Kleibercare Limited

Wordsworth House Dental Practice

Inspection Report

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Overall summary

The inspection took place on 28 January 2015 as part of our national programme of comprehensive inspections.

Wordsworth House Dental Practice provides private dental treatment to patients of all ages. The practice provides general dental services and specialist treatments such as implants. The practice team consists of the principal dentist, who is the registered manager and a part time dental therapist. The clinical team are supported by a dental nurse, a receptionist and a treatment coordinator. The practice manager fulfils the role of treatment coordinator and works at the practice part time to support the registered manager with the day to day running of the service.

The practice is housed in a converted three storey residential property. There are two treatment rooms one on the ground floor and one on the first floor. The reception and waiting area are on the ground floor with a dedicated decontamination room on the second floor.

During our inspection we spoke with two patients and reviewed one comment card, which a patient had completed in the week before our visit. Patients commented positively about the care and treatment they had received and the friendly professionalism of staff.

Our key findings were:

- All staff were kind and caring in the way they dealt with patients
- There was a regular schedule of staff meetings which included staff training.
- Patients were able to make routine and emergency appointments and patients were seen the same day if they had a dental emergency.
- There was clear leadership of the practice and staff told us they felt well supported and comfortable to raise concerns or make suggestions.

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

- Ensure infection prevention and control procedures are audited every six months to assess compliance with Department of Health guidance and take action when shortfalls are identified.
- Update the Infection Control Policy to provide staff with information which reflects current guidance.
- Provide a suitable decontamination area and equipment which meets the essential standards in the Department of Health guidance HTM01-05, to include providing staff with guidance and facilities for carrying out hand hygiene during the decontamination process.

Summary of findings

You can see full details of the regulations not being met at the end of this report

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

- Ensure all policies are dated and regularly reviewed to reflect current practices and procedures.
- Ensure the Health and Safety Executive are notified of the practice's use of ionising radiation to conform with the Ionising Radiation (Medical Exposure) Regulations.
- Have available a copy of local rules with each X-ray set to give easily accessible guidance to staff.
- Ensure an automated external defibrillator (AED) is available as part of the emergency equipment kept at the practice.

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?

All recommended emergency medicines were available and staff were trained to deal with such emergencies.

All equipment at the practice was regularly maintained, tested and monitored for safety and effectiveness. There were procedures in place for the decontamination and sterilising of instruments however the layout of the dedicated decontamination room and the facilities available did not follow national guidance. The decontamination process had not been regularly audited to identify the shortfalls and to provide an action plan to meet compliance with the department of health guidance.

Are services effective?

The practice ensured that patients were given sufficient information about their proposed treatment to enable them to give informed consent.

Dental care records showed a systematic and structured approach to assessing and planning patient care and treatment. Appropriate diagnostic tests and examinations were carried out and recorded. Patients' medical histories were taken and regularly updated. The dentist was aware of any medical issues which could affect the planning of a patient's treatment. Patients' smoking status was included in their consent to treatment to ensure they were aware of the implications of smoking on the success of some treatments.

Health education for patients was provided by the dentist and dental therapist. They provided patients with advice to improve and maintain good oral health.

Are services caring?

The practice was sensitive to the needs of their patients. Patients commented positively on the caring compassionate staff, describing them as friendly, reassuring and professional.

Patients felt listened to by all staff and were given appropriate information and support regarding their care or treatment. They felt their dentist explained the treatment they needed in a way they could understand. The practice had a treatment coordinator who was able to spend time with patients to ensure they were fully informed about their options for treatment.

Are services responsive to people's needs?

The practice offered same day appointments for any patient in an emergency.

Appointment times varied in length according to the proposed treatment and to ensure patients and staff were not rushed.

The practice leaflet advertised flexible opening hours. We were told that the practice on occasions would open early or work late to meet the needs of patients who could not attend during the core opening hours.

Staff told us all patients who requested an urgent appointment would be seen within 24 hours. The practice had a 'never say no' policy. They would see any patient in pain, extending their working day if necessary.

Are services well-led?

There were systems in place to maintain clinical governance. The practice audited aspects of the service to monitor the quality of the service and to identify areas for improvement.

Summary of findings

There was a structured programme of weekly staff meetings with a rolling programme of topics which included training and opportunities for staff to remain informed about changes to the practice and plans for the future.

Staff felt supported and empowered to make suggestions for the improvement of the practice. There was a culture of openness and transparency. Staff at the practice were supported to complete training for the benefit of the patients and for their continuous professional development.

