Fair Oak Dental Practice

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Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 19 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 regulation.

Background
Fair Oak Dental Practice operates from a purpose built dental premises providing private treatment for both adults and children. In addition to general dental services Fair Oak provides sedation for nervous patients, dental implants and minor oral surgical procedures.

The practice is situated in Fair Oak Village, a suburb of Eastleigh, Hampshire. The practice has three dental treatment rooms. One is based on the ground floor. Decontamination is carried in individual surgeries following a common protocol.

The practice employs two dentists, a hygienist, two dental nurses and a receptionist. One dental nurse carries out reception duties while the second dental nurse is also the practice manager.

The practice opens 9am to 12pm and 2pm to 5pm on Monday and Thursday and 9am to 12pm on Tuesday, Wednesday and Friday.

There are arrangements in place to ensure patients receive urgent dental assistance when the practice is closed. An emergency number is left on the practice phone for the patients to call outside the above hours for advice and answered by the dentists evenings and weekends. When the dentists are away on training or holiday emergency cover is provided by arrangement with a nearby practice.

Summary of findings

One of the partners in the practice is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

During our inspection we reviewed 38 CQC comment cards completed by patients and obtained the views of six patients on the day of our inspection.

The inspection was carried out by a CQC specialist dental inspector.

Our key findings were:

- We found that the practice ethos was to provide patient centred dental care in a relaxed and friendly environment.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice appeared clean 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.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- 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 had received training appropriate to their roles and were supported in their continued professional development (CPD) by the practice owner
- Staff we spoke with felt well supported by the practice manager and were committed to providing a quality service to their patients.
- Information from 38 completed Care Quality Commission (CQC) 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 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:

- Review fire safety checking systems.
- Consider installing a hearing loop and adding a grab rail in the ground floor patient toilet.
- Consider providing the hygienist with the support of an appropriately trained member of the dental team.
- Review storage arrangements for Glucagon.
- Review MHRA notifications and alert management systems.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had arrangements in place for 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 properly maintained. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents. Staff 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 focused on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals. The staff received professional training and development appropriate to their roles and learning needs. Staff where appropriate were registered with the General Dental Council (GDC) 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 38 completed Care Quality Commission patient comment cards. 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. We obtained the views of six patients on the day of our visit. These also provided a positive view of the service the practice provided.

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. The practice provided patients with written information in a language they could understand and had access to telephone interpreter services when required.

Are services well-led?

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

The practice owner and the staff team had an open approach to their work and shared a commitment to continually improving the service they provided. The practice had essential clinical governance and risk management structures in place. Staff told us that they felt supported and could raise any concerns with the practice manager. Staff we met said that they were happy in their work and the practice was a good place to work.

Summary of findings

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.

Fair Oak Dental Practice

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 19 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 two members of staff and the principal dentist. 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 owner described a good awareness of RIDDOR (The reporting of injuries diseases and dangerous occurrences regulations). The practice had an incident reporting system in place along with forms for staff to complete when something went wrong, this system also included the reporting of minor injuries to patients and staff. Records showed that the four incidents between 2014 and 2016 were managed in accordance with the practices incident reporting policy. The practice manager explained that the practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA) through another location where the practice owner worked. These were then shared with staff at this location where necessary. We found this arrangement was generally informal and records of alerts were not kept. The practice owner undertook to introduce a system as soon as practically possible.

Reliable safety systems and processes (including safeguarding)

We spoke to a dental nurse about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current EU directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne diseases. The practice used a system whereby needles were not manually resheathed using the hands following administration of a local anaesthetic to a patient. The dentists were responsible for ensuring safe recapping using rubber and metal guards. These are recognised method used in dentistry for the recapping of used needles. 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 how they treated the use of instruments used during root canal treatment. They explained that these instruments were single patient use only. They also explained that root canal treatment was carried out where practically possible using a rubber dam by most of the dentists working at the practice. (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. When rubber dam was not used, dentists used other safety mechanisms to prevent inhalation or swallowing root canal files.

The practice owner acted as the safeguarding lead. They acted as a point of referral should members of staff encounter a child or adult safeguarding issue. A policy 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 staff had received appropriate safeguarding training for both vulnerable adults and children or were booked onto courses for this training in the near future. Information was displayed 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 in recent times.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. There was an automated external defibrillator, which is 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. The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with medical emergencies in a dental practice. Equipment included oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines.

Emergency medicines and oxygen were all in date except for the emergency medicine glucagon (a medicine used for the treatment of hypoglycaemia or low blood sugar). This emergency medicine was effectively out of date because of the storage arrangements that being outside of a refrigerator. The practice assured us that this medicine would be replaced as soon as practically possible. The emergency medicines and equipment were stored in a central location known to all staff and the expiry dates of medicines and equipment was monitored using monthly

Are services safe?

check sheets that enabled staff to replace out of date medicines and equipment promptly. Staff had received practice-based training in cardiopulmonary resuscitation (CPR) in June 2015.

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.

