The Tooth Booth Group Limited

Tooth Booth Beaconsfield

Inspection Report

28 Aylesbury End
Beaconsfield
Buckinghamshire
HP9 1LW
Tel: 01494 730 940
Website: www.toothbooth.co.uk/beaconsfield.htm

Date of inspection visit: 12/05/2016
Date of publication: 25/07/2016

Overall summary

We carried out an announced comprehensive inspection on 12 May 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
Tooth Booth operates from commercial premises providing NHS and private dentistry for both adults and children. The practice is situated in Beaconsfield, Buckinghamshire.

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 has three dental treatment rooms, one of which is based on the ground floor. The practice has a separate decontamination room used for cleaning, sterilising and packing dental instruments.

The practice employs five dentists, one hygienist, three dental nurses, of which two are trainees, three reception staff and a practice manager.The practice opens Monday and Thursday between8.30am and 8pm, Tuesday, Wednesday and Friday between8.30am to 5.30pm and Saturday between 8.30am and 1pm.

There are arrangements in place to ensure patients receive urgent dental assistance when the practice is closed. This is provided by an out-of-hours on call service provided by the 111 service.

There was no registered manager at the time of our inspection at this location. We were told that the current Practice Manager was going through the CQC registration process to become the registered manager. A registered manager is a person who is registered with the Care

Summary of findings

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 16 CQC comment cards completed by patients and obtained the view of 15 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:

- We found that the practice ethos was to provide patient centred dental care in a relaxed and friendly environment.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice appeared clean.
- Infection control procedures followed published guidance.
- The practice had processes in place for safeguarding adults and children living in vulnerable circumstances.
- There was a process in place for the reporting and shared learning when untoward incidents occurred in the practice.
- 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.
- Staff we spoke were committed to providing a quality service to their patients.
- Information from 16 completed Care Quality Commission (CQC) comment cards gave us a positive picture of a friendly, caring, professional and high quality service.

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

- Ensure appropriate systems are in place to meet health and safety regulations including risk assessment for fire and general health and safety criteria and fire safety training for relevant staff.
- Ensure that a system for collating the records of training of relevant staff members is established.

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

- Review COSHH and RIDDOR policies to ensure they are practice specific.
- Produce an annual statement in relation to infection prevention control required under The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- Review the arrangements for the disposal of confidential documents to meet current legislation and guidance.
- Review the availability of a hearing loop for patients who are hard of hearing.
- Repair foot operated bin, cleaning cupboard door and air conditioning unit.
- Consider providing the hygienist with the support of an appropriately trained member of the dental team.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had arrangements in place for essential areas such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found that 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. Staff were aware of their responsibilities regarding safeguarding children and vulnerable adults.

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 focused 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. We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals. Most staff received training and development appropriate to their roles and learning needs. Staff were appropriately registered with the General Dental Council (GDC) with the exception of one member of staff and were meeting the requirements of their professional registration.

Are services caring?

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

We collected 16 completed Care Quality Commission patient comment cards and obtained the views of a further 15 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 friendliness and helpfulness of the staff and 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.

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 provided patients with written information in language they could understand and had access to telephone interpreter services when required. The practice had one ground floor treatment room and level access into the building for patients with mobility difficulties and families with prams and pushchairs.

Are services well-led?

We found 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).

The practice carried out regular clinical audits as part of a system of continuous improvement and learning. There were some clearly defined leadership roles within the practice.

Most staff received the formal 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.

Summary of findings

The practice had clinical governance and risk management structures in place but these had not always been followed to ensure the service provided was assessed and monitored effectively to improve the quality and safety of services provided. For example, a fire and health and safety assessment had not been undertaken. We also found that an annual statement in relation to infection prevention control required under The Health and Social Care Act 2008 Code of Practice about the prevention and control of infections and related guidance had not been prepared.

We found that some cleaning fluids under COSHH regulations were not stored securely and certain paper patient records, such as paper medical histories and NHS administrative forms, were stored in areas of the practice that were not secure. We pointed this out to the practice owners who remedied the record storage issue at the time of our inspection and undertook to address the cleaning fluids storage as soon as practicably possible.

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

Tooth Booth Beaconsfield

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 12 May 2016. The inspection was carried out by a CQC inspector and a dental specialist adviser.