Wordsworth House Dental Practice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by the CQC.

- This inspection was carried out on 28 January 2015 by an inspector from the Care Quality Commission.
- Prior to the inspection we reviewed information that we held about the provider. We also viewed information that we asked the provider to send us in advance of the inspection.
- During the inspection we spoke with the principal dentist who is also the registered manager, a dental nurse, the practice receptionist and the practice manager who was also the treatment coordinator.
- We observed staff interaction with patients and looked around the premises and the treatment rooms.
- We spoke with two patients and reviewed one comment card to obtain the views of patients about the staff and the services provided.
- We reviewed a range of policies and procedures and other documents, including dental care records.

We informed the local Healthwatch that we were inspecting the practice; we did not receive any information of note from them.

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

Learning and improvement from incidents

There was a system for recording incidents and accidents with guidance for how they should be investigated and reflected upon by the dental practice. Staff told us they were confident about the need for reporting incidents and accidents. The practice had a health and safety policy which outlined responsibilities in Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). There were no reported incidents and staff told us as they were such a small team; they often informally discussed ways in which their service could be improved. There had not been any incidents for the practice to learn from at this time.

Reliable safety systems and processes (including safeguarding)

Staff told us they had completed training in safeguarding children and vulnerable adults. Staff were clear about their responsibilities to report any concerns relating to children or vulnerable adults. The practice had a child protection policy statement which had been signed by some staff however it was recorded that it was due to be reviewed in April 2014, this review had not taken place. The practice policy provided staff with the contact details should they need to raise any concerns about possible abuse of a vulnerable adult or child. The registered manager was the lead for safeguarding and all staff told us they would go directly to them if they had any concerns.

The dentist at the practice ensured that clinical practices reflected current guidance in relation to safety. For example, the dentist routinely used a rubber dam for certain procedures to ensure their patents safety and to increase the effectiveness of treatment. (Rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth).

Infection control

In November 2009, and updated in March 2013, the Department of Health published a document called 'Health Technical Memorandum 01-05 Decontamination in primary care dental practices' (HTM 01-05). This document describes in detail the processes and practices essential to prevent the transmission of infections and promote clean safe care. It is used by dental practices to guide them to deliver an expected standard of decontamination.

We saw that at this practice there were systems in place to reduce the risk and spread of infection. During our visit we spoke with the dental nurse, who had recently been appointed the lead for infection prevention and control. They were able to demonstrate they were aware of the safe practices required to meet the essential standards of HTM 01-05. They were aware of the need for personal protective equipment (PPE). We observed PPE being used appropriately within the surgery. However we noted that there were no heavy duty gloves available for staff in the decontamination room. These would provide staff with some protection from sharps injuries while cleaning instruments and equipment. The dental nurse was able to describe the decontamination procedures in operation within the surgery. They ensured that clinical areas were appropriately cleaned between patients and explained the clean and dirty areas in the surgery. The practice used single use equipment wherever possible.

The dedicated decontamination room had been set up to separate the decontamination of instruments from the patient treatment areas. The equipment was installed to enable staff to follow a dirty to clean workflow so that when instruments had been cleaned they would not be re-contaminated.

The room did not provide a tidy working environment where all areas could be wiped clean and contained items not suitable for storage in a decontamination room. For example a rattan chair was in the room and the window was covered in net curtaining. The decontamination room contained items not required and not suitable for storage in a decontamination room. Flooring in the ground floor surgery did not conform to the department of health guidance. The design of flooring could not be easily cleaned; it did not have coving or sealant between the floor and the wall to prevent the accumulation of dust and dirt in corners or crevices.

The decontamination room had one sink for the washing and rinsing of instruments. There were no removable bowls available to separate these processes. The decontamination room did not have a hand wash sink. The nearest sink was in the staff kitchen next door or in the

treatment room on the floor below. There was no written protocol for how and where staff could wash their hands or carry out hand hygiene between each stage of instrument decontamination.

The practice had carried out their own risk assessment in relation to Legionella (bacteria which can contaminate water systems in buildings) and had developed a testing and monitoring protocol. The practice had tested the water in each of the treatment rooms for the presence of Legionella and had a weekly log to record the flushing of little used water outlets. Dental unit water lines were maintained and tested in accordance with current guidelines. This included the flushing of dental unit water lines at the beginning and end of the day and between patients and monitoring biofilm growth with a dip slide test.

