relating to the fire, Legionella and electrical wiring have been and minimised for the safety of patients and staff.

Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. Eligible staff were registered with the General Dental Council (GDC). We were told staff received professional training and development appropriate to their roles and learning needs but we were not provided evidence to confirm this for all staff.

The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice.

Are services caring?

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

We collected 25 completed Care Quality Commission patient comment cards and obtained the views of a further nine patients on the day of our visit. These provided a positive view of the service the practice provided. All of the patients commented that the quality of care was very good. Patients commented on the friendliness and helpfulness of the staff and told us the dentists were good at explaining the treatment that was proposed.

Are services responsive to people's needs?

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

Patients could access treatment and urgent and emergency care when required. The service was aware of the needs of the local population and generally took these into account in how the practice was run. The practice had a ground floor treatment room for patients with mobility difficulties and families with prams and pushchairs but did not offer interpreting services or have a hearing loop available for patients who had hearing impairments.

Are services well-led?

We found that this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report).

Summary of findings

The practice owner and the staff team had an open approach to their work and shared a commitment to continually improving the service they provided. All the staff we met said they were happy in their work and the practice was a good place to work.

There were shortfalls in a number of governance arrangements for the practice. Legionella and fire safety risk assessments were not up to date, audits and actions required were not carried out. The provider undertook to address these issues and we have since received evidence to confirm these have been addressed.

Most staff received the training required to enable them to carry out their roles. However not all training had been completed. Areas of concern included fire safety, safeguarding vulnerable adults and children and infection control training.

The practice could not demonstrate it had effective recruitment procedures. The provider could not provide evidence to confirm all the checks required for new staff had been carried out.

North Street Dental & Aesthetic Practice

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 21 March 2016. The inspection was carried out by a lead inspector and a dental specialist adviser.

During our inspection visit, we reviewed policy documents and staff records. We spoke with five members of staff. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the computer system that supported the patient dental care records. We reviewed CQC comment cards completed by patients and obtained the view of patients on the day of our inspection.

Patients gave positive feedback about their experience at the practice.

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

Staff had an awareness of RIDDOR (The reporting of injuries diseases and dangerous occurrences regulations). The practice had an incident reporting system in place along with forms for staff to complete when something went wrong, this system also included the reporting of minor injuries to patients and staff. The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA) via email. The practice told us there were no significant events or incidents in 2015.

Reliable safety systems and processes (including safeguarding)

We spoke to staff about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current EU Directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne diseases. The practice used a system whereby needles were not manually re-sheathed using the hands following administration of a local anaesthetic to a patient. The dentists were responsible for ensuring safe recapping using a 'scoop' method. Staff explained the practice protocol should a needle stick injury occur. The systems and processes we observed were in line with the current EU directive on the use of safer sharps.

We asked how the practice treated the use of instruments used during root canal treatment. They explained these instruments were single use only. They also explained that root canal treatment was carried out where practically possible using a rubber dam. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). On the day of our visit we saw a patient was booked in for root canal treatment and that a rubber dam was used. The practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam.

The practice owner was the safeguarding lead professional and acted as a point of referral should members of staff encounter a child or adult safeguarding issue. A policy was in place for staff to refer to in relation to children and adults who may be the victim of abuse or neglect. Training records showed that five out of eight staff had received appropriate safeguarding training for both vulnerable adults and children. Information was available in the practice that contained telephone numbers of whom to contact outside the practice if there was a need, such as the local authority responsible for investigations. The practice reported there had been no safeguarding incidents that required further investigation by appropriate authorities in recent times.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. There was an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. This included oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines.

The emergency medicines and oxygen were all in date and stored in a central location known to all staff. The expiry dates of medicines and AED were monitored using a monthly check sheet that enabled staff to replace out of date medicines promptly. However we did note that although the oxygen cylinder was full regular checking of the cylinder had not been carried out for several weeks. Staff had received update training in 2015.

Staff recruitment

All the dentists and dental nurses who worked at the practice had current registrations with the General Dental Council. We looked at recruitment files for five staff employed since the provider registered with CQC and found the registered provider had not fully undertaken all the required checks to comply with Schedule 3 of the Health and Social Care Act 2008 (amended 2014). Checks required included proof of identity, a full employment history, evidence of relevant qualifications and employment checks including references.

Four staff did not have satisfactory evidence of conduct in their previous employment, evidence to confirm eligibility to work in the UK and satisfactory evidence of any physical or mental health conditions. Three did not have

photographic evidence to confirm their identity. We saw evidence to confirm criminal records checks had been carried out for all four staff. Although one member of staff had evidence of a criminal records check being carried out this was dated three years prior to the start date of their employment at North Street in 2014.

