Petrie Tucker and Partners Limited

# St Peter Street Dental Centre

## Inspection Report

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## Overall summary

We carried out a comprehensive inspection of St Peter Street Dental Centre on Friday 9 January 2015. This is part of the Integrated Dental Holdings (IDH) corporate group of dental providers.

St Peter Street Dental Centre provides a full range of NHS and private treatments. An endodontist takes referrals from across the region for root canal treatment, which is largely private practice.

The practice is open from 8.30am till 6pm on Mondays and Tuesdays, 8.30am till 5.30pm on Wednesdays and from 9am till 5.30pm on Thursdays and Fridays. It is in the centre of Tiverton.

Two dentists and a hygienist worked at the practice. A dentist had recently left and another was due to start in the week following this visit.

Patients of all ages and diverse backgrounds are registered, with a higher than average proportion of older patients. The patient list was quite stable. New patients were not being taken on at the time of this visit but staff told us that the books had been opened twice a year for short periods.

Feedback was given by 17 patients who completed our comment cards and we spoke with two patients by phone after the visit.

Patients praised the service they had received, the friendliness of the staff and the quality of the dentistry.

One person said they had been a nervous patient but they had been treated with respect and care and received such good treatment they no longer felt anxious. Patients said they had been well informed about their treatment at each visit.

Patients found the environment to be clean and hygienic. Most said they had nothing to complain about but some said they were not happy with appointments being changed or cancelled and with changes to staff.

Our key findings were:

- Patients told us they found their dentist good, efficient and helpful with preventative measures.
- Dentists followed professional guidance for delivering good oral health with respect to assessment of the teeth and soft tissues and recording the treatment they provided.
- Systems were in place to maintain a safe service, including arrangements for infection control and preparedness for dealing with medical emergencies.
- Dentists and staff had attended training to ensure they had the skills they needed and to maintain their registration.
- The premises, though not suitable for wheelchair users, were well maintained, clean and attractive.
- A new practice manager had been recently appointed with the skills and knowledge to implement appropriate policies and ensure procedures were followed to ensure a safe and effective service.

# Summary of findings

There were areas where the provider should make improvements:

The provider should

- Ensure audits of X-rays are completed at 12 monthly intervals or sooner and that the results of these are acted upon.
- Ensure that staff clean the boxes used to bring instruments to be decontaminated and then return them promptly to treatment rooms.
- Ensure measures required by the Legionella risk assessment are carried out.
- Store all medicines that need to be kept chilled, including glucagon, in the refrigerator.
- Keep a record of the temperature of the medicines fridge.
- Ensure written evidence of immunity to hepatitis B is available for all staff.
- Carry out an assessment of the premises in accordance with the Disability Discrimination Act 2005.

# 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 suitable arrangements were in place for infection control, staff recruitment, and dealing with medical emergencies. Staff we spoke with understood their responsibilities to raise concerns and report incidents and there were systems and processes in place to support this. Staff were trained and aware of their responsibilities for safeguarding vulnerable adults and child protection.

The equipment and the environment were well maintained, and staff followed suitable infection prevention and control practices. Medicines were stored suitably and securely, and checked regularly to ensure they were within their expiry dates. When any shortfalls were identified, prompt action was taken and the practice manager was aware that some improvements were needed in respect of infection prevention and control measures and the auditing of X-rays.

**Are services effective?**

Patients' records showed that guidance provided by the Department of Health for delivering better oral health had been implemented. Patients told us they found their dentist good, efficient and helpful with preventative measures.

The dentist checked the medical history before each patient, including details of prescribed medicines. The clinical history in the treatment records contained details of the condition of the teeth, gums and soft tissues lining the mouth. The details of the treatment provided including the type of local anaesthesia and filling materials used were also recorded in the clinical notes.

Dentists discussed treatment options with patients and gained their consent and agreement in drawing up their treatment plan. When providing a private treatment such as veneers, the dentist printed the treatment and fees information to give to patients. There was space on the printed information for the patient to sign and date, to show they understood the treatment was not NHS provision.

A specialist dentist provided a private endodontic (root canal treatment) service to patients on referral from practices across the south west of England.