The practice had an infection control policy and we saw an audit which we were told had been carried out recently. The audit was not dated and there was no recorded action plan to improve the decontamination process and procedures. Shortfalls or areas they could improve and work towards best practice had not been identified. There was no record of previous audits of the decontamination process having taken place. It is a recommendation of the HTM 01-05 that these audits are completed by each dental practice every six months.

The practice had an infection control policy which covered many aspects of infection prevention and control and decontamination of instruments. Parts of the policy had not been completed such as to state the names and job role of the responsible personnel. Other parts of the policy did not reflect current guidance on safe and effective procedures, for example it directed staff to rinse instruments under running water which poses a risk of aerosol contamination. The protocol posted in the decontamination room correctly directed staff to rinse instruments in a clean tub in the sink. There was no clean tub available for staff. The protocol for the safe storage of sterilised instruments did not reflect the changes made to HTM 01-05 guidance in 2013.

Cleaning equipment at the practice followed the national guidelines for colour coding. This meant that equipment could be identified for use in different areas of the practice. Equipment used in high risk areas was stored separately from that used for general and non-clinical areas.

Equipment and medicines

There was a system in place to ensure that all equipment was regularly maintained and serviced. This included equipment such as autoclaves (equipment used in the sterilising of instruments), the oxygen cylinders and X-ray machines. Equipment records showed servicing; maintenance and validation had taken place in accordance with manufacturer's instructions.

The practice kept a supply of emergency medicines which were found to be in date and monitored regularly by staff to ensure they remained safe to use.

The patient records we reviewed showed that the prescribing of medicines was recorded. Records showed that quantities, batch numbers and expiry dates of local anaesthetics were always recorded. Medicines kept at the practice were stored securely.

Monitoring health & safety and responding to risks

The practice had carried out a practice risk assessment on 12 January 2015. This had included for example a risk assessment in relation to fire safety, equipment, radiation and electrical equipment. The practice manager had completed a walk through risk assessment of the practice building to identify any hazards. Posters in staff areas gave guidance about evacuation procedures and actions in case of fire.

Staff were aware of their responsibilities in relation to the control of substances hazardous to health (COSHH). There was a prominently displayed poster in the decontamination room as a reminder of the significance of COSHH symbols.

The practice had minimised risks in relation to used sharps (needles and other sharp objects which may be contaminated) by ensuring sharps bins, although not secured to the wall, were stored appropriately in the treatment room. Staff and patients were protected from these items being accidentally knocked over.

Medical emergencies

There were arrangements in place to deal with foreseeable emergencies. We saw that the practice had emergency medicines and oxygen available which may be needed to deal with any medical emergencies should they arise. There was suitable equipment available for dealing with medical emergencies. The emergency equipment did not include an automatic external defibrillator (AED), a

portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. An AED is listed as a minimum requirement by the Resuscitation Council (UK). The registered manager told us the practice had discussed the requirement for an AED at recent medical emergencies training and had decided that the response time for an ambulance was short enough to be able to justify not keeping one on site. This risk assessment and discussion had not been formally recorded to support this decision.

Checks were made of the emergency medicines and oxygen to ensure they were in date and ready for use should they be needed, and records kept. All staff had taken part in annual basic life support training provided by an external company. The training had included medical emergency scenarios which they may encounter. Annual cardiopulmonary resuscitation (CPR) is a requirement of all staff registered with the General Dental Council (GDC) as part of their continuing professional development.

Staff recruitment

We were told by the practice manager that the staff files contained evidence of the checks they carried out to ensure staff working at the practice were suitable for their role. However these personnel files were kept at the provider's other practice and were not available for us at this inspection.

We were provided with a copy of the employee handbook and contracts between the practice and their clinical staff. The registered manager and practice manager explained how they had ensured they had satisfactory documentary evidence of the suitability of all the staff.

We were unable to check if the provider kept evidence of continuous employment with an explanation of any gaps although this check formed part of the interview process which we saw copies of. The employee handbook detailed that criminal records checks by the disclosure and barring service (DBS) were required for staff according to their role. The registered manager told us they did not have a copy of the DBS check for the dental therapist which another provider had carried out, however gave us assurances that they would obtain a copy for their records and took action during the inspection to obtain a copy.