Monitoring health & safety and responding to risks

The practice had a health and safety risk management process in place, which enabled them to assess, mitigate and monitor risks to patients, staff and visitors to the practice. However, this policy had not been dated so we were not assured that the risk assessment had been updated in line with changes to the health and safety guidance. There was a business continuity arrangement in place describing the arrangements for patients should the practice be unable to provide services for prolonged periods.

Although the practice had in place systems to deal with foreseeable emergencies, there were shortfalls. For example, we found that a fire risk assessment was unavailable, although arrangements were in place to maintain fire equipment. We had concerns that risks may not have been fully identified and mitigated and discussed this with the practice and the provider undertook to carry out a further audit as soon as practically possible. We have since been provided with evidence to confirm this has taken place.

The practice had in place a system to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. We looked at the COSHH file and found this to be comprehensive where risks (to patients, staff and visitors) associated with substances hazardous to health had been identified and actions taken to minimise them.

Infection control

The practice had in place an infection control policy that was regularly reviewed. There were effective systems in place to reduce the risk and spread of infection within the practice. This was demonstrated through direct observation of the cleaning process and a review of practice protocols that showed HTM 01 05 (national guidance for infection prevention control in dental practices') Essential Quality Requirements for infection control were being met. We observed that audits of infection control processes carried out in March 2016 confirmed compliance with HTM 01 05 essential quality requirements.

The three dental treatment rooms, waiting areas, reception and toilet appeared clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available including liquid soap and paper towels in each of the treatment rooms and toilet. Hand washing protocols were also displayed appropriately in various areas of the practice. We noted that bare below the elbow working was not always observed by one of the dentists. We made the provider aware of this and they undertook to address the concern immediately.

The drawers of treatment rooms were inspected and these were clean, ordered and free from clutter. Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

A dental nurse described to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. This included how the working surfaces; dental unit and dental chair were decontaminated. 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) they described the method they used which was in line with current HTM 01 05 guidelines and essential requirements. However, we saw that a Legionella risk assessment had not been carried out at the practice by a competent person. We had concerns that risks may not have been fully identified and mitigated in relation to Legionella. The provider undertook to address this and we have received evidence a risk assessment has been carried out by a professional company.

The practice had two separate decontamination rooms for instrument processing. The decontamination room on the ground floor serviced the dental hygienists treatment room. The dental nurse demonstrated the process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a system of manual scrubbing for the initial cleaning process. Following inspection with an illuminated magnifier instruments were placed in an autoclave (a device for sterilising dental and medical

instruments). The practice had three autoclaves, one of the autoclaves was a vacuum autoclave used for sterilising those instruments and devices used for surgical dentistry. The practice specialised in the provision of dental implants. The dental nurse told us the single use items that formed part of each dental implant system were for single patient use only. They explained that several components of one system they used are not sterilised on receipt from the manufacturer. The lead dental nurse explained these components were sterilised prior to use and were disposed of after use.

When instruments had been sterilised, they were pouched and stored until required. Pouches were dated with an expiry date in accordance with current guidelines. We were shown the systems in place to ensure that the autoclaves used in the decontamination process were working effectively. For example we observed the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were always complete and up to date in the decontamination room on the ground floor. The decontamination room on the first floor used an electronic data logging system to record each sterilisation cycle.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained and disposed of in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. This was stored in a separate locked location room prior to collection by the waste contractor. Waste consignment notices were available for inspection. We also saw that general environmental cleaning was carried out according to a cleaning plan developed by the practice. Cleaning materials were stored appropriately.

Equipment and medicines

Most equipment checks were carried out in line with the manufacturer's recommendations. For example, the autoclaves had been serviced and calibrated in February 2015 and were due to be serviced again in April 2016. Two out of the three X-ray machines had been serviced and calibrated as specified under current national regulations. However we did note that one X-ray set had not received a routine service in accordance with current Ionising Radiation Regulations. We have since received evidence to confirm this set has been serviced.

The practice dispensed their own medicines as part of a patients' dental treatment. These medicines included a range of antibiotics and over the counter painkillers. The dispensing procedures were robust and medicines were stored according to manufacturer's instructions. The practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid spillage.

Radiography (X-rays)

We were shown documents which were generally in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). This information included the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and most documentation pertaining to the maintenance of the X-ray equipment.

Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported upon and quality assured. A system was in place to record the quality of X-rays but one dentist could not evidence that findings had been audited in accordance with current guidelines. We saw training records that showed most staff where appropriate had received training for core radiological knowledge under IRMER 2000, but there were gaps in the training records.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists carried out consultations, assessments and treatment in line with recognised general professional guidelines. Both dentists described to us how they carried out their assessment of patients for routine care. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following clinical assessment the diagnosis was discussed with the patient and treatment options explained in detail.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general dental hygiene procedures such as tooth brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Dental care records showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. A BPE is a simple and rapid screening tool that is used by dentists to indicate the level of treatment needed in relation to a patient's gums. These were carried out where appropriate during a dental health assessment.

Health promotion & prevention

The practice web site provided information and advice to patients about how to maintain healthy teeth and gums. The waiting room and reception area at the practice contained leaflets that explained the services offered at the practice. This included information about how to carry out effective dental hygiene and how to reduce the risk of poor dental health. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums. These were available in the reception area.

Two dental hygienists had been appointed to work alongside the dentists to deliver preventive dental care. Adults and children attending the practice were advised during their consultation of steps they could take to maintain healthy teeth. Tooth brushing techniques were explained to them in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate. The dentist we spoke with explained that the children they did see who were at high risk of tooth decay were offered fluoride varnish applications or high concentrated fluoride tooth paste to keep their teeth in a healthy condition. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. Dental care records seen demonstrated dentists had given oral health advice to patients.

Staffing

The practice employed three dentists, of whom one was the practice owner; dentists were supported by three dental nurses and a receptionist. The practice also employed two dental hygienists. All clinical staff had current registration with their professional body, the General Dental Council.

We were told clinical staff were responsible for ensuring they completed their own continuing professional development requirements. The provider did not maintain records to confirm what training had been carried out by staff. It was apparent from discussion with the provider and evidence supplied after our inspection that some staff were not up to date with relevant training such as radiography, basic life support, fire safety, infection control and safeguarding training.

We saw there was a structured induction programme in place for new members of staff but records confirmed this had only been used for one member of staff who started in 2015.

We were told the dental hygienists worked without chairside support. We drew to the attention of the practice manager the advice given in the General Dental Council's

Are services effective?

(for example, treatment is effective)

Standard (6.2.2) for the Dental Team about dental staff being supported by an appropriately trained member of the dental team at all times when treating patients in a dental setting.

Working with other services

Dentists were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as oral surgery or special care dentistry. This ensured that patients were seen by the right person at the right time.

Consent to care and treatment

We spoke with two dentists in the practice about how they implemented the principles of informed consent; all of the dentists had a very clear understanding of consent issues. They explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options.

They went onto explain how they would obtain consent from a patient who suffered with any cognitive impairment that may mean they might be unable to fully understand the implications of their treatment. If there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed. The dentists went on to say they would involve relatives and carers if appropriate to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005. Although the practice treated relatively few children the dentists were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence principles help clinicians to identify children aged under 16 who have the legal capacity to consent to examination and treatment.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting areas and we saw that doors were closed at all times when patients were with dentists. Conversations between patients and dentists could not be heard from outside the treatment rooms which protected patient's privacy. Computers were password protected and regularly backed up to secure storage with paper records stored in locked cabinets behind the reception desk. Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality.

Before the inspection, we sent Care Quality Commission (CQC) comment cards so patients could tell us about their experience of the practice. We collected 25 completed CQC patient comment cards and obtained the views of nine patients on the day of our visit. These reported a positive view of the service the practice provided. All of the patients commented that the quality of care was very good. Patients commented that treatment was explained clearly and the staff were caring and put them at ease. They also said the reception staff were always helpful and efficient. During the inspection, we observed staff in the reception area being polite and helpful towards patients and the general atmosphere was welcoming and friendly.

Involvement in decisions about care and treatment

All the patients we asked said the dentist was good at involving them in decisions about their care and treatment. The practice provided clear treatment plans to their patients that detailed possible treatment options with indicative costs where necessary. A group of patients receiving care at the practice were part of a national insurance scheme for dental care that involved paying a monthly fee for their dental care. A poster detailing private treatment costs was displayed in the waiting area. The dentists told us they paid particular attention to patient involvement when drawing up individual care plans. Patient care records seen confirmed dentists recorded the information they had provided to patients about their treatment and the options open to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we looked at examples of information available to patients. We saw that the practice waiting area displayed a variety of information including the practice patient information leaflet. This explained opening hours, emergency 'out of hours' contact details and arrangements and how to make a complaint. The practice web site also contained useful information for patients such as the different types of services and treatments available and how to provide feedback about the services provided.

