Dominus Et Al Limited

Welton Dental Care

Inspection Report

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Overall summary

We carried out this announced inspection on 9 September 2019 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

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 form the framework for the areas we look at during the inspection.

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Welton Dental Care is in Welton, a village in the West Lindsey district of Lincolnshire. It provides private dental treatment to adults and children.

There is level access for people who use wheelchairs and those with pushchairs with use of a portable ramp. There are no patient car parking facilities on site, but those with wheelchairs and mobility problems can be allocated a parking space in a private car park adjacent to the premises. There is free car parking outside the practice and within short distance of the premises.

The dental team includes one dentist, two dental nurses (one more dental nurse is in the process of being

Summary of findings

recruited), one dental hygienist and a practice manager. Dental nurses share receptionist duties. The practice has two treatment rooms. One is on the ground floor. There is also a separate decontamination room.

The practice is owned by a company and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at Welton Dental Care is the principal dentist.

On the day of inspection, we collected 47 CQC comment cards filled in by patients.

During the inspection we spoke with one dentist, two dental nurses and the practice manager. We looked at practice policies and procedures, patient feedback and other records about how the service is managed.

The practice is open: Monday to Thursday 9am to 5:30pm.

Our key findings were:

- The practice appeared clean and well maintained.
- The provider had infection control procedures which reflected published guidance.
- Staff knew how to deal with emergencies. Appropriate medicines and most life-saving equipment were available, except for a child self-inflating bag with reservoir and not all the sizes of clear face masks for self-inflating bag were held. An order was placed after the day to obtain the items.
- The provider had systems to help them manage most risks to patients and staff. We noted some areas that required review, such as a risk assessment for staff whose hepatitis B immunity levels were not known and a lone worker risk assessment.
- The provider had suitable safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider had not implemented a recruitment policy but had thorough staff recruitment procedures.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.
- The provider had taken ownership of the practice in 2018. There was evidence of effective leadership. They were in the process of developing a culture of continuous improvement.
- Staff felt involved and supported and worked well as a team.
- The provider asked staff and patients for feedback about the services they provided.
- The provider had systems to deal with complaints.
- The provider had suitable information governance arrangements.

There were areas where the provider could make improvements. They should:

- Review guidance regarding basic periodontal examination (BPE) from the British Society of Periodontology, when treating younger children.
- Ensure that X-ray equipment is fitted with rectangular collimation to reduce exposure to patients.
- Improve the practice's risk management systems for monitoring and mitigating the various risks arising from the undertaking of the regulated activities.
- Take action to ensure audits of radiography and infection prevention and control are undertaken at regular intervals to improve the quality of the service. The practice should also ensure that, where appropriate, audits have documented learning points and the resulting improvements can be demonstrated.
- Improve the practice's arrangements for ensuring good governance and leadership are sustained in the longer term.

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?	**No action** 
Are services effective?	**No action** 
Are services caring?	**No action** 
Are services responsive to people's needs?	**No action** 
Are services well-led?	**No action** 

Are services safe?

Our findings

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

Safety systems and processes, including staff recruitment, equipment and premises and radiography (X-rays)

Staff had systems to keep patients safe.

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. The lead for safeguarding was the principal dentist.

We saw evidence that staff received safeguarding training, although the hygienist did not have the level of training completed on their certificate. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns.

The provider had a system to highlight vulnerable patients and patients who required other support such as with mobility or communication within dental care records. Alerts could be included on patients' records.

The provider had a whistleblowing policy which was combined with the Duty of Candour policy. This included an external organisation contact details for reporting concerns. Staff said they felt confident they could raise concerns without fear of recrimination.

The dentist used dental dams in line with guidance from the British Endodontic Society when providing root canal treatment.

The provider had a business continuity plan describing how they would deal with events that could disrupt the normal running of the practice. The plan included contact details for other practices that could be used in the event of the premises becoming un-useable.

