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Newmarket Dental Surgery

Inspection Report

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Date of inspection visit: 7 July 2015
Date of publication: 20/08/2015

Overall summary

We carried out an announced comprehensive inspection on 7 July 2015 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 not 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

We carried out a comprehensive inspection of Newmarket Dental Surgery on 7 July 2015. The practice provides both NHS and private dental treatment to patients of all ages. It employs two full-time dentists, one part-time orthodontist and one part-time dental hygienist. They are supported by three dental nurses and three receptionists.

The practice manager 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.

The practice is located in the basement of a large listed building, and access is down steep stone steps. It has three treatment rooms, a small staff kitchen area and one decontamination room for cleaning, sterilising and packing dental instruments.

We spoke with three patients during our inspection and also received 48 comments cards that had been completed by patients prior to our inspection. We received many positive comments about the cleanliness of the premises, the empathy and responsive of staff and the quality of treatment provided. Four people told us that staff understood their nervousness about dental

Summary of findings

treatment and dealt with it well. Some patients told us that staff worked well with their children. Patients also appreciated the text service offered, which helped remind them of their appointments

However two people commented that although the service they received was good, they were not always clear about the costs involved in their treatment particularly around charges for the hygienist. Two patients told us that getting an appointment with the orthodontist was difficult, and they often had to wait many weeks, before one became available. One patient found the environment of the practice depressing, with little natural light.

Our key findings were:

- The practice had systems to help ensure patient safety. These included safeguarding children and adults from abuse, maintaining the required standards of infection prevention and assessing risks to staff and patients.
- Staff had received training appropriate to their roles and were supported in their continued professional development.
- There were sufficient numbers of staff to meet patients' needs.
- Patients' needs were assessed and care was planned in line with guidance from the National Institute for Health and Care Excellence (NICE).
- The practice sought feedback from staff and patients and used it to improve the service provided.

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

- take appropriate action if there is a clinical or medical emergency by having suitable equipment in place to manage the more common medical emergencies encountered in general dental practice.
- have systems and processes in place to identify risk to health, safety and welfare of people who use services by ensuring the practice's policies are kept up to date; that significant events and incidents are analysed, and that dental care records reflect patients' consent and decisions in relation to their treatment.

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

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

- Appoint a safeguarding lead within the practice and ensure that all staff are aware of who this is.
- Ensure all dental staff have regard to NHS England's publication for Delivering Better Oral Health- an evidence based toolkit to support dental practices in improving their patients' oral and general health.
- Review the practice's arrangements for the audit of infection control procedures, the monitoring of autoclave cycles and the storage of loose items in treatment room drawers.
- Ensure that all dental care records are completed to the same high standard across the practice.
- Ensure that notes from staff employment interviews are recorded to evidence they are undertaken in line with good employment practice.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this practice was not providing safe 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 at the end of this report).

Staff had received training in safeguarding, whistleblowing and knew the signs of abuse and who to report them to. Infection control procedures were good and equipment was well maintained. There were effective risk management processes in place to reduce harm to both staff and patients. However, the practice did not have appropriate equipment in place to deal effectively with medical emergencies.

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. Staff were suitably trained and skilled to meet patients' needs and there were sufficient numbers of them available at all times.

Are services caring?

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

Patients told us they had very positive experiences of the dental care provided at the practice and felt they were treated with respect and empathy by all members of staff. Patients felt involved in decisions about their treatment and that staff explained treatment to them in a way that they understood. Information about patients was, in most cases, treated confidentially.

Are services responsive to people's needs?

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

The practice offered a range of services to meet patients' needs, and had employed dental specialists to provide additional services such as orthodontics and the treatment of gum disease.

Most appointments were easy to book and the practice offered extended opening hours one evening a week to meet the needs of those who could not attend during normal opening hours. The practice offered dedicated emergency slots each day enabling responsive and efficient treatment of patients with urgent dental needs.

