Eastgate Dental Centre Limited

Eastgate Dental Centre

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 26 April 2016 to ask the practice the following key questions;

Are services safe, effective, caring, responsive and well-led?

Our findings were:

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

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

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

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

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

Background
Eastgate Dental Centre provides NHS and private preventive, cosmetic and implant dentistry for both adults and children. The practice is situated in Aylesbury and has been established since 2005.

The practice has ten dental treatment rooms. Seven of which are based on the ground floor and two separate decontamination rooms used for cleaning, sterilising and packing dental instruments. The ground floor is accessible to wheelchair users, prams and patients with limited mobility.

The practice employs eight dentists, three hygienist, eight dental nurses, four reception staff and a deputy practice manager.The practice opens 8.30am to 1pm and 2pm to 5.30pm Tuesday to Friday, 8.30am to 1pm and 2pm to 7pm on Monday and Saturday morning from 10am to 1pm.

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

Mr. Sanjay Rayarel is registered as an individual and is legally responsible for making sure that the practice meets the requirements relating to safety and quality of care, as specified in the regulations associated with the Health and Social Care Act 2008.

Summary of findings

During our inspection we reviewed 21 CQC comment cards completed by patients and obtained the view of 41 patients and nine staff on the day of our inspection.

The inspection was carried out by a lead inspector and a dental specialist adviser.

Our key findings were:

- We found that the practice ethos was to provide patient centred dental care in a relaxed and friendly environment.
- Strong leadership was provided the practice owner.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice appeared clean and well maintained.
- Infection control procedures were robust and the practice followed published guidance.
- The practice had a safeguarding lead with effective processes in place for safeguarding adults and children living in vulnerable circumstances.
- There was a policy and procedure in place for recording adverse incidents and accidents.
- Dentists provided dental care in accordance with current professional and National Institute for Care Excellence (NICE) guidelines.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Patients could access treatment and urgent and emergency care when required.
- Staff recruitment files were incomplete.
- Staff had received training appropriate to their roles and were supported in their continued professional development (CPD) by the practice manager.
- Staff we spoke with felt well supported by the practice owner and were committed to providing a quality service to their patients.
- Information from 21 completed Care Quality Commission comment cards gave us a positive picture of a friendly, caring, professional and high quality service.
- The practice reviewed and dealt with complaints according to their practice policy.

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

- Ensure the practice's recruitment policy and procedures are suitable and the recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.

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

- Establish a system for collating training records of all staff
- Review the storage of products identified under Control of Substances Hazardous to Health (COSHH) 2002 Regulations to ensure they are stored securely.
- Review the availability of a hearing loop in both the ground and first floor reception areas for hearing aid users.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had robust arrangements for essential areas such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found that all the equipment used in the dental practice was well maintained. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents. There were sufficient numbers of suitably qualified staff working at the practice. Staff received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence to guide their practice. We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals. The staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council and were meeting the requirements of their professional registration

Are services caring?

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

We collected 21 completed Care Quality Commission patient comment cards and obtained the views of a further 41 patients on the day of our visit. These provided a positive view of the service the practice provided. All of the patients commented that the quality of care was very good. Patients commented on friendliness and helpfulness of the staff and dentists were good at explaining the treatment that was proposed.

Are services responsive to people's needs?

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

The service was aware of the needs of the local population and took those these into account in how the practice was run. Patients could access treatment and urgent and emergency care when required.

Are services well-led?

We found that this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report).

Strong leadership was provided by the practice owner. The practice had clinical governance and risk management structures in place. Staff had an open approach to their work and shared a commitment to continually improving the service they provided. There was a no blame culture in the practice. Staff told us that they felt well supported and could raise any concerns with the practice owner. All the staff we met said that they were happy in their work and the practice was a good place to work.

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

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Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 26 April 2016. The inspection was carried out by a CQC inspector and a dental specialist adviser.