During our inspection visit, we reviewed policy documents and staff recruitment records and spoke with nine 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

The practice had a generic policy in place describing how the practice would deal with incidents under RIDDOR (the reporting of injuries diseases and dangerous occurrences regulations) but this was not dated or specific to the practice. The practice had an incident reporting system in place when something went wrong; this system also included the reporting of minor injuries to patients and staff. We found the accident book was maintained appropriately and showed the history of minor accidents over a period of years. The practice reported that there had been no serious incidents within the last 12 months that required investigation. The practice received national patient safety alerts from their head office such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA). Where relevant these alerts were shared with all members of staff by the area manager. The practice owner explained that relevant alerts would also be discussed during staff meetings to facilitate shared learning, these meetings occurred monthly.

Reliable safety systems and processes (including safeguarding)

We spoke to a dental nurse 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 practice used a special rubber needle protector following the administration of dental local anaesthetics to prevent needle stick injuries from occurring during the recapping of the used needle. The dentists were responsible for the disposal of used sharps and needles. A practice protocol was in place 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 the lead dental nurse how they treated the use of instruments used during root canal treatment. They explained that these instruments were single patient 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). Clinical records seen where root canal treatment had been carried out confirmed that a rubber dam was used. Patients can be assured that the practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam.

The practice had appropriate arrangements in place to deal with safeguarding issues. A policy and protocol was in place for staff to refer to in relation to children and adults who may be the victim of abuse or neglect. Information was available in the practice that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. A senior dentist at the practice told us that there had been no safeguarding incidents that required further investigation by appropriate authorities in recent years. Training records available showed that three of the eight clinical staff had carried out Safeguarding Children level 2 training and two of the eight clinical staff had carried out Safeguarding Vulnerable Adults level 2 training.

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. Staff had received training in how to use this equipment. 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. The practice had access to 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 we saw were all in date and stored in a central location known to all staff. The practice held training sessions each year for the whole team so that they could maintain their competence in dealing with medical emergencies. Staff we spoke with demonstrated they knew how to respond if a person suddenly became unwell.

Are services safe?

Staff recruitment

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 five staff recruitment files and records confirmed they had been recruited in accordance with the practice's recruitment policy.

Staff recruitment records were ordered and stored securely.

Monitoring health & safety and responding to risks

The practice had some arrangements in place to monitor health and safety and deal with foreseeable emergencies although there were some shortfalls which included fire safety and general environmental health and safety. We pointed these shortfalls out to the practice owners who assured us that these shortfalls would be dealt with as soon as practically possible. We saw risk assessments for radiation and legionella and generic policies in relation to assessing risk for example for staff who were pregnant.

The practice maintained a Control of Substances Hazardous to Health (COSHH) file. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients. We found shortfalls with respect to the storage arrangements for some materials. We pointed these shortfalls out to the practice owners who undertook to address these as soon as practically possible.

Infection control

Systems were in place to reduce the risk and spread of infection within the practice. The practice had an infection control policy that was regularly reviewed. 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 exceeded. It was observed that audit of infection control processes carried out in March 2016 confirmed compliance with HTM 01 05 guidelines.

We saw that the three 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 towel dispensers in each of the treatment rooms. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

The drawers of each treatment room was inspected and these appeared 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.

The dental nurse we spoke with 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. They demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental unit water lines.

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. We saw that a Legionella risk assessment had been carried out at the practice by a competent person in 2013 and the water systems were reviewed on an annual basis thereafter by a competent person. The recommended procedures contained in the report were carried out and logged appropriately.

The practice had a separate decontamination room for instrument processing. The lead dental nurse we spoke with 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 and an ultra-sonic cleaning bath for the initial cleaning process, following inspection with an illuminated magnifier the instruments were placed in an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilised, they were pouched and stored until required. All 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. It

was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were complete and up to date. The recommended foil and protein tests for the ultra-sonic cleaning bath were carried out in accordance with current guidelines, the results of which were recorded on appropriate data sheets.