Two of the five staff recruitment files examined found they did not have satisfactory evidence of conduct in their previous employment and satisfactory evidence of any assessment for physical and mental health conditions. Both staff files contained evidence of a criminal records check being carried out but these were dated two and six years prior to the start date of their employment at Fair Oak Dental Practice in 2013 and 2016 respectively.

Monitoring health & safety and responding to risks

The practice had a health and safety risk management process in place, which enabled them to assess, mitigate and monitor risks to patients, staff and visitors to the practice.

There were arrangements in place to deal with foreseeable emergencies. We found the practice had a fire risk assessment that had been reviewed in June 2015. Fire safety signs were clearly displayed, fire extinguishers had been serviced regularly and staff demonstrated to us how to respond in the event of a fire. Other assessments included a health and safety risk assessment carried out in August 2015 and was due to be reviewed in August 2017 and a radiation risk assessment.

There were effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. We looked at the COSHH file and found this to be comprehensive where risks (to patients, staff and visitors) associated with substances hazardous to health had been identified and actions taken to minimise them. The file was regularly updated when new materials or chemicals were introduced to the practice.

Infection control

There were systems in place to reduce the risk and spread of infection within the practice. The practice had in place a robust infection control policy that had been reviewed in February 2016. 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 was being met. It was observed that audit of infection control processes carried out in January 2016 confirmed compliance with HTM 01 05 guidelines.

The three dental treatment rooms, waiting area, reception and toilets 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 and bare below the elbow working was observed.

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

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

The dental 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 were supplied evidence to confirm an overdue Legionella risk assessment had been arranged by a competent person. These measures ensured that patients' and staff were protected from the risk of infection due to Legionella.

The practice carried out decontamination in a designated area within two of the treatment rooms. The dental nurse demonstrated the process from taking the dirty

Are services safe?

instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a system of manual scrubbing and an ultrasonic cleaning bath for the initial cleaning process, following inspection with an illuminated magnifier they were placed in an autoclave (a device for sterilising dental and medical instruments). When instruments had been sterilised, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines. We were shown the systems in place to ensure that the two 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. We also noted that foil validation test for the ultrasonic cleaning bath were also complete and up to date.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained and was in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. This was stored in a separate locked location adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection. We also saw that general environmental cleaning was carried out cleaning according to a cleaning plan developed by the practice. Cleaning materials and equipment were stored in accordance with current national guidelines.

Equipment and medicines

Equipment checks were generally regularly carried out in line with the manufacturer's recommendations. For example, the practices' X-ray machine had been serviced and calibrated as specified under current national regulations of every three years. Portable appliance testing had been carried out in August 2015. However, we did note that records showed that the practices autoclaves had not been serviced since 2014. The recommended time interval between services should be no longer than 14 months. The practice owner undertook to deal with this oversight and since our inspection we have been provided with evidence to confirm the autoclaves have been serviced.

Medicines such as local anaesthetics were stored securely for the protection of patients. The practice dispensed their own medicines as part of a patients' dental treatment. These medicines were a range of antibiotics. The dispensing procedures were robust and medicines were stored according to manufacturer's instructions. We observed that the practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid spillage.

Radiography (X-rays)

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

A copy of the radiological audit carried out during 2015 was available for inspection. Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured. These findings showed that practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. We saw training records that showed all staff where appropriate had received training for core radiological knowledge under IRMER 2000.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We spoke with the practice owner on the day of our visit. They all demonstrated they carried out consultations, assessments and treatment in line with recognised general professional guidelines. They 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 oral cancer. Patients were 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.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general dental hygiene procedures 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 given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

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

The practice carried out a small number of cases each year involving intra-venous sedation for patients who were very nervous of dental treatment and required complex dental treatment such as the provision of dental implants. One dentist carried out sedation whilst the other dentist carried out the dental treatment. We found that the practice owners had put into place governance systems to underpin the provision of conscious sedation.

The governance systems supporting sedation included pre and post sedation treatment checks, emergency equipment requirements, medicines management, sedation equipment checks, personnel present, patient's checks including consent, monitoring of the patient during treatment, discharge and post-operative instructions and staff training.

We saw one example of a patient who had undergone conscious sedation found that the patient was appropriately assessed for sedation. We saw clinical records that showed that the patient undergoing sedation had important checks made prior to sedation this included a detailed medical history, blood pressure and an assessment of health using the American Society of Anaesthesiologists classification system in accordance with current guidelines. The records demonstrated that during the sedation procedure important checks were recorded at regular intervals which included pulse, blood pressure, breathing rates and the oxygen saturation of the blood. This was carried out using specialised equipment including a pulse oximeter which measures the patient's heart rate and oxygen saturation of the blood. Blood pressure was measured using a separate blood pressure monitor. The measures in place ensured that patients were being treated safely and in line with current standards of clinical practise.

Health promotion & prevention

The practice was focussed on the prevention of dental disease and the maintenance of good oral health. To facilitate this aim the practice appointed a dental hygienist to work alongside of the dentists in delivering preventative dental care. The dentist we spoke with explained that children at high risk of tooth decay were identified and were offered fluoride varnish applications and prescriptions for 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 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

Are services effective?

(for example, treatment is effective)

line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. Dental care records we observed demonstrated that dentists had given oral health advice to patients.

