Whitecross Dental Care Limited

High Street Dental Centre Petersfield

Inspection Report

34 – 34a High Street
Petersfield
GU32 3JL
Tel: 01730 265580
Website: www.mydentist.co.uk

Date of inspection visit: 20/11/2015
Date of publication: 25/02/2016

Overall summary

We carried out an announced comprehensive inspection on 20 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 not providing well-led care in accordance with the relevant regulations

Background
High Street Dental Centre is a dental practice providing mainly NHS and some private treatment and caters for both adults and children. The practice is situated in a converted commercial property. The practice has four dental treatment rooms and a separate decontamination room for cleaning, sterilising and packing dental instruments for the three dental treatment rooms on the first floor and a reception and waiting area. One of the dental treatment rooms is situated on the ground floor enabling disabled access. To facilitate access to this treatment room, a hydraulic lift is in place to help wheelchair users and other patients with mobility impairments negotiate the two steps leading to this treatment room.

The practice has five dentists a dental hygienist and five dental nurses four of whom were in training and on a recognised training course. All of the dental nurses who were qualified were registered with the General Dental Council. Supporting the clinical staff was a practice manager who had previously trained as a dental nurse and two reception staff. The practice's opening hours are 8:00am – 5:30pm Monday to Friday. There are arrangements in place to ensure patients receive urgent medical assistance when the practice is closed. This is provided by an out-of-hours service.

Summary of findings

The practice manager 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.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice. We collected eight completed cards and asked 26 patients for their feedback about the service during our visit. These provided a positive view of the services the practice provided.

We carried out an announced comprehensive inspection on 20 November 2015 as part of our planned inspection of all dental practices. The inspection was carried out by a lead inspector and a dental specialist adviser.

Our key findings were:

- The practice had an empowered practice manager who provided robust leadership within the practice.
- Staff had been trained to handle emergencies. Appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice was visibly clean and well maintained.
- Infection control procedures were robust and the practice followed published guidance.
- The practice had a dedicated safeguarding lead and processes in place for referring safeguarding concerns to appropriate organisations.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- The practice had enough staff to deliver the service.
- Staff we spoke with felt well supported by the practice manager and were committed to providing a quality service to their patients.
- All complaints were dealt with in an open and transparent way by the practice manager if a mistake had been made.
- The practice had a programme of clinical and non-clinical audit in place.

We identified regulations that were not being met and the provider must:

- Ensure recruitment arrangements include all necessary employment checks for all staff.

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

- Keep accurate staff training records to confirm staff have the appropriate skills and knowledge to undertake 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 care which was safe in accordance with the relevant regulations.

The practice had robust arrangements for essential topics such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found all the equipment used in the dental practice was well maintained. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents. There were sufficient numbers of suitably qualified staff working at the practice. We were told that staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults but we were not provided evidence of safeguarding training to confirm this.

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. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. The staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council and were meeting the requirements of their professional registration.

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

We collected eight completed comment cards. These provided a completely positive view of the service; we also asked 26 patients for their views which aligned with these. Patients commented that the quality of care was generally very good. Whilst all comments were favourable, one patient told us their treatment appeared hurried.

Are services responsive to people's needs?
We found that this practice was providing responsive care in accordance with the relevant regulations.

The service was aware of the needs of the local population and took those these into account in how the practice was run. Patients could access treatment and urgent care when required. The practice provided patients with written information and had access to telephone interpreter services when required. A dental treatment room on the ground floor enabled ease of access into the building for patients with mobility difficulties and families with prams and pushchairs.

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

The practice manager provided effective local leadership and the corporate provider had in place a system of managers who provided support and leadership to the practice manager. The practice had clinical governance and risk management structures in place. Staff told us they felt well supported and could raise any concerns with the practice manager. All the staff we met said the practice was a good place to work.