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 was in accordance with current guidelines. We noted that the kick bin pedals were broken in one of the first floor treatment rooms which could present a health and safety hazard due to protruding pieces of sharp metal. We pointed these shortfalls out to the practice owners who assured us that these shortfalls would be dealt with as soon as practically possible. The practice used an appropriate contractor to remove clinical waste from the practice. This 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.

General environmental cleaning was carried out cleaning according to a cleaning plan developed by the practice however there were shortfalls in the storage of cleaning materials and equipment. This included the cupboard door which was broken and not secure. We pointed these shortfalls out to the practice owners who assured us these would be dealt with as soon as practically possible.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the new autoclave had been checked and calibrated prior to installation and the practice compressor in May 2016. The practices' X-ray machines had been serviced and calibrated as specified under current national regulations. Portable appliance testing (PAT) had been carried out in March 2016. We found that one of the air conditioning units in the first floor treatment room was not working. We pointed this shortfall out to the practice owners who assured us this would be dealt with as soon as practically possible.

Medicines were stored securely and batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. The practice stored NHS prescription pads securely to prevent loss due to theft. A prescription log book was also maintained to account for prescriptions issued by each dentist. The practice had equipment to deal with minor first aid incidents such as minor eye problems and body fluid and mercury spillage.

Radiography (X-rays)

We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). 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. Included in the file were the three yearly maintenance logs, radiology risk assessment, quality assurance process and a copy of the local rules.

We saw that a radiological audit for each dentist had been carried out in 2016. Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured. These findings showed that practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. Training records seen confirmed all staff, where appropriate, had received training for core radiological knowledge under IRMER 2000 Regulations.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We spoke with two dentists on the day of our visit. They explained how they carried out consultations, assessments and treatment which followed recognised general professional guidelines. Dentists described 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 the clinical assessment the diagnosis was then 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 oral hygiene instruction 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 presented to us by the dentists demonstrated 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. The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums. These were carried out where appropriate during a dental health assessment.

Health promotion & prevention

The practice focused on the prevention of dental disease and the maintenance of good oral health. To facilitate this aim the practice appointed a dental hygienist to work alongside of the dentists in delivering preventative dental care. The dentists we spoke with explained that children at high risk of tooth decay were identified and were offered fluoride varnish applications to keep their teeth in a healthy condition. They also placed fissure sealants (a special plastic coating on the biting surfaces of permanent back teeth in children) who were particularly vulnerable to dental decay. Other advice included tooth brushing techniques explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. Dental care records we observed demonstrated that the dentist had given oral health advice to patients. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area.

Staffing

We observed a friendly atmosphere at the practice. All of the patients we asked told us they felt there was enough staff working at the practice. Staff we spoke with told us the staffing levels were suitable for the size of the service. Staff we spoke with told us they felt supported by the practice manager and owner.

The practice employed five dentists, one hygienist, three dental nurses, of which two were trainees, three reception staff and a practice manager. All but one of the clinical staff had current registration with their professional body, the General Dental Council. This member of staff was a newly qualified dental nurse. We were told their application for registration was in progress and provided evidence to confirm this.

Staff told us they felt they had acquired the necessary skills to carry out their role and were encouraged to progress. However, when asked, the practice manager provided evidence to confirm that four out of eight clinical staff received infection control training and safeguarding training. They also told us that fire safety training had not been undertaken by any staff.

There was a structured induction programme in place for new members of staff.

We were told the dental hygienists worked without chair side 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, special care dental services and orthodontic providers.

Consent to care and treatment

Both dentists we spoke with explained how they implemented the principles of informed consent; they had a very clear understanding of consent issues. The dentists 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.

The dentists went onto explain how they would obtain consent from a patient who suffered with any mental impairment that may mean that 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. They 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. Staff were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The treatment rooms and reception desk were situated away from the main waiting area and we saw that treatment room 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 patients' privacy. Patients' clinical records were stored electronically and in paper form. Computers were password protected however we did find that large numbers of certain patient records, such as paper medical histories and NHS administrative forms, were stored in areas of the practice which were not secured for example under the reception desk. We pointed this out to the practice owners who remedied this at the time of our inspection. 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 16 completed CQC patient comment cards and obtained the views of 15 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 that treatment was explained clearly and the staff were caring and put them at ease. They also said reception staff were always helpful and efficient. During the inspection staff in the reception area were polite and helpful towards patients and the general atmosphere was welcoming and friendly.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to patients that detailed possible treatment options and indicative costs. Posters detailing NHS and private charges were displayed in the waiting area. The dentists we spoke with paid particular attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the dentist recorded the information they had provided to patients about their treatment and the options open to them. This included information on the standard NHS treatment planning forms for dentistry where applicable.