A dental nurse told us that each morning they met with the dentist before patients arrived. They went through the treatments and appointments for the session. They checked the medical history before each patient, considering their list of prescribed medicines.

**Are services caring?**

Patients said the staff were very pleasant, helpful and professional. We saw that receptionists, dentists and nurses engaged well with patients.

Patients told us they had been given good explanations about their treatment and their oral care and they felt fully informed and involved in decisions about their treatment. Some praised the excellent customer service and said how confident and comfortable the dentists and staff made them feel.

Some expressed frustration about appointments that had been cancelled or changed, which had caused them inconvenience.

**Are services responsive to people's needs?**

The practice had dedicated time slots for emergencies each day. Patients told us they were not normally kept waiting long. A notice on the wall of the waiting room invited patients to speak to reception staff if they were delayed by 20 minutes.

# Summary of findings

There were two steps at the front door, with a portable ramp available on request. There was no other local IDH practice that was accessible for wheelchair users. Staff advised patients to look on the NHS Choices website to find an alternative dental practice if they could not manage to get into this practice.

The complaints procedure was displayed in public areas. All complaints records were held centrally by IDH, for management oversight. When any complaint about dental care was received, acknowledgment was sent the same day. Action had been taken in response.

**Are services well-led?**

A practice manager had been appointed with the skills and knowledge to implement policies and procedures to ensure a safe and effective service. She had arranged one to one meetings with team members the week following this inspection, to give feedback on performance and discuss training needs. Staff told us the team all pulled together and helped each other in order to provide a good service.

There had been changes in personnel, with recruitment continuing and a new dentist due to start work at the practice in the week following this inspection. Staff guidance was provided via policies and procedures distributed on the company's intranet service. There was provision for induction and training for staff.

# St Peter Street Dental Centre

**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 9 January 2015 by a lead inspector and a specialist dental advisor.
- We reviewed the information we had about this provider from the previous inspection. The provider sent us the statement of purpose.
- During the inspection we toured the premises, spoke with the dentists and staff, observed methods of working and reviewed documents. To assess the quality of care provided by the practice, we looked at practice policies and protocols and other records.
- Seventeen patients completed our comment cards and we spoke with two patients by phone after the visit.

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**

The practice had suitable processes around reporting and discussion of incidents. The practice manager had introduced meetings where such incidents, when they arose, were shared and discussed. The record of significant events showed that learning was shared following events. For example, since a computer failure in 2013, the day lists of patients' appointments had been printed out two days in advance so that work could continue smoothly.

A staff member had fallen on a staircase. The practice manager marked the edges of the steps with black and yellow tape and there had been no further problem.

Information was displayed in the staff room and treatment rooms giving staff guidance, including a flowchart, on what to do if they suffer a sharps injury, which means if they cut themselves with a needle or sharp instrument in the course of their work. Such incidents need careful assessment as there may be infection control issues. The latest such incident recorded was in January 2013, and it had been reported to occupational health.

**Reliable safety systems and processes including safeguarding**

Dentists and staff had attended training on child protection and safeguarding vulnerable adults. No alerts had been made and staff had not received disclosures from any patient.

A copy of the provider's generic whistle blowing policy, dated October 2013, was available for staff guidance. The CQC contact details were included, but not the General Dental Council (GDC) for whistle blowing about GDC registrants. Staff told us they had read the policies and protocols and would know who to speak to should they have any concerns.

Risk assessments had been undertaken for issues affecting the health and safety of staff and patients using the service. This included for example water quality, electrical installation and equipment and security of the premises.

**Infection control**

Patients had seen the practice to be clean and hygienic, as we also observed during our visit.

The practice had a policy on infection prevention and control (IPC). It had been reviewed and signed by staff in April 2014. New staff joining the team had signed it since then, showing they had read it, most recently by the new practice manager on 31 December 2014. It was comprehensive and covered the decontamination process, environmental cleaning, clinical waste, hand hygiene, protective personal equipment (PPE) including masks and gloves, work surfaces and equipment. Needle stick injuries were included. The policy gave guidance on assessing the risk to staff but said any such accident must be reported to occupational health regardless of the level of risk assessed within the practice, to ensure any necessary measures are taken.

All but two staff records showed their immunity status with respect to Hepatitis B. The other two records did not provide clear information about this.