There was a clear complaints procedure and information about how to make a complaint was displayed in the waiting area.

Are services well-led?

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

The practice had a number of policies and procedures to govern activity and held regular staff meetings. It proactively sought feedback from staff and patients, which it acted on. However, we found that the registered manager was not allocated enough time to fulfil the responsibilities of her role and this had impacted on her ability to effectively oversee the day to day running, and governance of the practice.

We found a lack of consistency in practice amongst the dentists and there was no system of peer review in place to help monitor their performance and drive improvement.

Summary of findings

There was no specific significant events log and no annual analysis of events, incidents or complaints to detect any common themes, or share learning from.

Newmarket Dental Surgery

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

The inspection took place on 7 July 2015 and was conducted by a CQC inspector and a dental specialist advisor.

During the inspection we spoke with three dentists, the practice manager, one dental nurse and a member of the reception team. We also spoke with three patients. We reviewed 48 comment cards about the quality of the service that patients had completed prior to our inspection. We observed one patient consultation, reviewed policies, procedures and other documents relating to the management of the service.

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 received national and local alerts relating to patient safety and safety of medicines. There was a system for logging these and for making sure that all members of the dental team received copies of relevant information. Copies of relevant alerts were printed off by the practice manager and put in each treatment room and also in a specific file on the practice's computer so they could be accessed if needed.

Staff understood the process for accident and incident reporting including the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). We viewed the accident book and found that incidents had been recorded in some detail. The information showed that the practice had taken appropriate action in each case. However, there was no specific significant events log and no annual analysis of events and incidents to detect any common themes, from which learning could be shared. For example, there had been an incident where a patient had taken ill whilst attending an appointment. This was not recorded in the incident log, and there was no evidence to show how the practice had learned from the incident, or that it had been discussed at the staff meeting.

Reliable safety systems and processes (including safeguarding)

The practice had satisfactory child protection and vulnerable adult policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff and staff had access to contact details for both child protection and adult safeguarding teams in each treatment room and the reception area. Staff knew how to recognise signs of abuse in vulnerable adults and children, and all had completed level two training in child protection. We were told there was a specific safeguarding lead within the practice, however none of the staff were aware of who this was.

The British Endodontic Society uses quality guidance from the European Society of Endodontology recommending the use of rubber dams for endodontic (root canal) treatment. 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 showed us that they had rubber dam kits available for use when carrying out endodontic (root canal) treatment. However we noted that the use of rubber dams was not universally applied, as they were used routinely by one dentist, but only sporadically by the others.

We noted that there was good signage throughout the premises clearly indicating fire exits, the location of first aid kits, medical emergency equipment and x-ray warning signs to ensure that patients and staff were protected

Medical emergencies

All staff, including receptionists, had received training in cardiopulmonary resuscitation and first aid and those we spoke with knew the location of all the emergency equipment in the practice .We checked the emergency medical treatment kit available and found that this had been monitored regularly to ensure that it was fit for purpose. However it did not have adequate equipment in place to deal with all medical emergencies as recommended by the Resuscitation Council (UK). For example there was no automated external defibrillator, (or easy access to one), no blood glucose measurement device**,** no portable suction unit and no self inflating bags. Not all staff were familiar with how to use the emergency oxygen. Emergency medical simulations were not regularly rehearsed by staff so that they were clear about what to do in the event of an incident at the practice.

Emergency drugs were in line with guidelines issued by the British National Formulary were available to deal with a range of emergencies including angina, asthma, chest pain and epilepsy, and all drugs were within date for safe use. The location of first aid boxes and emergency equipment was clearly signposted.

Staff recruitment

We checked records for three staff which contained evidence of their GDC registration, employment contract, job description, indemnity insurance, and a disclosure and barring check (DBS) The Disclosure and Barring Service carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. All new staff underwent an induction to their job which they reported had been

Are services safe?

useful. However notes from prospective staff's employment interviews were not kept to evidence that they had been conducted in line with good employment practices, and interviews were only conducted by one person.