On the day of our visit we observed that the appointment diaries were not unduly overbooked. This provided capacity each day for patients with dental pain to be fitted into urgent slots for each dentist. Patients were also invited to come and sit and wait if these slots had already been allocated.

Tackling inequity and promoting equality

The practice was based over two floors with the reception desk being on the ground floor and treatment rooms on the first floor accessed by stairs. The building was spacious and the ground floor was fully accessible to wheelchair users, prams and patients with limited mobility. The reception desk had a lower counter at one end which accommodated wheelchair users without them needing to move to a separate area.

A wheelchair accessible toilet was available and the surgery on the ground floor was large and accessible to patients who could transfer from wheelchairs should they wish to.

Access to the service

Appointments were available on Monday, Wednesday and Thursday from 8.30am to 5.30pm, Tuesday and Friday from 8.30am to 2pm. Appointments could be made in person, by telephone or on-line via the practice website. All the patients we asked said they were satisfied with the practice opening hours.

Staff told us patients were seen as soon as possible for urgent care during practice opening hours and this was normally within 24 hours. Appointments were available each day to accommodate this. Patients told us and comment cards reflected they felt they had good access to routine and urgent dental care.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an out-of-hours service run by a number of local dentists who operated an on-call system. If patients called the practice when it was closed, an answerphone message gave the telephone number patients should ring depending on their symptoms.

Concerns & complaints

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was an effective system in place which ensured a timely response.

The provider was the designated lead member of staff for the handling of complaints. Staff we spoke with were aware of the procedure to follow if they received a complaint and forms were available for recording complaint information. For example, a complaint would be acknowledged within two working days and a full response would be provided to the patient within ten working days. We were told no complaints had been received in the previous 12 months of our inspection.

Patient information about how to make a complaint was visible in the practice. We asked nine patients if they knew how to make a complaint if they had an issue and eight said 'yes' with one patient stating they weren't sure.

Are services well-led?

Our findings

Governance arrangements

The governance arrangements for this location consisted of the principal dentist who was responsible for the day to day running of the practice. We found the governance files underpinning the care provided at the practice were not were not dated which meant it was not possible to evidence they were regularly reviewed to ensure they reflected the most recent guidance and government legislation. Other areas of concern found included staff recruitment and maintaining records of staff training.

Leadership, openness and transparency

It was apparent through our discussions with the dentists and nurses the patient was at the heart of the practice with the dentist adopting a holistic approach to patient care. We found staff to be hard working, caring and committed to the work they did.

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Most staff said they felt comfortable about raising concerns with the provider.

Learning and improvement

We found there were a number of clinical and non-clinical audits taking place at the practice. These included infection control, clinical record keeping and some X-ray quality. There was evidence of repeat audits at appropriate intervals and these demonstrated standards and improvements were being maintained. For example Infection Prevention Society audits were undertaken in accordance with current guidelines.

We were told staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. However evidence to confirm all relevant staff were up to date with their mandatory training and their Continuing Professional Development was not available during or after our inspection.

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

The practice had gathered feedback from patients through patient feedback forms in the waiting area, compliments and complaints. Changes made as a result of this feedback included extended appointment times for one dentist who ran late on occasions. We were told patient feedback forms were read and actioned as appropriate but no analysis was carried out over a period of time which would detect patient satisfaction trends or the results fed back to patients.

We were told staff turnover and sickness absence was low. Staff told us they felt valued and were proud to be part of the team. Regular staff meetings were held and staff told us they felt included in the running of the practice. They went on to tell us how the dentists listened to their opinions and respected their knowledge and input at meetings. For example, staff worked on a four month rotation system to enable them to work in different positions at the practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staffing We found the provider did not have effective systems in place to support training, professional development, supervision and appraisal as is necessary to enable staff to carry out the duties they are employed to perform. This was in breach of regulation 18 (1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. • Formal staff training in fire safety, safeguarding children and vulnerable adults and infection prevention and control had not been carried out for all relevant staff.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Fit and proper persons employed We found the provider had not ensured persons employed for the purposes of carrying on a regulated activity were of good character and that all other information specified in Schedule 3 was available in relation to each such person employed. This was in breach of Regulation 19 (1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. • Pre-employment checks missing included conduct in previous employment, eligibility to work in the UK, photographic proof of identity and information about any health conditions.