The practice manager had given the responsibility of lead role for IPC to a dental nurse. They showed us the system used for decontaminating instruments used in dentistry. The infection control standards expected of modern dental practices are set out clearly in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05). This document was published by the Department of Health and updated on 1 April 2013. It sets out in detail the processes and practices essential to prevent the transmission of infections.A small room was dedicated to this work, and kept locked when not in use. Equipment had been installed in order that the work could follow a clear flow starting with the dirty instruments brought in covered boxes from the treatment rooms. The work processes moved in a clockwise direction, so that cleaned items would not be in contact with contaminated surfaces.

First, instruments were cleaned manually, scrubbed under water. Then they were put into an ultrasonic cleaner. After this cycle they were rinsed in a separate sink. Staff then carefully examined each item under an illuminated magnifier before putting them on to trays to fit into the autoclave to be sterilised. Dental hand pieces were sprayed, scrubbed and rinsed then examined and sterilised.

# Are services safe?

There was little room on the clean side of the autoclave for bagging the sterilised instruments. The staff member on duty was able to do this on top of the autoclave, then put them into clear boxes for transportation back to the treatment rooms.

Only one treatment room was in action on the day of our visit. We observed that the blue boxes used to transport the dirty instruments had not been returned to the area of the treatment rooms reserved for collecting dirty instruments. Instead they had been stacked beside the clean boxes. Space in the decontamination room was limited so failure to return the boxes to the treatment rooms caused potential for cross contamination.

Waste bins with hands-free lids had been provided for clinical waste. We saw that clinical waste was stored in large lidded locked yellow bins in the outside yard. Consignment notes demonstrated it was disposed of legally, as were hazardous waste, non-hazardous waste, sharps and medicines.

A suitable infection control audit had been completed on 5 January 2015. Current guidance required this to be done six monthly, but there had been a lapse as the previous audit was dated 7 January 2014. The recent audit assessed compliance as 98%, using the Infection Prevention Society's single audit document. Guidance in the HTM 01-05 states that reamers and files used for root canal treatment should be treated as single patient use. The recent audit had identified that dentists at the practice were re-using these. As a result of the audit this had been stopped and these instruments were now treated as single use.

The practice employed a cleaner for the communal areas. A schedule showed completion of weekly and daily tasks. This work was done while the practice was closed, and the practice manager kept in contact by phone with the staff member to ensure standards were maintained.

A professional legionella risk assessment was carried out on 18 June 2010, which required actions to be taken to maintain safety. Legionella is a bacterium which can contaminate water systems. Most had been carried out. The hot and cold water outlet temperature had been checked monthly, with records signed by staff. There had been a full system clean and chlorination. The instruction to flush through toilets and disinfect outlets weekly had not been followed. An engineer was called out in June 2014 because staff identified that the hot water was not hot enough to manage the risk of legionella bacteria developing. The new practice manager had attended training in Legionella management in June 2013.

**Equipment and medicines**

All dental materials and medications were safely and securely stored and prescription pads securely locked away. Dentists had attended suitable courses with respect to prescribing antibiotics. Batch numbers were recorded for local anaesthetics that were used.

On the second floor there was a staff room with a lockable medicines fridge where dental materials were stored. The display showed red if it went out of temperature range.

No record was kept of the temperature. The practice manager agreed to give a staff member responsibility for checking the fridge.

Two compressors were installed in the cellar, to provide clean compressed air to work the handpieces, delivery units and chair valves. Appropriate warning signs were displayed on the door to the stairs. The equipment used in the practice was maintained in accordance with the manufacturer's instructions, this included the equipment used to sterilise the instruments, the X-ray sets and the compressor. The practice manager had a process that ensured tests of machinery were carried out at the right time. There were complete service agreements in place for autoclaves and ultrasonic machines.

**Monitoring health & safety and responding to risks**

A professional fire risk assessment was carried out in November 2014. This identified actions that were needed. For example, an evacuation plan for patients with disabilities was needed. We saw this had been produced and was displayed in a public place beside the extinguishers. The final exit doors had needed a lock with no key, and we saw this was in place.