Monitoring health & safety and responding to risks

The practice had comprehensive health and safety policies in place, which covered a range of issues including moving and handling, equipment, medicines and radiation. We found evidence that the practice conducted regular health and safety checks to ensure the environment was safe for both staff and patients. There was a detailed risk assessment in place which had identified areas of risk in each part of the building. These had been careful assessed and control measures implemented to reduce the hazards.

The practice had carried out a fire risk assessment in 2014 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training. However they did not practise regular fire drills to ensure that patients and staff could be evacuated from the building in the event of a fire. This was of concern, given the particularly difficult access to and from the premises.

A legionella risk assessment had been completed and staff carried out regular checks of water temperatures in the building as a precaution against the development of legionella. Regular flushing of dental water lines was carried out in accordance with current guidelines.

A business continuity plan was in place to deal with a range of emergencies that might impact on the daily operation of the practice. Risks identified included loss of utilities, fire and flooding. The document contained relevant contact details for staff to refer to. For example, contact details of equipment and IT suppliers and tradesmen. However this plan was kept at the practice itself and not off site so it could be accessed in an emergency.

Infection control

Patients who completed our comment cards reported that they always found the practice clean and had no concerns about cleanliness or infection control. We found that the dental treatment areas, decontamination room and the general environment was clean, tidy and clutter free

The practice had a range of relevant written policies in place for the management of infection control including those for exposure to blood borne viruses, hand hygiene and Legionella management. Training files we viewed showed that staff had received appropriate training in infection prevention. However, regular audits of infection control were not undertaken to ensure the practice's procedures were effectively implemented. The practice had a record of staff immunisation status in respect of Hepatitis B, and there were clear instructions for staff about what they should do if they injured themselves with a needle or other sharp dental instrument.

The 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05) published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for the cleaning, sterilising and storage of dental instruments and reviewed their policies and procedures. This assured us that the practice was meeting the HTM01-05 essential requirements for decontamination in dental practices. However, we noted that new matrix bands were not routinely sterilised before their use.

The nurse showed us how the practice checked that the two autoclaves (equipment used to sterilise dental instruments), were working effectively. They showed us the paperwork which staff used to record the essential validation checks of the sterilisation cycles. However a daily visual observation check of the autoclaves was not undertaken at the start of the day to check they were operating effectively.

We inspected the drawers in one treatment room which were clean and tidy. All of the instruments were in dated packs and it was clear which items were single use. However we noted a number of uncovered items in the drawers such us local anaesthetic cartridges which could have become contaminated over time being in close proximity to where patients were treated.

We noted good infection control procedures during the patient consultation we observed. Staff's uniforms were clean, long hair was tied back and their arms were bare below the elbows to reduce the risk of cross infection. We saw both the dentist and dental nurse wore appropriate personal protective equipment and the patient was given eye protection to wear during their treatment. Following the consultation, we saw that the dental nurse wiped down all areas where there had been patient contact, as well as the dental hand pieces and the lamp.

Are services safe?

The practice used an appropriate contractor to remove dental waste from the practice and we saw the necessary waste consignment notices. Sharps boxes were sited safely, and assembled and labelled correctly.

Equipment and medicines

The equipment used for sterilising instruments was checked, maintained and serviced in line with the manufacturer's instructions. Records showed that the equipment was in good working order and being effectively maintained. Portable electrical equipment was routinely tested to ensure its safety and was last tested in May 2014.

The dentist confirmed that any adverse drug reaction would be reported via British National Formulary yellow card scheme. This scheme collects information on suspected problems or incidents involving medicines. The batch numbers and expiry dates for local anaesthetics were always recorded in the dental records.

Processes were in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Prescription pads were stored securely with a system in place to monitor their issue to prevent incidents of prescription fraud.