The provider did not have a recruitment policy. Processes were however established regarding checks to be completed for new staff, to ensure they reflected the relevant legislation. We looked at three staff recruitment records to check compliance. Required documentation was held. Following the inspection, the practice manager informed us that a policy was in the process of being implemented.

We noted that clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover.

Staff ensured that equipment and most facilities were safe. We noted that five yearly fixed wiring testing required completion. We saw a certificate for electrical installation dated February 2013 when new wiring was installed. Following our inspection, testing was completed and found to be satisfactory.

Equipment was maintained according to manufacturers' instructions and gas safety testing was undertaken annually.

Records showed that fire detection and firefighting equipment were tested and serviced. Fire extinguishers were overdue for annual servicing as this was last completed in May 2018. The practice manager told us this had been an oversight. Following our visit, we were informed that a new service contract had been agreed with another provider and new extinguishers had been fitted.

The practice had most arrangements to ensure the safety of the X-ray equipment, although we noted that a rectangular collimator had not been fitted to an X-ray unit. The radiation protection file required review as it did not include all up to date or completed information such as the local rules, employer's procedures and operating protocols. Following our inspection, we noted that action had been taken and the provider had sought external specialist support to assist them.

We saw evidence that the dentists justified, graded and reported on most of the radiographs they took, from a small sample of records we viewed.

The current provider had taken ownership of the practice in 2018. One radiography audit had been completed within this time. The provider had identified deficiencies in the audit process which had impacted upon the ability to obtain useful data for analysis. Staff were planning to re-audit this area in 2020, but following discussions held on the day of our inspection, the provider planned to re-audit within a shorter time frame.

Are services safe?

We were informed that clinical staff completed continuing professional development (CPD) in respect of dental radiography. We did not view documentation for the principal dentist, as they had been unable to locate their certificate but assured us that they had updated their training in 2015. Following our visit, the dentist told us they were updating their training again and had completed most of the modules.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

The practice's health and safety policies, procedures and risk assessments were reviewed regularly to help manage potential risk. We found some exceptions where risk assessments had not been implemented.

The provider had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The dentist used traditional needles rather than a safer sharps system. There was a safeguard available for those who handled needles. A sharps risk assessment had been completed. This included a provision that dental nurses were not to handle used needles. Traditional matrix bands were used; these were dismantled after they had been through the sterilisation process to reduce risk of injury to staff.

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the hepatitis B virus. We found that the effectiveness of the vaccination had not been checked for two dental nurses. The practice manager told us that action had been ongoing to obtain this information. After the day, we were provided with information to show how the risk had been mitigated in the interim whilst they were waiting for this information.

Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support every year. Training was last undertaken in January 2019. We discussed that staff may benefit from undertaking rehearsals in between annual training to ensure their knowledge is refreshed.

Emergency medicines and most equipment was available as described in recognised guidance. We noted exceptions in relation to a child self-inflating bag with reservoir and not all the sizes of clear face masks for self-inflating bag were held. An order was placed for these items.

We found staff kept records of their checks of medicines and equipment held to ensure they were available, within their expiry date, and in working order.

A dental nurse worked with the dentist but not the dental hygienist when they treated patients. A risk assessment had not been completed for when the dental hygienist worked without chairside support. Following our inspection, a formal assessment was completed based on a discussion with the hygienist and sent to us.

The provider had suitable risk assessments to minimise the risk that can be caused from substances that are hazardous to health.

The provider had an infection prevention and control policy and procedures. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health and Social Care. Staff completed infection prevention and control training and received updates as required.

The provider had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. We did not see that disinfectant was held for manual cleaning purposes should this be required; however, we were informed that manual cleaning was not undertaken. We also did not see handwash available in the decontamination room or the surgeries; an alcohol-based rub was displayed.

The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance. There were suitable numbers of dental instruments available for the clinical staff and measures were in place to ensure they were decontaminated and sterilised appropriately.

We found staff had systems in place to ensure that any work was disinfected prior to being sent to a dental laboratory and before treatment was completed.