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

High Street Dental Centre Petersfield

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 20 November 2015. 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 eight members of staff, including the practice manager. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We observed the dental nurse carrying out decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area. We reviewed comment cards completed by patients and spoke with patients. 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

The company had a significant events policy in place which we observed. The practice manager explained how this policy operated in practice. We saw three examples of incidents that had occurred during 2015 and the significant events forms used by the company had been completed. One of the more significant incidents showed that the staff member involved had completed a reflective log diary. This followed the process of what and why the incident had occurred. It then reflected on what went well and what perhaps did not go well; finally it identified what could have been done differently. As a result of this particular case the practice manager arranged for each surgery to have its own rubber dam kit (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).

Reliable safety systems and processes (including safeguarding)

We spoke to a dental nurse about the prevention of needle stick injuries. She explained that the treatment of sharps and sharps waste was in accordance with the current European Union (EU) Directive with respect to safe sharp guidelines, thus protecting staff against blood borne viruses. The practice used a system whereby needles were not resheathed using the hands following administration of local anaesthetic to a patient. The dentists were responsible for the disposal of contaminated sharps waste in accordance with the company policy. A single use delivery system was used to deliver local anaesthetic to patients. The dental nurse was also able to explain the practice protocol in detail 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 which were used during root canal treatment. A dentist we spoke with explained these instruments were single use only. They explained root canal treatment was also carried out where practically possible using a rubber dam. Patients can be assured the practice followed appropriate guidance by the British Endodontic Society in relation to the use of the rubber dam.

The practice had a nominated individual, the registered manager, who acted as the practice safeguarding lead professional. This individual 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 appear to be the victim of abuse. Information was available 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 dentists we spoke with were able to describe in detail the types of behaviour a child would display that would alert them if there were possible signs of abuse or neglect. The practice reported there had been no safeguarding incidents that required further investigation by appropriate authorities. We were told that staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults but the manager could not provide evidence of training to confirm this. We wrote to the practice manager and provider's CQC compliance manager to request this after our visit but at the time of writing our report we have not received a response.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had 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 the emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had two emergency medicine and equipment kits in place, one on each floor. The practice also had oxygen cylinders and other related items such as manual breathing aids and portable suction were available in line with the Resuscitation Council UK guidelines on each floor.

All emergency medicines and oxygen were in date. The expiry dates of medicines and equipment were monitored using a daily and monthly check sheet which enabled the staff to replace out of date medicines and equipment promptly. The practice held training sessions annually for the whole team to maintain their competence in dealing with medical emergencies. This training had taken place in February and April 2015.

Are services safe?

Staff recruitment

All the dentists and dental nurses who worked at the practice had current registrations with the General Dental Council. All of the 26 patients we asked told us they had confidence and trust in the dentist.

The practice had a recruitment policy which detailed the checks required to be undertaken before a person started work. For example, proof of identity, a full employment history, evidence of relevant qualifications and employment checks including references.

We looked at six staff recruitment files and records and found evidence missing to confirm that all had been recruited in accordance with the practice's recruitment policy. Evidence missing included conduct in previous employment and criminal records check such as through the Disclosure and Barring Service. We wrote to the practice manager and provider's Senior Regulatory Officer to request this information after our visit but at the time of writing our report we have not received a response.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice carried out a number of risk assessments including a Control of Substances Hazardous to Health (COSHH) file. Other assessments included fire safety, health and safety and water quality risk assessments.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. It was demonstrated through direct observation of the cleaning process and a review of practice protocols that HTM 01 05 (national guidance for infection prevention control in dental practices') Essential Quality Requirements for infection control were being met. It was observed that a current audit of infection control processes confirmed compliance with HTM 01 05 guidelines. The last audit was dated 13 November 2015.

We noted that the four dental treatment rooms, waiting area, reception and toilet were 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 toilets. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was seen.

We asked a dental nurse to describe to us the end to end process of infection control procedures at the practice. The dental nurse explained the decontamination of the general treatment room environment following the treatment of a patient. They demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental unit water lines.