During our inspection visit, we reviewed policy documents and staff records. We spoke with nine members of staff. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the computer system that supported the patient dental care records. We reviewed CQC comment cards completed by patients and obtained the view of patients on the day of our inspection.

Patients gave positive feedback about their experience at the practice.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had in place a system for the reporting of RIDDOR (The reporting of injuries diseases and dangerous occurrences regulations) and accidents. The practice reported that there were no incidents during 2015-2016 that required investigation. The deputy practice manager explained that the practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority. They explained that relevant alerts would be discussed during staff meetings to facilitate shared learning these meetings occurred every month.

Reliable safety systems and processes (including safeguarding)

We spoke to a dental nurse about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current European Union (EU) directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne diseases. The practice used a system whereby needles were not manually resheathed using the hands following administration of a local anaesthetic to a patient. A single use local anaesthetic delivery system was in place. Dentists were also responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps.

We asked the practice owner how they treated the use of instruments used during root canal treatment. They explained that these instruments were single patient use only. They also explained that all dentists in the practice carried out root canal treatment where practically possible using a rubber dam. This was confirmed by two other dentists we spoke with. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work. The practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam.

One of the associate dentists in the practice was the lead for safeguarding and acted as a point of referral should members of staff encounter a child or adult safeguarding issue. A policy and protocol was in place for staff to refer to in relation to children and adults who may be the victim of abuse or neglect. Training records showed that all staff had received appropriate safeguarding training for both vulnerable adults and children. Information was available in the practice that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an automated external defibrillator, a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Staff received training in how to use this equipment. The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common dental emergencies.

The practice had access to oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines and oxygen we saw were all in date and stored in a central location known to all staff. The practice held training sessions yearly for the whole team so that they could maintain their competence in dealing with medical emergencies. Staff we spoke with demonstrated they knew how to respond if a person suddenly became unwell.

Staff recruitment

All the dentists and dental nurses who worked at the practice had current registrations with the General Dental Council. We looked at recruitment files for five staff employed since the provider registered with CQC and found the registered provider had not fully undertaken all the required checks to comply with Schedule 3 of the Health and Social Care Act 2008 (amended 2014). Checks required included proof of identity, a full employment history, evidence of relevant qualifications and employment checks including references.

We looked at five staff recruitment files and found that three had proof of identity and eligibility to work in the UK

and two had evidence of conduct in previous employment. All five staff staff did not have evidence of their employment history or satisfactory evidence of any physical or mental health conditions.

We saw evidence to confirm a criminal records check had been carried out for only one of the five members of staff but this was dated three years prior to the start date of their employment at Eastgate in 2015.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice maintained a comprehensive system of policies and risk assessments which included radiation, fire safety, general health and safety and those pertaining to all the equipment used in the practice. The practice had a business continuity plan to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service. The practice had in place a Control of Substances Hazardous to Health (COSHH) file. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients. We noted during our inspection bottles of cleaning fluid containing bleach were not stored securely in one of the decontamination rooms. This presented a risk of unauthorised access by the general public, specifically children, because this room was part of the general escape route used in the event of a fire it was not lockable. The practice owner stated that there was a suitable lockable cupboard available elsewhere in the practice and undertook reviewing their safe storage as soon as practically possible.

Infection control

All 41 patients we asked said they felt the practice was clean and hygienic. There were effective systems in place to reduce the risk and spread of infection within the practice. The practice had in place an infection control policy that was regularly reviewed. It was demonstrated through direct observation of the cleaning process and a review of practice protocols that HTM 01 05 (national guidance for infection prevention control in dental practices') Essential Quality Requirements for infection control were being exceeded. It was observed that audit of infection control processes carried out in January 2016 confirmed compliance with HTM 01 05 guidelines.

All the dental treatment rooms, waiting area, reception were clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available including liquid soap and paper towel dispensers in each of the treatment rooms and toilet. Hand washing protocols were also displayed appropriately in various areas of the practice.