Fire extinguishers had been provided on all floors including the cellar, and had been checked and serviced on 4 February 2014. The fire alarms and emergency lighting had been tested on 10 October 2014. Staff had recently been involved in a fire drill.

# Are services safe?

The team carried out their Control Of Substances Hazardous to Health (COSHH) assessments together during a staff meeting. This ensured that all staff were aware of risks and their responsibilities in handling the substances.

**Medical emergencies**

Emergency medicines were kept in sealed bags. When any item was used the suppliers would replace the bag and reseal it. The list of medicines provided was as recommended in the British National formulary (BNF) guidance. A glucagon 1mg kit was included. It was kept with the other medicines rather than in a fridge. The practice manager said they brought forward the expiry date to reflect this, however this meant the expiry date was not guaranteed.

All staff had received training and annual updates on cardiopulmonary resuscitation (CPR). The newly recruited member of staff attended this on the afternoon of this inspection. During a practice meeting on 18 December 2014, the new practice manager had led a simulation of a medical emergency to ensure a satisfactory staff response. Staff had experienced medical emergencies previously when the response had gone well, but staff did not know how it should be recorded. Now, the necessary forms were stored centrally and staff knew where they were.

Suitable equipment including an automated external defibrillator (AED) were provided. An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. Oxygen was also available for dealing with medical emergencies. This was in line with the Resuscitation UK Council guidelines. The AED was checked daily. The tags on the emergency medicines bags were checked daily to ensure that they had not been tampered with. When emergency medicines and equipment were approaching their expiry date, an email arrived from IDH showing the order made out for the replacement. We saw an example of an order for a new mask to be used during CPR.

**Staff recruitment**

IDH provided a recruitment form which showed the process that was followed when selecting new members of staff. The company also had a list of documents they would need for recruitment to be in accordance with their policy.

The form required a minimum of five years employment history. There was not a full employment history that would show whether any gaps in employment needed risk assessment.

Disclosure and Barring Service (DBS) checks had been made on all staff to ensure they were safe to work with children and vulnerable adults.

References had been requested on behalf of the recently recruited staff member, but not yet received. Photographic evidence of identity was recorded.

When employing a dental nurse from an agency, the practice manager checked their GDC certificate and indemnity. Copies of training certificates had been provided and the practice manager had assessed their achievements and competence, and worked through a full health and safety induction checklist, with a tour of the premises.

A new dentist was due to start the Monday following this inspection. They were currently working in another practice within the same company. They had an interview with the clinical director and were then separately interviewed by the practice manager and area manager. This was followed by an induction at head office. Their recruitment documents had been gathered centrally and were not available in the practice.

**Radiography**

The practice was working in accordance with the Ionising Radiation Regulations 1999 (IRR99) and the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). Individuals were named as radiation protection adviser (RPA) and radiation protection supervisor (RPS) for the practice. The practice's radiation protection file contained the necessary documentation demonstrating the maintenance of the X-ray equipment.

The dentists' radiograph (X-ray) log book showed that each X-ray taken had been recorded with a unique patient identifier and technical quality graded. A clinical evaluation of radiographs was recorded in most patients' records but this had not been done in every case. We saw ten X-rays, pertaining to four patients, where clinical evaluation and satisfactory quality were recorded.

X-ray audits had been carried out in surgeries one and three in June and December 2013 and found to be

# Are services safe?

satisfactory. In surgery two, the audit in June 2013 was incorrectly completed and in January 2014 the analysis was incomplete. The new practice manager was aware of this gap in assessment and had asked the dentists to re-audit.

# Are services effective?

(for example, treatment is effective)

## Our findings

**Consent to care and treatment**

The dentist had discussed treatment options with patients and gained their consent and agreement in drawing up their treatment plan. The dentist demonstrated a clear understanding of the consent process and had involved family members in discussion about recommended treatment for a patient with memory problems.

The dental nurse told us they helped the dentist by discussing straightforward treatment plans and consent forms with patients. They had explained complex treatment forms to patients and talked through treatments. Patients with a learning disability had always come with a carer. Nurses had not yet met a patient who could not understand their explanation of treatment.

The practice manager had made a booking with the local authority for training, in the week following this inspection, which included the Mental Capacity Act 2005 and its relevance for the dental team. Staff who spoke with us had not met issues of concern with respect to the best interest of patients who were unable to give informed consent to their treatment.