Radiography (X-rays)

The practice radiation protection file contained information required to meet the requirements of the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R 2000) and the Ionising Radiation Regulations 1999(IRR99). This file contained details of the radiation protection advisor, the radiation protection supervisor, evidence of the maintenance and critical testing of the X-ray set. There was a copy of the local rules in the file which was in the process of updating but these were not displayed beside the X-ray set. The local rules for the safe use of ionising radiation were not dated and contained conflicting information to the information contained elsewhere in the radiation protection file. Local rules should be displayed to provide staff with guidance on the safe use of radiography within the practice. The radiation protection file did not contain a copy of the provider's notification to the Health and Safety Executive (HSE) of their use of ionising radiation.

The dentist continually assessed the quality of X-ray images. The dentist graded the radiographs (X-rays) they took to monitor their quality to ensure they did not have to be repeated, which could pose a risk to patients. The practice used digital X-rays and aiming devices (these are devices used to ensure the X-ray film and machine are correctly placed) which improved the quality of images which meant the number that had to be retaken was minimal. The quality of the X-rays were within the recommended range so there were no recorded actions required to improve quality.

We looked at a sample of dental care records which clearly documented when X-rays had been taken. When X-rays were taken the records showed the reason why they were necessary and recorded any findings. Patients told us that the dentist always explained treatment options to them which included why X-rays were required and what they showed.

Are services effective?

(for example, treatment is effective)

Our findings

Consent to care and treatment

The practice ensured that patients were given sufficient information about their proposed treatment to enable them to give informed consent. The dentist and treatment coordinator told us how they explained treatment options with their patients including the risks and benefits of each option. We saw that these discussions were recorded in dental care records and that patients were provided with a written treatment plan which ensured they were aware of the financial and time commitment of their treatment. Patients were asked to sign a copy of the treatment plan to confirm their understanding and to consent to the proposed treatment. Signed consent forms were scanned into the electronic record system.

Patients told us they felt fully informed about their treatment and they were given time to consider their options before giving their consent to treatment.

We did not see a record that staff had attended training in relation to the Mental Capacity Act 2005. However staff were clear about how they would deal with a situation, should it arise, if they had reason to believe a person lacked the capacity to consent to dental treatment. They were aware of who to consult for support and advice.

Monitoring and improving outcomes for patients

Patients' care and treatment was assessed, planned and delivered according to their individual need. We looked at a selection of dental care records which showed a systematic and structured approach to assessing and planning care and treatment.

All patients had an up to date medical history completed when they attended for examination, these were updated at each visit. Patients told us that the dentist always asked if there had been any changes to medical conditions or any medication they were taking. This information was recorded in the dental care record with any relevant medical condition highlighted to the dentist by symbols or alerts on the electronic care record. The dentist was aware of any medical issues which could affect the planning of a patient's treatment. Patients' smoking status was included in their consent to treatment to ensure they were aware of the implications of smoking on the success of some treatments.

Dental care records enabled us to see the information recorded for each examination. The dentist kept a record of their examination of soft tissues, teeth and other relevant observations. We saw that checks of patients gum health was followed up with more in depth assessments for those who would require specialist treatment. Diagnostic tests, such as radiographs (x-rays), were carried out if they were clinically necessary. The results were discussed with the patient. Patients told us they were aware of the dentist carrying out an examination of their whole mouth. They said that the dentist explained what they were doing and why.

Patients were referred by the dentist to the dental therapist for treatment and oral health education. The dentist ensured they provided sufficient direction and information for the dental therapist and recorded this in the patients' dental care records.

The principal dentist discussed with us the audit they had carried out to assess the effectiveness of the treatment they provided. This included an audit into the type of filling materials used to reduce post treatment sensitivity. They had also carried out an audit into the success rate of implants for controlled and uncontrolled diabetic patients and for smokers. These audits had led to a change in the filling materials used and also to help inform patients of the success rate of their treatment.

Working with other services

The practice referred patients for secondary (hospital) care when necessary, for example for assessment or treatment by oral surgeons. The dentist explained the system and route they would follow for urgent referrals if they detected any problems during the examination of a patient's soft tissues.

The provider had another practice where dentists with specialist skills worked. Patients were referred when necessary to ensure they were treated by the dentist most suitably qualified or skilled to meet their needs. The dentist at this practice treated patients on referral from other dentists for implants or prosthodontics (improving appearance by replacing missing or deficient teeth).

Health promotion & prevention

A dental therapist worked at the practice on a part time basis. The dentist and dental therapist provided patients

Are services effective?

(for example, treatment is effective)

with advice to improve and maintain good oral health. Details of discussions between the clinician and their patient were recorded which included diet advice, the use of fluoride paste and rinses and smoking cessation advice.