The drawers of several of the treatment rooms were inspected and these were clean, ordered and free from clutter. Each treatment room had the appropriate personal protective equipment available for staff use, this included aprons, protective gloves and visors.

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

The dental unit water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings) they described the method they used which was in line with current HTM 01 05 guidelines. We saw that a Legionella risk assessment had been carried out at the practice by a competent person in September 2015. The recommended procedures contained in the report were carried out and logged appropriately. These measures ensured patients' and staff were protected from the risk of infection due to Legionella.

The practice had two separate decontamination rooms for instrument processing. The lead dental nurse demonstrated the process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used automated washer disinfectors for the initial cleaning process, following inspection with an illuminated magnifier the instruments were placed in an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilized, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines. We were shown the systems in place to ensure

Are services safe?

that the autoclaves used in the decontamination process were working effectively. It was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were always complete and up to date. All recommended tests for the validation of the washer disinfectors were carried out in accordance with current guidelines, the results of which were recorded on appropriate data collection sheets.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. Clinical waste bags and municipal waste were properly maintained and was in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. This was stored in a separate locked location adjacent to the practice prior to collection. Waste consignment notices were available for inspection.

Environment cleaning was carried out by an external cleaner. We saw cleaning plans for each treatment room and other areas of the practice. We pointed out to the practice owner that there were areas of the toilet on the first floor that were being neglected by the cleaner, the practice owner undertook to address this issue with the company concerned.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the practice sterilisers had been serviced and calibrated in November 2015. The practices' X-ray machines had been serviced and calibrated as specified under current national regulations in October and November 2015. Portable appliance testing (PAT) had been carried out in March 2016.

The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored securely for the protection of patients. The practice stored prescription pads in a safe overnight to prevent loss due to theft. The practice also had a prescription logging system to account for the prescriptions issued to prevent inappropriate prescribing or loss of prescriptions. We observed that the practice had equipment to deal with minor first aid problems such as eye problems, body fluid and mercury spillage.

Radiography (X-rays)

We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for each X-ray set along with the three yearly maintenance logs and a copy of the local rules. The maintenance logs were within the current recommended interval of three years.

A radiological audit for each dentist had been carried out in October 2015. Dental care records showed where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured. These findings showed practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. We were not able to see training records that showed all staff where appropriate had received training for core radiological knowledge under IRMER 2000 Regulations. The deputy practice manager explained that a system would be put into place as soon as practically possible to collate all relevant members of staff training records in relation to dental radiography.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Dentists carried out consultations, assessments and treatment in line with recognised general professional guidelines. The dentists described to us how they carried out their assessment of patients for routine care. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained in detail.

Preventative dental information was given in order to improve the outcome for the patient where relevant. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

We saw dental care records that were completed by all of the dentists working at the practice. We saw that the findings of the assessment and details of the treatment carried out were recorded appropriately by each dentist. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums. These were carried out where appropriate during a dental health assessment.

Health promotion & prevention

The practice was very focused on the prevention of dental disease and the maintenance of good oral health. To facilitate this aim the practice appointed three dental hygienists to work alongside of the dentists in delivering preventative dental care. Two dentists we spoke with explained that children at high risk of tooth decay were identified and were offered fluoride varnish applications or the prescription of high concentrated fluoride tooth paste to keep their teeth in a healthy condition. They also placed fissure sealants (special plastic coatings on the biting surfaces of permanent back teeth in children) who were particularly vulnerable to dental decay.

Other preventative advice included tooth brushing techniques explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. Dental care records seen demonstrated that dentists had given oral health advice to patients. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area. Underpinning this was a range of leaflets explaining how patients could maintain good oral health.

Staffing

The practice employed eight dentists, three hygienist, eight dental nurses, four reception staff and a deputy practice manager. All clinical staff had current registration with their professional body, the General Dental Council.

We observed a friendly atmosphere at the practice. All 41 patients asked told us they felt there were enough staff working at the practice. We asked nine members of staff if they felt the staffing levels were adequate. Four said no but went on to say they understood new staff were being recruited.