When providing a private treatment such as veneers, the dentist printed the treatment and fees information off from the computer. There was space on this for the patient to sign and date, to show they understood the treatment was not NHS provision. For NHS treatments a dedicated form (FP17DC) was used for a treatment plan and fees.

A specialist dentist provided a private endodontic (root canal treatment) service to patients referred by practices all over the south west of England. A staff member who worked as their dental nurse, personal assistant and treatment co-ordinator told us when they received a referral, they sent a 'welcome letter' to the patient, giving their proposed treatment and the cost. When the patient arrived for their appointment, they use a standard IDH medical history form. Verbal consent was gained from the patient after examination and they were asked to sign the treatment plan, but it was not made clear that this signified that they gave consent. On completion of the treatment, a letter and copy of any X-rays were sent to the referring dentist, with a copy of this letter sent to patient.

**Monitoring and improving outcomes for people using best practice**

Dentists used an medical history form provided by the company which used satisfactory questions to help patients give their information. As well as sections about health and medicines the form included sections on smoking, drinking, chewing and a smile check. The patient and dentist signed and initialled the medical history form with a date, and initialled and dated any amendments. We saw the medical history form was completed and updated each time in accordance with guidelines. The practice met the general health preventive agenda by recording the smoking and alcohol consumption of the patient and providing advice accordingly.

A dental nurse told us that each morning they met with the dentist before patients arrived. They went through the treatments and appointments for the session. They checked the medical history before each patient, considering their list of prescribed medicines.

The clinical history in the dental care records contained details of the condition of the teeth, gums and soft tissues lining the mouth. We saw examples of soft tissue examination and a periodontal (gum) health record using a standard form of assessment. The details of the treatment, including the type of local anaesthesia and filling materials used were also recorded. An audit of clinical records had last been carried out in 2012 and was now due. This was included in the new practice manager's schedule.

**Health promotion & prevention**

Two hygienists were employed, but not present during this inspection. One was attending a conference about oral health. Patients' records showed that guidance provided by the DOH for delivering better oral health had been implemented. Smoking cessation advice, oral cancer advice and general health issues were discussed with patients and recorded in the dental care records. Patients told us they found their dentist good, efficient and helpful with preventative measures.

**Staffing**

Two dentists were employed, one of whom was a specialist endodontist. The new practice manager was supporting

# Are services effective?

## (for example, treatment is effective)

the team through a period of change. The provider had plans to increase the service. Recruitment was on-going, with a new dentist starting work on the Monday following this visit.

The practice manager had a training plan, which showed the wide range of their accomplishment. They had arranged for staff to undertake the training they needed.

For example, the recently appointed staff member had been provided with an induction programme and a training session on CPR. They had previously done training in health and safety, safeguarding children and vulnerable adults, fire safety and manual handling while working for the company at a different location.

# Are services caring?

## Our findings

**Respect, dignity, compassion & empathy**

All the patients who spoke with us or gave feedback on a Care Quality Commission (CQC) comment card said they had been pleased with service provided and that it had all been very good in all respects. They said the staff were very pleasant, helpful and professional. One patient said their dentist was always kind and good, while another, who had been nervous of dentistry in general, had found that at this practice they had been treated with respect and care and received such good treatment they had been made to feel very comfortable.

The receptionists greeted patients on arrival and we saw throughout our visit that they treated them professionally. We observed that the dental nurse and dentist engaged well with their patients.

Some patients said that on occasions their appointment had been cancelled and two patients felt let down by changes to staff and appointments. They did not say their treatment had been inadequate, but that changes in appointment times caused inconvenience.

**Involvement in decisions about care and treatment**

Patients told us they had been well informed on each visit. They had been given good explanations about their treatment and their oral care afterwards and they felt fully informed. We saw evidence in the records that patients were given information to enable them to make a choice regarding their dental treatment.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

The practice had dedicated time slots for emergencies each day. Patients told us they were not normally kept waiting long. A notice on the wall of the waiting room invited patients to speak to reception staff if they were delayed by 20 minutes.