We saw staff had procedures to reduce the possibility of legionella or other bacteria developing in the water systems, in line with a risk assessment. An external risk

Are services safe?

assessment had been completed in April 2016 and recommendations actioned. A further in-house assessment was completed since this time by the practice manager. Whilst there had been no changes made within the premises since the previous assessment, there was scope for the practice manager to undertake further training within legionella management.

Records of water testing were in place; the records showed that on occasion the water temperature had reached 48 degrees. Whilst bacteria multiply where temperatures are between 20 to 45 degrees, the Health and Safety Executive (HSE) recommend temperatures reach 55 degrees in healthcare premises. Dental unit water line management was in place.

We saw cleaning schedules for the premises. The practice was visibly clean when we inspected.

The provider had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. We noted that whilst the external clinical waste bin was locked and placed in an area away from public access, it was not secured to a fixed object which would prevent its unauthorised removal.

The practice manager had carried out infection prevention and control audits twice a year. The latest audit in August 2019 showed the practice was meeting the required standards. We noted there was scope to further improve the audit process to include additional training for those undertaking the audits and ensuring that clear standards and resulting action plan(s) were implemented.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients. A written protocol was not yet in place to prevent a wrong tooth extraction based on the Local Safety Standard for Invasive Procedures tool kit.

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at a sample of dental care records to confirm our findings and noted that individual records were written and managed in a way that kept patients safe. Dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation requirements.

Patient referrals to other service providers contained specific information which allowed appropriate and timely referrals in line with practice protocols and current guidance.

Safe and appropriate use of medicines

The provider had reliable systems for appropriate and safe handling of medicines.

There was a suitable stock control system of medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required.

The dentists were aware of current guidance with regards to prescribing medicines.

Track record on safety, and lessons learned and improvements

The practice had a positive safety record. The practice had processes to record and investigate accidents if they occurred. There had been no accidents reported since the current provider had taken ownership.

The practice had a policy for reporting near miss incidents and significant events. We saw that one incident had been reported regarding a data protection issue. This was investigated and was due to be discussed at the next practice meeting. We found there was scope to further improve incident reporting as the practice had not identified all possible untoward incidents or near misses that had occurred. We discussed this with the practice manager and they informed us that they would seek to widen the scope of identification and reporting of any issues.

There was a system for receiving and acting on safety alerts. This had been recently implemented. The practice manager told us they would review previous alerts issued to ensure any relevant ones were identified. Following our inspection, we were advised that this task had been completed and the practice had been unaffected by historic alerts.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

We received very positive comments from 47 patients about treatment received. Patients described the treatment they received as 'excellent', 'efficient' and 'first class'. One patient told us they travelled a considerable distance to remain as a patient receiving care.

The practice had systems to keep the dental practitioner up to date with current evidence-based practice. We saw that clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

The staff were involved in quality improvement initiatives including peer review as part of their approach in providing high quality care.

Helping patients to live healthier lives

Comments received in CQC comment cards included that staff had a 'great approach to their children, with their first experience at two years old' and another patient told us that their children and their grandchildren received ongoing care at the practice.

The practice was providing preventive care and supported patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentist prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for patients based on an assessment of the risk of tooth decay.

The dentist and hygienist where applicable, discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of dental products for sale. The practice did not have health promotion leaflets on display for patients.

Staff were aware of national oral health campaigns and local schemes in supporting patients to live healthier lives. For example, local stop smoking services. They directed patients to these schemes when necessary.

The dentist described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition. We noted that basic periodontal examinations (BPE) were not undertaken for children from the age of seven years old, as recommended in guidance.

Patients with more severe gum disease were recalled at more frequent intervals for review and to reinforce home care preventative advice. A dental hygienist was employed by the practice; when required, referrals to the hygienist were made.

Consent to care and treatment

Staff obtained consent to care and treatment in line with legislation and guidance.

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentists gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions and we saw this documented in-patient records. Patients confirmed their dentist listened to them and gave them clear information about their treatment. One patient stated that they were always listened to and were given excellent advice'.