All the staff we spoke with told us they felt supported by the practice manager and owner. They told us they felt they had acquired the necessary skills to carry out their role and were encouraged to progress.

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

We were told the dental hygienists worked without chairside support. We drew to the attention of the deputy practice manager the advice given in the General Dental Council's Standard (6.2.2) for the Dental Team about dental staff being supported by an appropriately trained member of the dental team at all times when treating patients in a dental setting.

Are services effective?

(for example, treatment is effective)

Working with other services

Dentists were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as oral surgery, special care dentistry and orthodontic providers.

Consent to care and treatment

We spoke with three dentists about how they implemented the principles of informed consent; all had a very clear understanding of consent issues. They explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options. They went on to say that patients should be given time to think about the treatment options presented to them, the practice owner utilised a system of 'chat appointments' whereby patients would be brought back to the practice to discuss complex treatment options prior to the start of treatment. This process made it clear that a patient could withdraw consent at any time.

The dentists went onto explain how they would obtain consent from a patient who suffered with any mental health impairment that may mean that they might be unable to fully understand the implications of their treatment. If there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed. They went on to say they would involve relatives and carers if appropriate to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005.

Staff were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting areas and we saw that doors were closed at all times when patients were with dentists. Conversations between patients and dentists could not be heard from outside the treatment rooms which protected patient's privacy. Patients' clinical records were stored electronically and any paper documents were scanned into notes and shredded. Computers were password protected and regularly backed up. Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality.

Before the inspection, we sent Care Quality Commission (CQC) comment cards so patients could tell us about their experience of the practice. We collected 21 completed CQC patient comment cards and obtained the views of 41 patients on the day of our visit. These provided a positive view of the service the practice provided. All of the patients commented that the quality of care was very good. Patients commented that treatment was explained clearly and the staff were caring and put them at ease. They also said that the reception staff were always helpful and efficient. During the inspection, we observed staff in the reception area. We observed that they were polite and helpful towards patients and that the general atmosphere was welcoming and friendly.

Involvement in decisions about care and treatment

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

All the patients we asked told us the dentist was good at explaining treatment and involved them in decisions about their care and treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we looked at examples of information available to patients. The practice waiting areas displayed a wide variety of information including the practice patient information leaflet and leaflets about the services the practice offered and how to make a complaint. The patient information leaflet explained opening hours, emergency 'out of hours' contact details and arrangements, staff details. The practice website also contained useful information to patients such as different types of treatments which patients could down load and how to provide feedback on the services provided.

We observed that the appointment diaries were not overbooked and that this provided capacity every 30 minutes for patients with dental pain to be fitted into urgent slots for each dentist. The dentists decided how long a patient's appointment needed to be and took into account any special circumstances such as whether a patient was very nervous, had a disability and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice made reasonable adjustments to prevent inequity for disadvantaged groups in society. The practice building was spacious and the ground floor was fully accessible to wheelchair users, prams and patients with limited mobility.

The reception desk was low which accommodated wheelchair users without them needing to move to a separate area. A wheelchair accessible toilet was available and the treatment rooms were large and accessible to patients who could transfer from wheelchairs.

Telephone interpreter services were also available for patients whose first language was not English.

Access to the service

Eastgate Dental Centre offered NHS and private dental care services for adults and children 8.30am to 1pm and 2pm to 5.30pm Tuesday to Friday, 8.30am to 1pm and 2pm to 7pm on Monday and Saturday morning from 10am to 1pm.

Appointments could be made in person, via the practice website or by telephone. Staff told us patients were seen as soon as possible for urgent care during practice opening hours and this was normally the same day as urgent appointment slots were available every 30 minutes. Patients told us and comment cards reflected they felt they had good access to routine and urgent dental care

All 41 patients asked said they were satisfied with the practices' opening hours.There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an out-of-hours service. If patients called the practice when it was closed, an answerphone message gave the telephone number patients should ring depending on their symptoms.