The dental therapist focused on treating gum disease and giving advice on the prevention of decay and gum disease including advice on tooth brushing techniques and oral hygiene products. There was some information available for patients about oral health on the practice website and information leaflets were given out by staff.

Staffing

The practice had systems in place to support staff to be suitably skilled to meet patients' needs. Records showed staff were up to date with their continuing professional development. (All people registered with the General Dental Council (GDC) have to carry out a specified number of hours of continuing professional development (CPD) to maintain their registration.)

Staff told us that they were supported by the practice to gain further relevant qualifications and had been encouraged to do so. There was a system of staff appraisals which were used to monitor staff performance and to identify training needs. This gave staff protected time to discuss their employment and personal development needs.

Staffing levels were monitored and staff absences planned for to ensure the service was uninterrupted. Staff were required at times to provide cover for their colleagues at the provider's other practice and nursing and reception staff from the sister practice provided cover when required at Wordsworth House. We were told that there were no instances of the dentist working without appropriate support from a dental nurse and the dental therapist was appropriately supported while carrying out patient treatment.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

During and our visit we spoke with patients about their care and treatment, we also reviewed a comment card. Patients commented positively on the caring staff, describing them as friendly, reassuring and professional.

Patients told us they felt listened to by all staff. We observed reception staff interacting with patients before and after their treatment and speaking with patients on the telephone. Although we were able to hear appointment arrangements being made we did not hear any personal information discussed. Reception staff were polite and friendly.

On the day of our visit one dentist was working at the practice. All treatment was carried out with the treatment room doors closed. Patients' privacy and confidentiality was maintained.

Involvement in decisions about care and treatment

Patients who use the service were given appropriate information and support regarding their care or treatment.

Patients told us that the dentist discussed the treatment options that were available to them. They felt that the dentist explained the treatment they needed in a way they could understand. They told us they understood the risks and benefits of each option. Patients were given written treatment plans which documented the proposed treatment and related costs.

New patients were also asked to complete a personal assessment of their oral health and appearance including a smile analysis which they discussed with the treatment coordinator before meeting the dentist. This gave the dentist information about what the patient wished to achieve or any concerns they may have. Following their examination patients they were able to spend more time with the patient coordinator to ensure they understood their treatment options.

We saw from dental care records the dentist had documented conversations with their patient when treatment options had been decided. Records showed that, when necessary, patients had been given relevant information including the risks and benefits of complex treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patient's needs

The practice provided general dentistry as well as specialist treatments. Patients were informed of the treatments available through the practice website and by their initial consultation at the practice. Specialist treatment was provided by staff with the appropriate qualifications and experience. Appointment times varied in length according to the proposed treatment and to ensure patients and staff were not rushed. The dentist was supported by a dental therapist who provided general conservative dentistry and met the needs of those patients who needed treatment and support to maintain good oral health.

The practice had responded to the needs of those patients who found dental treatment stressful. Some patients were provided with sedation for their treatment. This was planned in advance and the practice arranged for a sedationist to attend to carry out the sedation. The practice had a sedation protocol to ensure the sedationist was supported appropriately and that patients were monitored by the sedationist until completely recovered. The visiting sedationist was responsible for providing the medicines and monitoring equipment required for the procedure.

This practice provided treatment privately; there was no provision for treatment on the NHS. The practice had developed a number of payment options to meet the needs of those patients who preferred to spread the cost of their treatment.

Tackling inequity and promoting equality

There was a policy on equal opportunities which was available to staff in the employee handbook. The aim of the policy was to ensure that no member of staff was discriminated against either directly or indirectly, for example; on the grounds of age, disability, race, religion or gender.

The dentist was able to describe the treatment of one of their patients with a learning disability, how appointment times were altered and extended to allow time to build a rapport and acclimatize the patient to their surroundings before commencing treatment.

The practice was not accessible to patients who had mobility difficulties. The practice facilities were on the ground and first floor of the building. Access to the building was up a number of steps and once inside there was a step down into the reception area. The waiting room, one treatment room and toilets were on the ground floor. The practice made arrangements to see all patients who could not manage a full flight of stairs in the ground floor treatment room. New patients were made aware of access limitations if they contacted the practice by telephone. The practice was able to offer treatment at their sister practice which, we were told, was fully accessible to patients.

Access to the service

The practice leaflet advertised flexible opening hours. We were told that the practice on occasions would open early or work late to meet the needs of patients who could not attend during the core opening hours.