The practice's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who might not be able to make informed decisions. The policy also referred to Gillick competence, by which a child under the age of 16 years of age may give consent for themselves. Staff were aware of the need to consider this when treating young people under 16 years of age.

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

The practice kept mostly detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. We looked at a small sample of patient records. We found there was

Are services effective?

(for example, treatment is effective)

some scope to include the detail recorded. For example, the risk assessment for caries, oral cancer, tooth wear and periodontal condition. The dentists assessed patients' treatment needs in line with recognised guidance.

We saw the practice audited patients' dental care records to check that the dentists/clinicians recorded the necessary information.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. Staff worked closely together and adopted a team approach. A new staff member who had not yet commenced work was bringing additional skills with them. They had completed training in topical fluoride application, impression taking and oral health education.

Staff new to the practice had a period of induction. A new structured induction checklist was in the process of development at the time of our visit.

We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council. However, we were unable to view the radiography update training for the principal dentist within their current cycle.

Staff discussed their training needs at annual appraisals. We saw evidence of completed appraisals and how the practice addressed the training requirements of staff.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

The dentists confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide.

Staff had systems to identify, manage, follow up and where required refer patients for specialist care when presenting with dental infections.

The provider also had systems for referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist.

Staff logged in to their referral system to check the status of referrals, although a separate log was not maintained. We noted that this may assist the provider in ensuring that all referrals were all dealt with promptly.

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

Staff were aware of their responsibility to respect people's diversity and human rights.

Patients commented positively that staff were helpful, empathetic and accommodated their needs.

We saw that staff treated patients respectfully and appropriately and were friendly towards patients at the reception desk and over the telephone.

Patients said staff were compassionate and understanding. One patient told us that their dentist 'understood my fears and was so patient'. Another patient said that their hygienist 'was like an old friend and always pleased to see us' and helped them feel relaxed.

Patients told us staff were kind and helpful when they were in pain, distress or discomfort.

A selection of magazines was available for patients whilst they waited to

Privacy and dignity

Staff respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and the waiting area provided limited privacy when reception staff were dealing with patients. If a patient asked for more privacy, staff told us they would take them into another room. The reception computer screen was not visible to patients and staff did not leave patients' personal information where other patients might see it.

Staff password protected patients' electronic care records and backed these up to secure storage. They stored paper records securely.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care and were aware of the requirements under the Equality Act.

We saw:

- Interpreter services were available for patients who did not speak or understand English.
- Staff told us they communicated with patients in a way that they could understand.

Staff gave patients clear information to help them make informed choices about their treatment. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. One patient told us 'Any problems or issues are fully explained, and my questions always answered'.

The dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

The dentist described to us the methods they used to help patients understand treatment options discussed. These included for example, using online video images to support explanations given, written and pictorial information.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

Staff were clear on the importance of emotional support needed by patients when delivering care.

One patient told us that they 'used to have an aversion to dental care but feel confident I am in safe hands'. A young patient told us that they had a health condition and staff knew how to help them.

Staff told us they knew their patients well and were considerate to their needs and requirements.

Patients described high levels of satisfaction with the responsive service provided by the practice.

The practice currently had some patients for whom they needed to make adjustments to enable them to receive treatment. There was access to a downstairs treatment room which helped those with mobility problems.

The practice had made most reasonable adjustments for patients with disabilities. This included step free access and an accessible toilet with a hand rail. The toilet was situated close to the reception desk, so staff would hear if a patient required help. The provider had plans to lower part of the reception desk to improve existing arrangements for patients who used wheelchairs. The practice did not have a hearing loop installed. We were informed that there were three patients who were deaf or hard of hearing. Appointments were made through a special telephone translation service which they had access to and when they attended, lip reading and written word were also used to communicate.

Pre-appointment reminders were issued to patients in advance of their planned attendance at the practice. These were issued in accordance with patient preference.