The drawers of a treatment room were inspected in the presence of one of the dentists. These were well stocked, clean, well ordered and free from clutter. All of the instruments were pouched and it was obvious which items were single use and these items were clearly new. Each treatment room had the appropriate routine personal protective equipment available for staff and patient use.

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). A dental nurse described the method used which was in line with current HTM 01-05 guidelines. A Legionella risk assessment had been carried out at the practice by a competent person in January 2015. We saw evidence this was regularly reviewed. The recommended procedures contained in the report were being carried out and logged appropriately. This included regular testing of the water temperatures of the taps in all rooms in the building. We saw a complete set of records which demonstrated these were carried out each month. These measures ensured patients' and staff were protected from the risk of infection due to Legionella.

The practice had a separate decontamination room on the first floor servicing the three treatment rooms on that floor. The treatment room on the ground floor carried out decontamination of instruments within this room. This was to mitigate possible moving and handling risks of transporting instruments from the ground floor to the decontamination room on the first floor due to the narrow and steep stairs leading to the first floor. The decontamination room was organised, clean, tidy and clutter free. Dedicated hand washing facilities were available in this room. The dental nurse demonstrated to us the decontamination process from taking the dirty

Are services safe?

instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a system of ultrasonic cleaning for the initial cleaning process followed by rinsing in a separate bowl. Following inspection with an illuminated magnifier they were placed in an autoclave (a machine used to sterilise instruments). The practice had three vacuum autoclaves. When instruments had been sterilized they were pouched and stored appropriately until required. All pouches were dated with an expiry date in accordance with current guidelines. The nurse also demonstrated systems were in place to ensure that the autoclaves and ultrasonic cleaning baths used in the decontamination process were working effectively. These included the automatic control test and steam penetration test. We observed the data log books used to record the essential daily and weekly validation checks of the autoclaves were always completed and up to date. Essential checks for the ultrasonic cleaning bath were also carried out and were available for inspection, including weekly protein residue and foil tests.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. We observed sharps containers, clinical waste bags and municipal waste were properly maintained and was in accordance with current guidelines. The practice used an appropriate contractor to remove dental waste from the practice and was stored in a separate locked location adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection. Patients could be assured they were protected from the risk of infection from contaminated dental waste.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example the three autoclaves had been serviced and calibrated in September 2015. The practices four X-ray machines had been serviced and calibrated in September 2015. We saw local anaesthetics and medicines were stored safely for the protection of patients. Dentists recorded batch numbers and expiry dates for local anaesthetics in patient dental care records in line with company policy. A log of all medicines prescribed via an NHS prescription was kept to prevent incidents of prescription fraud or inappropriate prescribing from occurring. The practice had installed a hydraulic lift to help patients with limited mobility. We asked for servicing records to confirm it was working effectively. We were told this information was not available at the location and the provider held it at head office. We wrote to the practice manager and provider's CQC compliance manager to request this after our visit but at the time of writing our report we have not received a response.

Radiography (X-rays)

We were shown a maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000. This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. At this location each individual dentist acted as the Radiation Protection Supervisor for their dental treatment room. Included in the file were the critical examination packs for each X-ray set along with the three yearly maintenance logs and a copy of the local rules. The maintenance logs were within the current recommended interval of three years.

A copy of the most recent radiological audit for each dentist was available for inspection this demonstrated a very high percentage of radiographs were of grade 1 standard. These audits were carried out during May 2015. When dental X-rays were taken they were justified, reported upon and quality assured each time. This was corroborated when we viewed dental treatment care records. These findings showed practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

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. We spoke with two dentists who described to us how they carried out their assessment. 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 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 the 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 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 we saw showed the findings of the assessment and details of the treatment carried out were recorded appropriately. The records of one dentist were particularly well set out and recorded. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance about treatment needed. These were carried out where appropriate during a dental health assessment.