Radiography (X-rays)

The practice had a named Radiation Protection Adviser and Supervisor as required by the Ionising Regulations for Medical Exposure Regulations (IR (ME) R 2000) and a well maintained radiation protection file. This contained the required information including the local rules and inventory of equipment, critical examination packs for the X-ray machine and maintenance logs.

The practice monitored the quality of the X-rays images on a regular basis. This ensured that they were of the required standard and reduced the risk of patients being subjected to further unnecessary X-rays.

We looked at a sample of dental care records where X-rays had been taken. These showed that the dentists recorded the reasons they had taken X-rays, and the results.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We saw that dental care records contained a written medical history which the practice always obtained before starting to treat a patient. These were then updated regularly. Dental care records we viewed evidenced that NICE guidance was followed for the recall frequency, antibiotics prescribing and the management of wisdom teeth. However, the quality of the dental records we saw varied. Some were well-structured and contained in-depth detail about each patient's dental treatment. Others were less so, with important information about the patients' risk of gum disease, dental decay, and soft tissue status not recorded. We also found there was a lack of consistency in how patients with a high risk of gum disease were managed. For example patients with a score of 3 or 4 would result in a referral to a dental hygienist by one clinician, but not by another.

Health promotion & prevention

We viewed one patient consultation and noted that the dental nurse checked the patient's smoking habits and spent some time explaining to them the dental risks that smoking entailed.

Some dental care records we viewed demonstrated that patients were given comprehensive advice about dental hygiene, diet, tobacco and alcohol consumption. However this was not universal across all the dental records we viewed. Some dental clinicians had a limited knowledge and understanding of NHS England's publication for Delivering Better Oral Health- an evidence based toolkit to support dental practices in improving their patients' oral and general health.

The practice manager had undertaken additional training in smoking cessation and had previously set up smoking cessation sessions for patients. However, these had ceased, with the manager citing a lack of interest from patients and lack of time to continue with this work.

Staffing

The practice employed two full time dentists, one part-time orthodontist and one part-time hygienist. They were supported by three full time dental nurses, one of whom was also the practice manager. Records showed that all staff were up to date with their continuing professional development. (All people registered with the General Dental Council (GDC) have to carry out a specified number of hours of continuing professional development (CPD) to maintain their registration). Staff told us the practice supported them in their learning and one of the reception staff stated that she often sat in on infection control talks and product trainings organised for the dental nurses. The practice manager was an experienced dental nurse had completed a level five diploma in leadership and management**.**

There was an established staff team at the practice and staff absences were planned for to ensure the service was uninterrupted. Agency dental nurses were used if needed. Staff told us there were enough of them to maintain the smooth running of the practice.

All dental nurses and non-clinical staff received an annual appraisal of their performance and had personal development plans in place. These appraisals were carried out by the practice manager who assessed staff's performance in a range of areas.

Working with other services

Patients requiring specialised treatment such as complex restorative work, oral surgery or pathology were referred to other dental specialists. We viewed a small sample of referral letters which were comprehensive and contained detailed information about patients' needs. One of the practice's dentists kept a specific tracking log to allow them to monitor the progress of each referral.

Consent to care and treatment

Dental care record we viewed demonstrated that patients' consent to their treatment had been obtained and that this was recorded. However we noted that the quality of recording in the dental records varied considerably, with some clearly demonstrating that the risks and benefits of each treatment option had been discussed with patients so they could give informed consent, and in others less so. One dentist regularly used information leaflets about dental conditions and treatment to help gain valid and informed consent from patients.

Dental nurses spoke knowledgeably about the importance of gaining patients' consent to their treatment, and told us that patients were always asked to sign relevant consent

Are services effective?