**Tackling inequity and promoting equality**

Patients of all ages and diverse backgrounds were registered with the practice, with a higher than average proportion of older patients.

There were two steps at the front door. A portable ramp was available for the use of patients in wheelchairs wishing to come into this practice. Patients were advised that staff did not assist patients up the ramp, so if they needed assistance they would need to have someone with them. There were no accessible toilet facilities. Staff advised patients to look on the NHS Choices website if they could not manage to get into this practice, as there was no local IDH practice that was accessible. An assessment of the premises in accordance with the Disability Discrimination Act 2005 had not been carried out.

**Access to the service**

The practice was open from 8:30am to 6pm on Mondays and Tuesdays, 8:30am to 5:30pm on Wednesdays and 9am till 5:30pm on Thursdays and Fridays. Slots were kept for urgent treatments on the day. Information about how to get help if the practice was closed was displayed in the front window where it could be seen from the street, but it was rather high to be seen by passers-by with disabilities or poor sight. The practice's website did not provide information for patients on how to get emergency dental care out of hours.

Information was available about NHS payment bands. The private treatment price guide was displayed in the upstairs waiting room along with information about insurance and payment plans that could make it easier for some patients to choose a private treatment.

**Concerns & complaints**

The complaints procedure was displayed in public areas. It included time scales in which the practice would respond to any concern and how quickly they would expect to conclude an investigation. The complaints policy committed the practice manager to acknowledging a complaint in three working days and dealing with it in 20 days. The procedure gave the contact details that patients could use to escalate a complaint if they were not satisfied with the local resolution.

All complaints were held centrally by the provider for management oversight. The practice could view its own complaints. When any complaint about dental care was received, acknowledgment was sent the same day. Action had been taken in response to complaints received, such as arranging a second opinion, or arranging for an assessment by the clinical director for the company.

Patients told us they were not normally kept waiting long. A notice on the wall of the waiting room invited patients to speak to reception staff if they were delayed by 20 minutes.

# Are services well-led?

## Our findings

**Leadership, openness and transparency**

The practice aims and objectives were reviewed by the new practice manager and team during December 2014. They covered the quality of care, access to care and the involvement of health care professionals in the development of the service. The practice had been part of the IDH group for eight years. Staff were confident in working with this company. They told us if they had problems of any sort, they discussed them with the practice manager and for serious issues, consulted the area manager for the company.

Staff told us they worked well as a team, and chose to continue working at this practice as they were happy working there.

The practice manager also managed another practice within the group and planned to work alternate days at each. Because the practices were four miles apart they could easily work at both on any one day. They had prepared well for this inspection although they had been in post less than a month.

**Governance arrangements**

Minutes of a staff meeting held on 15 May 2014 showed a staff member was given responsibility for checking emergency medicines. No meetings had been recorded between then and 18 December 2014. Since starting at the practice in December 2014 the practice manager had introduced monthly team meetings. We saw that the meeting in December 2014 had included information for staff about accessing training through IDH academy. A simulation of a medical emergency was carried out as part of the meeting to update staff training and awareness.

The practice manager had a system to ensure that all checks would be carried out at appropriate intervals. She had arranged for staff to carry out an audit of their arrangements for taking X-rays in accordance with Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) and carried out a spot check of arrangements for maintaining infection control. She had instigated a clinical record audit and asked the dentists to carry out an audit of the quality of X-rays.

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

A report of a patient survey was displayed on the first floor waiting room, showing an overall satisfaction with treatment and waiting times. The practice manager had included in the team meeting held on 18 December 2014 the need to gather patient feedback for on-going quality monitoring.

The practice manager had arranged one to one meetings with team members the week following this inspection, to give feedback on performance and discuss training needs. Staff told us the team all pulled together, the staff helped each other in order to provide a good service.

**Management lead through learning and improvement**

Staff showed us they accessed IDH policies which were provided through the company's intranet service. Staff had been asked to complete training modules on information governance which was also on the intranet.

We were shown certificates in the staff files that demonstrated staff had attended appropriate training for their role. Records showed staff accomplishment with training through the provider's intranet academy and training they had undertaken to maintain their professional registration. The company funded practitioners for two study days per year. The hygienist was attending a conference on oral health on the day of this inspection.