Health promotion & prevention

The waiting room and reception area at the practice contained literature in leaflet form that explained the services offered at the practice. This included information about effective dental hygiene and how to reduce the risk of poor dental health. The company web site also provided information and advice to patients about how to maintain healthy teeth and gums.

Adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. Tooth brushing techniques were explained to them in a way they understood and dietary, smoking and alcohol advice was also given to them.

The practice used the services of a dental hygienist who worked under the prescription of the dentists working at the practice. The hygienist service was on a private basis only. They provided a variety of treatments including simple scaling and polishing of teeth to more complex gum treatments for patients suffering from the more aggressive forms of gum disease. They would also provide tailored preventative advice and treatments where necessary.

Staffing

All but one of the dental nurses supporting the dentists were qualified dental nurses, others were trainees who were on recognised training course. However we did note that the dental hygienist was working without chairside support. We drew to the attention of the practice manager the advice given in the General Dental Council's Standards 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.

The practice manager told us the practice ethos was that all staff should receive appropriate training and development. The practice used a variety of ways to ensure staff development including internal company training through the academy programme and staff meetings as well as attendance at external courses and conferences. The company provided a rolling programme of professional development. This included training in cardiopulmonary resuscitation, infection control, child protection, adult safeguarding and other specific dental topics. This was evidenced through observing the individual dentist's training profile via the company's intranet. However on the day of our visit some of the training for some staff could not be evidenced. We were told records may have been lost on the computer system due to the recent rebranding of the company. Part of the re branding included an overhaul of the company intranet which had resulted in previous training records being lost.

Are services effective?

(for example, treatment is effective)

Working with other services

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients. Referrals when required were made to other dental specialists. Systems had been put in place by local commissioners of services and secondary care providers whereby referring practitioners would use bespoke designed referral forms. This helped ensure the patient was seen in the right place at the right time. We saw a selection of these forms which included referrals for oral surgery problems, suspected mouth cancer cases, orthodontics and patients who required special care dental services as a result of physical and mental impairment. When the patient had received their treatment they would be discharged back to the practice for further follow-up and monitoring.

Consent to care and treatment

We spoke to three dentists on duty on the day of our visit. They all had a 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. We saw an example of the consent process one dentist used when providing complex care such as dental implant placement. Very detailed letters were provided to patients setting out the entire end to end process of the treatment proposed. This was then reinforced by a synopsis at the end of each section of the treatment plan in language the patient could understand to ensure the patient fully understood the treatment being proposed.

The dentists we spoke with explained how they would obtain consent from a patient who suffered with any mental impairment which may mean that they might be unable to fully understand the implications of their treatment. They explained they would involve relatives and carers to ensure the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting area and we saw doors were closed at all times patients were with dentists. Conversations between patients and dentists could not be heard from outside the rooms which protected patient's privacy. Patients clinical records were stored electronically and in paper form. Computers were password protected and regularly backed up to secure storage with paper records stored in lockable wooden filing cabinets. 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.

Involvement in decisions about care and treatment

The practice provided clear treatment plans for their patients which detailed possible management options and indicative costs. Information about NHS and private treatment costs was displayed in the waiting area. The practice website also gave details of the cost of treatment and entitlements under NHS regulations. The dentists we spoke with paid particular attention to patient involvement when drawing up individual care plans.

All of the 23 patients we asked told us the dentist was good at involving them in decisions about their care and treatment. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them. This information was recorded on the standard NHS treatment planning forms for dentistry.

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 people. We saw the practice waiting area displayed a variety of information including the opening hours, emergency 'out of hours' contact details and arrangements. The company web site also contained useful information for patients such as how to book appointments on-line and how to provide feedback about the services provided. We looked at the appointment schedules for patients and found patients were given adequate time slots for appointments of varying complexity of treatment. The dentists we spoke with said they had the clinical freedom to determine the most appropriate length of appointment.