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. The practice waiting area displayed a variety of information. This explained opening hours, emergency 'out of hours' contact details and arrangements and how to make a complaint. Appointment diaries were not overbooked and that this provided capacity each day for patients with dental pain to be fitted into urgent slots for each dentist. The dentist decided how long a patients appointment needed to be and took into account any special circumstances such as whether a patient was very nervous, had a disability and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to help prevent inequity for patients that experienced limited mobility or other issues that hamper them from accessing services. The practice used a translation service, which they arranged if it was clear that a patient had difficulty in understanding information about their treatment. To improve access, the practice had level access and treatment rooms on the ground floor for those patients with a mobility impairments as well as parents and carers using prams and pushchairs. Access to the practice for wheelchair users was via a back door where a portable ramp was available. We spoke to the practice about the possibility of a patient, that required use of the portable ramp, arriving at the back door without the knowledge of the reception staff. The practice owner undertook to arrange a bell system to alert staff of the patient's need for assistance.

Access to the service

Tooth Booth offered NHS and private dental care services for adults and children on Monday and Thursday between 8.30am and 8pm, Tuesday, Wednesday and Friday between 8.30am to 5.30pm and Saturday between 8.30am and 1pm.

Appointments could be made in person, via the practice website or by telephone.

We asked 15 patients if they were satisfied with the practices' opening hours.All but one said they were whilst one patient did not have an opinion either way.

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 complaints 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 two days and a full response would be provided to the patient within 28 days. The practice listed three complaints received over the previous year which records confirmed had been concluded satisfactorily.

Information for patients about how to make a complaint was seen in the patient leaflet and on display in the practice waiting room. We asked 15 patients if they knew how to make a complaint if they had an issue and 12 said yes but three were not sure.

Are services well-led?

Our findings

Governance arrangements

The governance arrangements for this location consisted of the practice owners and a practice manager who were responsible for the day to day running of the practice.

The practice maintained a system of policies and procedures although there were shortfalls. This included not having in place a current fire risk assessment or a general health and safety risk assessment. Fire safety shortfalls included the lack of staff training.

We found that certain patient records and substances under COSHH regulations were not securely stored. This shortfall was remedied at the time of our visit. All of the staff we spoke with were aware of the policies and how to access them. We noted management policies and procedures were generally kept under review by the practice manager on a regular basis however there were a number of policies such as those pertaining to RIDDOR and COSHH which were generic and not practice specific or dated.

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. Staff said they felt comfortable about raising concerns with the dentists, practice manager or owner of the practice. They felt they were listened to and responded to when they did raise a concern.

Learning and improvement

There was a system to monitor the quality of the service. The practice manager showed us they had a programme of clinical and non-clinical audits in place. These included audits of record keeping, radiographs and the cleanliness of the environment.

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. We were told staff working at the practice maintained their continuing professional development (CPD) as required by the General Dental Council (GDC). Evidence of training undertaken was not coordinated by the practice manager which meant they could not satisfy themselves that staff were carrying out recommended training. An example of this being infection control and safeguarding training.

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

The practice gathered feedback from patients through feedback cards, surveys, compliments and complaints. For example, as a result of patient feedback the waiting room had been refurbished.

There was a robust complaints procedure in place, with details available for patients in the waiting area. We were told there had not been any complaints made since 2014.

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 management listened to their opinions and respected their knowledge and input at meetings. For example, one staff member requested flexible working to allow for travelling to work by public transport. 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 17 HSCA (RA) Regulations 2014 Good governance We found that the provider did not have effective systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. • A risk assessment for fire safety and health and safety had not been carried out. We found the provider did not have effective systems in place to maintain securely such records are necessary to be kept in relation to persons employed in the carrying on of the regulated activity. This was in breach of regulation 17 (1)(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. • The provider was unable to demonstrate that relevant training had been undertaken by all relevant staff.