(for example, treatment is effective)

forms before their treatment took place. However some staff were less sure about how to support patients who did not have the mental capacity to agree to their treatment, other than ensure a relative accompanied them.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Before the inspection we sent comment cards to the practice for patients to use to tell us about their experience of the practice. We collected 48 completed cards in total. These provided a positive view of the service the practice provided. Patients commented that staff were respectful, efficient and empathetic to their needs. Some patients commented that staff were particularly good at treating their children and several wrote that they were seen on time and were pleased with their dental treatment.

We spent time in the patient's waiting area and found the general atmosphere was welcoming and friendly. Staff were polite and helpful towards patients, both in person and on the phone. We sat in on one consultation and noted that the dental nurse explained to the patient many of the benefits of stopping smoking in a supportive, empathetic and non-judgemental way.

Patient confidentiality was taken seriously by staff, and we noted minutes of a meeting held in December 2014 where the procedure for protecting people's identity had been reiterated to staff. If patients wanted to talk to reception staff in confidence they could be taken to another room, and the reception phone was mobile so calls could be taken privately if needed. However, we were concerned to read of an incident where confidential medical information about a child was given out over the phone to someone claiming to be the child's social worker, without staff checking the social worker's identity.

Involvement in decisions about care and treatment

Patients we spoke with, and comments cards we received, indicated that patients felt they were involved in decisions about their dental care, and that the dentist explained treatments in a way that they could understand.

One dentist's notes demonstrated that full and comprehensive discussions about treatment planning, options and consequences had been conducted with patients to ensure they were fully involved in decisions about their care. This dentist also frequently gave out information leaflets to patients to help them better understand their treatment and oral health care. However, this was less evident in other dental care records we viewed.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided a range of services to meet patients' needs. It employed a part-time dental hygienist to offer patients preventative advice treatments, and also an orthodontist two days a week. It offered both NHS and private treatment to children and adults.

There was good information for patients about the practice available both in the waiting area and also in the practice leaflet. This included details about the dental team, the services on offer, how to raise a complaint, and who to contact in an emergency. Although there was good information about NHS costs on display in the waiting room, there was none available about private treatment costs however.

We noted there was a small play area with toys in the waiting room for children to enjoy whilst they waited.

Tackling inequity and promoting equality

The practice was based in the basement of a grade 2 listed building, down some steep steps to its front door, making it difficult to access for those in wheelchairs or with push chairs. As a result it was not able to meet the needs of wheelchair users. However, this was made explicit in the practice's information leaflet and reception staff signpost patients to other practices if needed. The practice had taken action to make the steep steps as safe as possible by providing a hand rail on the wall, covering them in a non slip finish and making them visible with bright colours. Hazardous steps inside the practice had also been made more visible by the use of brightly coloured tape.

The practice did not have access to any translation services but had a multi-national team who between them spoke several Eastern European languages including Russian, Latvian and Lithuanian.

Despite a large number of older patients in the practice there was no hearing loop to help those with a hearing impairments and no information in different formats e.g. large print, or other languages.

Access to the service

The practice was open Monday to Friday and offered extended hours one evening a week until 7 pm to meet the needs of patients unable to attend during the working day. Appointments could be booked by phone or in person. Staff told us patients were seen as soon as possible for emergency care and this was normally within 24 hours. Half an hour each day was held for patients needing same day or urgent appointments. The practice's answer phone message detailed how to access out of hours emergency care if needed. However there was no information outside the building informing patients of out of hours emergency services, should they come to the practice when it was closed

Most patients we spoke with were satisfied with the appointments system and said it was easy to use. They also particularly appreciated the text service which helped remind them of their appointment times. However, two patients told us that getting an appointment with the orthodontist was sometimes difficult, and they often had to wait many weeks before one became available.

Concerns & complaints

The practice had a system in place for handling complaints and concerns from patients. We noted there was good information in the waiting area telling patients how they could raise a complaint. There was also information about the local advocacy groups such as the patient advice and liaison service. Further information was available in the practice's information leaflet which included detail of external agencies that could help if patients did not want to complain directly to the practice. Patients we spoke with told us they felt confident that any concerns they had would be responded to appropriately by staff. Staff's knowledge of the practice's complaints procedure was assessed as part of their yearly appraisal process.