Timely access to services

Patients could access care and treatment from the practice within an acceptable timescale for their needs.

The practice displayed its opening hours in the premises.

The practice had an appointment system to respond to patients' needs. Patients who requested an urgent appointment were offered an appointment the same day. Patients had enough time during their appointment and did not feel rushed. Appointments ran smoothly on the day of the inspection and patients were not kept waiting.

The staff took part in an emergency on-call arrangement with some other local practices and patients were also directed to NHS 111.

The practice's information leaflet and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was closed. Patients confirmed they could make routine and emergency appointments easily and were rarely kept waiting for their appointment.

Listening and learning from concerns and complaints

The practice manager told us they would take complaints and concerns seriously and would respond to them appropriately to improve the quality of care.

The provider had a policy providing guidance to staff on how to handle a complaint. The practice made information available to patients about how to make a complaint.

The practice manager was responsible for dealing with complaints. Staff told us they would tell the practice manager about any formal or informal comments or concerns straight away so patients received a quick response.

The practice manager aimed to settle complaints in-house and told us they would invite patients to speak with them in person to discuss these, if any were to be received.

Information was available about organisations patients could contact if not satisfied with the way the practice manager had dealt with their concerns. The practice had not received any complaints, so we were unable to view the management process for this.

We looked at comments and compliments the practice received within the previous 12 months.

Are services well-led?

Our findings

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

Leadership capacity and capability

We found leaders had the capacity and skills to deliver high-quality, sustainable care. The provider had taken ownership of the practice in 2018 and their efforts towards developing the practice were ongoing.

The leaders demonstrated they had the experience, capacity and skills to deliver the practice strategy and address risks to it. Whilst we noted areas for review, such as some risks that had not been identified, responsive action was taken to mitigate these.

Leaders were visible and approachable. Staff told us they worked closely with them and others to make sure they prioritised compassionate and inclusive leadership.

We saw the provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

There was a vision and set of values. The practice's statement of purpose included their aims to make every one of their patients dentally fit and healthy, and that where intervention was required, the best quality treatment was provided in line with current practice.

Culture

Staff stated they felt respected, supported and valued. They were proud to work in the practice.

The staff focused on the needs of patients. We received a large amount of positive feedback from patients about the caring nature of the team and their effectiveness in providing dental care treatment.

Honesty and transparency were demonstrated when responding to an incident reported. We found there was scope to widen the types of incidents that could be reported.

The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

Staff could raise concerns and were encouraged to do so, and they had confidence that these would be addressed.

Governance and management

There were clear responsibilities, roles and systems of accountability to support governance and management.

The principal dentist had overall responsibility for the management and clinical leadership of the practice. The practice manager was responsible for the day to day running of the service. Staff knew the management arrangements and their roles and responsibilities.

The provider had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff and were reviewed on a regular basis.

We saw there were clear processes for managing most risks, issues and performance.

Appropriate and accurate information

Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.

The provider had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information.

Engagement with patients, the public, staff and external partners

Staff involved patients, staff and external partners to support high-quality sustainable services.

The provider used patient surveys and verbal comments to obtain staff and patients' views about the service. We saw examples of suggestions from staff the practice had acted on. For example, a member of staff had suggested a second handrail on the stairs; there was planning for this to be fitted.

The provider gathered feedback from staff through meetings and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

Continuous improvement and innovation

There were systems and processes for learning and continuous improvement, however there was scope to strengthen some areas.

The provider was developing their quality assurance processes to encourage learning and continuous

Are services well-led?

improvement. These included audits of dental care records, radiographs and infection prevention and control. Audits we looked at such as radiography and infection and prevention and control required further review to ensure that clear results and outcomes were evident.

Employed staff had annual appraisals. They discussed learning needs, general wellbeing and aims for future professional development. We saw evidence of completed appraisals in the staff folders.

Staff completed 'highly recommended' training as per General Dental Council professional standards. This included undertaking medical emergencies and basic life support training annually. The provider supported and encouraged staff to complete CPD.