Opening hours varied each day Monday 10am – 6pm, Tuesday 9 am – 5pm, Wednesday 9am – 6pm and Friday 8am – 5pm. Appointments were available Mondays Wednesdays, Fridays and alternate Tuesdays. Outside these hours patients were directed to the provider's other practice approximately 30 miles away.

Staff told us all patients who requested an urgent appointment would be seen within 24 hours. The practice had a 'never say no' policy. They would see any patient in pain, extending their working day if necessary.

Concerns & complaints

The practice had a complaints handling procedure and details of how to handle complaints were also provided for staff in the employee handbook. This provided staff with guidance about how to handle a complaint. Staff told us how they would raise any comments or concerns immediately with the dentist or the practice manager, to ensure these were responded to.

We looked at the practice procedure for acknowledging, recording; investigating and responding to complaints, concerns and suggestions should they be made by patients. The summary of complaints and concerns showed that the practice had responded to patients and resolved the complaint. They recorded any changes made to the practice as a result, for example the dental therapist and dentist increased their hours at the practice to improve the choice of appointments for patients.

Information for patients about how to raise a concern or make a complaint, titled 'The patient grievance procedure', was posted on the wall in the reception area. The practice website and leaflet did not offer patients advice about how to raise a concern or the procedure for making a complaint.

Are services well-led?

Our findings

Leadership, openness and transparency

There was clear leadership of the practice. The principal dentist was the registered manager and provided clinical leadership to all staff. The registered manager delegated responsibility for human resources and policies and procedures to the practice manager. Policies and procedures were in place to support the safe running of the service; however these were not all dated so it was not clear if they had been reviewed and updated or if they reflected current practice. For example, the local rules for the safe use of ionising radiation were not dated and contained conflicting information to the information contained in the radiation protection file. The registered manager and practice manager had also delegated lead roles, for example, infection control to suitably qualified and experienced members of staff.

Staff told us there was an open culture at the practice and they felt valued and well supported. They told us that the registered manager was very approachable. There were informal and formal arrangements for sharing information across the practice including general discussions amongst the small staff team at lunchtime or other break times.

A system of formal weekly team meetings was in place. The meetings were structured to ensure staff were informed about the practice. Each week there was a rolling programme of topics for example, clinical discussion, a presentation by a member of staff, finance and referrals or complex cases.

Meetings were also held with the wider staff group from the provider's other practice to ensure the practices did not work in isolation and the teams worked together. For example a full day, full staff meeting had been held in January 2015 when items for discussion had included; job roles, clinical protocols and the three year vision for the practices.

Staff told us the system of staff meetings and the ethos of continual improvement within the practice helped them keep up to date with new developments, to make suggestions and to provide feedback to the registered manager.

Governance arrangements

The registered manager was responsible for the day to day running of the service. They had along with the practice manager put systems in place to monitor the quality of the service. These were used to make improvements to the service. The practice manager led on the individual aspects of governance such as complaints and risk management. The registered manager was responsible for clinical governance and had assessed and monitored the quality of clinical practice to improve outcomes for patients.

Audits had been carried out to monitor the quality of the service and to identify if there were any areas for improvement, for example through an audit of their X-rays, infection control procedures, an implant audit and an audit on filling materials.

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

Patients who use the service were offered a number of ways of providing feedback about the service. There were patient feedback forms available in the waiting room. There was a comments book but no patients had written in it for a number of years. The practice had devised a patient satisfaction survey, however at the time of our inspection this had had not been used.

Staff told us they were always involved in discussions about changes to the practice and were able to make suggestions for improvements at any time. Staff meetings were held weekly. These meetings were recorded and gave all staff the opportunity to make suggestions for improvements to the practice.

Management lead through learning and improvement

Staff told us they had good access to training and the practice monitored staff training to ensure essential training was completed each year. Staff working at the practice were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC). It is a requirement of the GDC that all people registered with them complete a specified number of hours of CPD, including training in medical emergencies, to maintain their registration. Staff training also formed part of the programme of weekly staff meetings and full staff meetings held with the provider's other 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 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not ensured that people who use services and persons employed were protected against identifiable risks of acquiring a health associated infection. Regulation 12 (2)(h) How the regulation was not being met: The facilities used for the decontamination of instruments were not provided in accordance with the guidance from the Department of Health HTM 01-05 second edition March 2013. The infection control policy did not reflect current working practices and infection control procedures had not been regularly audited. This was a breach of Regulation 12 (1) (a)(b) (2) (a)(c)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 (2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.