Tackling inequity and promoting equality

The practice had equality and diversity and disability policies to support staff in understanding and meeting the needs of patients. The practice had installed a hydraulic lift to help patients with limited mobility to access the reception desk, treatment room and wheelchair accessible toilet on the ground floor. Telephone interpreter services were also available for patients whose first language was not English. One surgery was set up to treat patients in their own wheelchair who could not, or did not wish to, transfer to a dentist chair.

Access to the service

Appointments were available Monday to Friday between 8.00am and 5.30pm. Appointments could be made in person, by telephone or on-line via the practice website. We asked 26 patients if they were satisfied with the practice opening hours. Of these, 21 said yes, two told us they were neither satisfied nor dissatisfied.

The practice supported patients to attend their forthcoming appointment by having a reminder system in place. The practice had an arrangement in place with the local NHS dental commissioning team whereby 'access slots' were available for patients to obtain urgent pain relief if they did not have a regular dentist.

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. 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

The practice had a complaint policy and a procedure that set out how complaints would be addressed, who by, and the timeframes for responding. For example, a complaint would be acknowledged within three working days and a full response would be provided to the patient within 20 working days. This was seen to be followed. We saw a complaints log which listed 11 complaints received in the previous 12 months of our inspection. Complaints seen came from a variety of sources which included NHS Choices, telephone, letter and patient feedback forms. We were told all of these complaints had been resolved with a satisfactory outcome.

Information for patients about how to make a complaint was seen in the waiting areas of the practice, the practice leaflet and website. Lessons learnt and any changes implemented were shared with staff at monthly practice meetings. We asked 26 patients if they knew how to complain if they had an issue with the practice. Of these, 15 told us they would know, nine weren't sure and two did not know.

Are services well-led?

Our findings

Governance arrangements

The governance arrangements for this location consisted of a practice manager who was responsible for the day to day running of the practice. The corporate provider had in place a system of managers who provided support and leadership to the practice manager. Clinical support was provided by a clinical support manager who was a dentist working at this location who provided clinical advice and support to the other dentists and nurses working in the practice. The clinical support manager had appropriate support from a system of clinical directors operated by the company. The practice had a recruitment policy but the provider could not provide evidence to confirm all the checks required for new staff had been carried out.

Leadership, openness and transparency

We found staff to be hard working, caring towards the patients and committed to the work they did. We saw evidence from staff meetings that issues relating to complaints and compliments, practice performance including the quality of care provided was openly discussed and addressed by the whole team.

The company used a system known as 'My Reports' which detailed the performance of the dentist against the NHS commissioner's criteria for quality performance known as the vital signs report. These were freely available to each dentist at the practice via the company intranet. Dentists were able to analyse their own performance as well as being able to obtain support and guidance from the clinical support manager where there were particular difficulties.

Learning and improvement

We found there was a programme of audit taking place at the practice. Audits seen included important areas such as infection prevention and control, clinical record keeping and X-ray quality. We looked at a sample of them and they showed the practice was maintaining a consistent standard in relation to standards of patient assessment, infection control and dental radiography.

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

The practice had gathered feedback from patients through the NHS Friends and Family test, NHS Choices, My Dentist, compliments and complaints. We saw there was a robust complaint procedure in place, with details available for patients in the waiting area, practice leaflet and on the website. We reviewed complaints made to the practice over the past twelve months and found they were fully investigated with actions and outcomes documented and learning shared with staff through team meetings.

All of the staff we spoke with told us they felt included in the running of the practice. They went on to tell us how the dentists and practice management team listened to their opinions and respected their knowledge and input at meetings. 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.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the provider had not ensured that evidence was available to confirm that persons employed for the purposes of carrying on a regulated activity were of good character and that information specified in Schedule 3 was available in relation to each such person employed and such other information as appropriate. Evidence of checks missing included conduct in previous employment and DBS checks. This was in breach of regulation 19 (1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.