Staffing

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

The practice employed two dentists, a hygienist, two dental nurses and a receptionist. One dental nurse carried out reception duties while the second dental nurse was also the practice manager. All clinical staff had current registration with their professional body, the General Dental Council.

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 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.

Working with other services

The 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 and orthodontic providers. This ensured that patients were seen by the right person at the right time.

Consent to care and treatment

The dentist we spoke to explained how they implemented the principles of informed consent; they had a clear understanding of consent issues. 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. This made it clear that a patient could withdraw consent at any time and that they had received a detailed explanation of the type of treatment required, including the risks, benefits and options.

We also asked them about 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. 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. They 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' paper records were stored in lockable records storage cabinets. Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff were aware of the importance of providing patients with privacy and maintaining confidentiality.

All six patients asked told us the dentists were good at treating them with care and concern. Before the inspection, we sent Care Quality Commission (CQC) comment cards so patients could tell us about their experience of the practice. We collected 38 completed CQC patient comment cards. 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

All six patients asked told us the dentists were good at explaining their treatment options and involved them in decisions about their care and treatment. The provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. A poster detailing private treatment costs was displayed in the waiting area. All the patients we asked told us the dentist was good at explaining treatment and involved them in decisions about their care and treatment.

The dentist 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.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We saw that the practice waiting area displayed a variety of information on the patient notice board. Information included; opening hours, emergency 'out of hours' contact details and arrangements and how to make a complaint. On the day of our visit, we observed that the appointment diary for the dentist was not unduly overbooked. This provided capacity each day for patients with dental pain to be seen by the dentist with patients invited to come and sit and wait. The dentists decided how long a patient's appointments needed to be and took into account any special circumstances such as whether a patient was very nervous, had a disability and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to prevent inequity for disadvantaged groups in society. The practice was based over the ground and first floor of a purpose built building. The building was spacious over both floors and had a ground floor treatment room which made it fully accessible to wheelchair users, prams and people with limited mobility.

The reception desk was high throughout but staff told us they would always go to the patients' side when a wheelchair user entered the reception area. We observed a member of staff do this to support an older patient who was immediately supported to their seat next to the reception desk

A wheelchair accessible toilet was available and the ground floor surgeries were large and accessible to patients who could transfer from wheelchairs should they wish to. However the toilet did not have grab rails or an emergency alarm.

The practice used a translation service, which they arranged if it was clear that a patient had difficulty in understanding information about their treatment. The practice did not have a hearing loop in place for patients who may be hearing aid wearers.

Access to the service

Fair Oak Dental Practice offered private specialist dental care services for adults and children 9am to 12pm and 2pm to 5pm on Monday and Thursday and 9am to 12pm on Tuesday, Wednesday and Friday.. Appointments could be made in person or by telephone.

Patients told us they were able to get appointments when they needed them.

All six patients asked told us they were satisfied with the practices' opening hours.There were arrangements in place to ensure patients received urgent dental assistance when the practice was closed. This was provided by the dentists evenings and weekends. We were told when the dentists were away on training or holiday emergency cover was provided, by arrangement, with a nearby practice.

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 14 days. We were told the practice had not received any complaints in the previous 12 months.

Information for patients about how to make a complaint was seen in the patient information pack which was given to all new patients. All of the patients we asked said they knew how to make a complaint if they had an issue.

Are services well-led?

Our findings

Governance arrangements

The governance arrangements for this location were overseen by the practice owner who was responsible for the day to day running of the practice. The practice maintained a comprehensive system of policies and procedures 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.

We noted management policies and procedures were kept under review by the practice manager. Staff were aware of where policies and procedures were held and we saw these were easily accessible.

Leadership, openness and transparency

The practice ethos focussed on providing patient centred dental care in a relaxed and friendly environment. The comment cards we saw 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. 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 endeavoured to resolve problems as soon as practicably possible. 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 found there were a number of audits taking place at the practice. These included infection control, radiography (X-rays) and clinical record keeping. There was evidence of repeat audits at appropriate intervals and these reflected standards and improvements were being maintained. For example infection control audits were undertaken every six months. The radiography audits demonstrated that the practice had analysed the results to discuss and identify where improvement actions may be needed.

Staff were supported to maintain their continuing professional development as required by the General Dental Council. The practice provided a rolling programme of professional development. This included training in cardio pulmonary resuscitation (CPR), infection control, child protection and adult safeguarding, dental radiography. Training was completed through a variety of resources including the attendance at face to face and online courses. Staff were given time to undertake training which would increase their knowledge of their role.

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

The practice had gathered feedback from patients through compliments and complaints and a patient satisfaction survey system. Feedback from patients resulted in improvements, this included the redecoration of the waiting area.

Staff we spoke with said they felt listened to. Staff told us that the practice owner was very approachable and they felt they could give their views about how things were done at the practice. Staff confirmed that they had a practice meeting at the beginning of each day to discuss patients who may present with particular medical or social problems that staff should be aware of that could impact on the dental care proposed. Staff described the meetings as good with the opportunity to discuss successes, changes and improvements.

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 and information about any health conditions.