Concerns & complaints

The practice had a complaints policy and a procedure that set out how complaints would be addressed, who by, and the timeframes for responding. For example, a complaint would be acknowledged within three days and a full response would be provided to the patient within We spoke to the deputy practice manager about this timescale who told us it was not effective and undertook to change the resolution period to 20 working days. The practice listed four complaints received over the previous 12 months which records confirmed had been concluded satisfactorily.

Information for patients about how to make a complaint was seen in the patient waiting areas of the practice. The patient leaflet did not contain information about how to complain. We spoke with the practice owner who told us the practice leaflet was being updated and undertook to include complaints information in the revised copy. We asked 41 patients if they knew how to make a complaint if they had an issue and 26 said yes, 11 were not sure and four patients said they didn't know.

Are services well-led?

Our findings

Governance arrangements

The governance arrangements of the practice were developed through a process of continual learning and improvement. The governance arrangements for this location consisted of the practice owner and the deputy practice manager who were responsible for the day to day running of the practice. All of the staff we spoke with were aware of the policies and how to access them. We noted management policies and procedures were kept under review by the practice management on a regular basis however, staff recruitment arrangements did not include the recording of necessary checks required to meet Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Leadership, openness and transparency

Strong clinical leadership was provided by the practice owner. The practice ethos focussed on providing patient centred dental care in a relaxed and friendly environment. The comment cards we reviewed reflected this approach. The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said they felt comfortable about raising concerns with the practice manager or the principal dentist. There was a no blame culture within the practice. They felt they were listened to and responded to when they did raise a concern. We found staff to be hard working, caring and committed to the work they did.

All of the staff we spoke with demonstrated a firm understanding of the principles of clinical governance in dentistry and were happy with the practice facilities. Staff reported that the practice owner was proactive and resolved issues very quickly. As a result, staff were motivated and enjoyed working at the practice and were proud of the service they provided to patients.

Learning and improvement

We saw evidence of systems to identify staff learning needs which were underpinned by an appraisal system and a programme of clinical audit. For example we observed that the dental nurses and receptionists received an annual appraisal.

There was a system of informal peer review in place to facilitate the learning and development needs of the dentists. This system of peer review occurred during the lunch time period when the dentists could discuss the particular needs and risks of patients including issues around their medical, social and clinical needs.

We found there was a programme of clinical and non-clinical audits taking place at the practice. These included infection control, clinical record keeping and X-ray quality.

Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. Staff told us that the practice ethos was that all staff should receive appropriate training and development. The practice owner encouraged staff to carry out professional development wherever possible. We saw that staff had undergone update training in cardio pulmonary resuscitation (CPR), infection control, child protection and safeguarding.

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

The practice had gathered feedback from patients through the NHS Friends and Family test (FFT), compliments and complaints. We saw that there was a robust complaints procedure in place, with details available for patients in the waiting area.

Results of the FFT carried out in February 2016 indicated that 97.5% of patients, who responded, were happy with the quality of care provided by the practice and were highly likely to recommend the practice to family and friends.

The practice carried out its own monthly survey of 50 patients. February 2016's survey showed that 100% of patients, who responded, said they would recommend the practice to a friend. As a result of patient feedback the practice had introduced improvements suggested by patients which included text and email appointment reminders.

Staff told us that the practice manager and principal dentist were very approachable and they felt they could give their views about how things were done at the practice. Staff confirmed that they had practice meetings every month. Staff described the meetings as good with the opportunity to discuss successes, changes and improvements. Staff we spoke with said they felt listened to.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Fit and proper persons employed We found the provider had not ensured persons employed for the purposes of carrying on a regulated activity were of good character and that all other information specified in Schedule 3 was available in relation to each such person employed. This was in breach of Regulation 19 (1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. • Pre-employment checks missing included conduct in previous employment, current criminal records checks, full employment history, proof o identity and information about any health conditions.