We looked at all complaints received by the practice in the last year. We saw that these had been recorded, investigated and responded to appropriately. Learning from them had taken place: for example, a new protocol had been introduced in the practice in response to one complaint about the payment of treatment provided by the dental hygienist.

Are services well-led?

Our findings

Governance arrangements

The practice manager was experienced and dedicated to her job. However, she had only one day a week to fulfil her role as the practice manager and CQC registered manager for the service. We found that this had impacted on her ability to effectively manage all aspects of the day to day running of the practice, including having time to set up suitable equipment maintenance contracts, undertake regular infection control audits, organise electrical testing and undertake a range of personnel duties.

There was a full range of policies and procedures in use at the practice. These included health and safety, infection prevention control, needle stick injury and safeguarding people. However we noted some of these polices and procedures had not been updated since 2013, and there was no system in place to show that staff had read, understood and agreed to abide by them.

The practice completed the NHS information governance tool kit each year to measure its compliance with the laws regarding how patient information is handled.

There were meetings involving all the staff where a range of practice issues were discussed such as administrative protocols, appointment systems and targets. Minutes of the meetings were taken for those who could not attend.

Staff received a yearly appraisal of their performance, in which they were set specific objective which were then reviewed after six months. These appraisals were comprehensive and covered staff's performance in relation to their communication, complaints handling and patient information management. Staff reported that their appraisal was useful, and helped them identify any further training needs.

Staff had also recently been issued with a comprehensive hand book which outlined in detail a range of employment information such as the practice's capability and grievance policies, staff holiday entitlement, the whistle blowing policy and standards of dress.

Leadership, openness and transparency

Staff told us there were meetings where they felt able to raise concerns. Staff felt their suggestions were listened to: for example, their suggestion to improve the filing system for patients' notes and to implement a more comprehensive medical history form had been adopted.

Although they had not needed to use it, staff we spoke with were aware of the whistle blowing policy and understood when it was appropriate to use.

Management lead through learning and improvement

Staff working at the practice were supported to maintain their continuous professional development as required by the General Dental Council. Staff told us they had good access to training and the practice monitored it, to ensure essential training was completed each year.

We found a lack of consistency in practice amongst the dentists in relation to, the quality of dental records, the use of rubber dams, referral processes, and the recording of involvement of patients in their care and treatment in the dental records. There was no system of peer review in place for the dentists to help monitor their performance and drive improvement.

There was no specific significant events log and no annual analysis of events or incidents detect any common themes, or share learning from **.**

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

Regular surveys were undertaken to give patients the opportunity to give feedback and influence how the service was run. Results of these surveys were clearly displayed in the waiting room, along with the action taken by the practice to implement patients' suggestions, such as extending opening hours and installing air conditioning.

The practice gave patients the opportunity to complete the NHS family and friends test, (FFT) which is a national programme to allow patients to provide feedback on the services provided. Results of this test were monitored closely and discussed at staff meetings.

Although there was no specific survey for staff, most staff told us that the practice manager and dentists were approachable and they felt they could give their views about how things were done at the practice. Staff confirmed that they had regular meetings where they could suggest improvements to how the practice ran.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must have arrangements to take appropriate action if there is a clinical or medical emergency. Regulation 12 (2)(b) (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must assess, monitor and mitigate the risks relating to the health, safety and welfare of services users by ensuring the practice's policies are kept up to date and that significant events and incidents are analysed. Regulation 17(2)(b) (Regulated Activities) Regulations 2014. The provider must maintain accurate and complete records in respect of each service user. This includes an accurate record of all decisions taken in relation to care and treatment and make reference to discussions with people who use the service. This includes consent records. Consent records include the alternatives offered. Regulation 17(2)(c) (Regulated Activities) Regulations 2014.