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Stratfield Road Dental Practice

Inspection Report

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Date of inspection visit: 19 February 2020

Date of publication: 01/04/2020

Overall summary

We carried out this announced inspection on 19 February 2020 under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a Care Quality Commission, (CQC), inspector who was supported by two specialist dental advisers.

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

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

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

Our findings were:

Are services safe?

We found this practice was not providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Stratfield Road Dental Practice is in Basingstoke and provides NHS and private dental care and treatment for adults and children.

There is level access to the practice for people who use wheelchairs and those with pushchairs. Car parking spaces, including those for people with disabilities, are available near the practice.

Summary of findings

The dental team includes one dentist, one dental nurse, one trainee dental nurse and one receptionist. The practice has one treatment room.

The practice is owned by an individual who is the principal dentist. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

On the day of inspection, we collected 19 CQC comment cards filled in by patients and spoke with three other patients.

During the inspection we spoke with one dentist, one dental nurse and the receptionist. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

- Monday to Friday 9am to 5pm.
- Saturdays by arrangement.

Our key findings were:

- The practice appeared to be visibly clean and well-maintained.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.
- Staff felt involved and supported and worked as a team.
- The provider asked staff and patients for feedback about the services they provided.

- The provider dealt with complaints positively and efficiently.
- The provider had information governance arrangements.
- The clinical staff provided patients' care and treatment in line with current guidelines in most cases. However they did not carry out periodontal care or root canal treatment completely in accordance with guidance.
- Staff, although trained, were not confident in using emergency medicines or equipment.
- The provider had limited systems to help them manage risk to patients and staff.

We identified regulations the provider was not complying with. They must:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Full details of the regulation the provider was not meeting are at the end of this report.

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

- Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the Faculty of General Dental Practitioners.
- Take action to ensure the availability of an interpreter service for patients who do not speak English as their first language.
- Implement a system to ensure patient referrals to other dental or health care professionals are centrally monitored to ensure they are received in a timely manner and not lost.

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 this practice was not providing safe care in accordance with the relevant regulations.

Requirements notice 

Are services effective?

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

No action 

Are services caring?

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

No action 

Are services responsive to people's needs?

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

No action 

Are services well-led?

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

Requirements notice 

Are services safe?

Our findings

We found 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 section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

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

Staff had clear systems to keep patients safe.

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw evidence staff had received safeguarding training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC.

The provider had a system to highlight vulnerable patients and patients who required other support such as with mobility or communication, within dental care records.

The provider had an infection prevention and control policy and procedures. Staff told us they were unaware of guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care. Staff completed infection prevention and control training.

The provider had arrangements for transporting, cleaning, checking, sterilising and storing instruments which were in line with HTM 01-05, for example water was used for manual cleaning of instruments rather than disinfectant, a metallic bur brush was used when this is not recommended in guidance, no apron or visor was worn during the decontamination process to protect staff and there was no temperature measurement of water to ensure it was below 45 degrees centigrade. The records showed the autoclave and washer disinfectant used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance. Staff also had access to an ultrasonic cleaner.

However, the device was not validated or tested as recommended in guidance. The provider had suitable numbers of dental instruments available for the clinical staff but measures were not in place to ensure they were decontaminated and sterilised appropriately.

The staff usually carried out manual cleaning of dental instruments prior to them being sterilised. We advised the provider that manual cleaning is the least effective recognised cleaning method as it is the hardest to validate and carries an increased risk of injury from a sharp instrument.

The staff had systems in place to ensure that patient-specific dental appliances were disinfected prior to being sent to a dental laboratory and before treatment was completed.

There were no procedures to reduce the possibility of Legionella or other bacteria developing in the water systems. There was no legionella risk assessment. There were no records of water testing and dental unit water lines were not maintained in line with guidance.

We saw cleaning schedules to ensure the practice was kept clean. When we inspected we saw the practice was visibly clean in most areas. However, improvements could be made to the cleaning of the decontamination room window ledge and light fittings.

The provider had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance.

The provider did not carry out infection prevention and control audits twice a year as advised in guidance. There was no audit to show the practice was meeting the required standards.

The provider had a Speak-Up policy. Staff felt confident they could raise concerns without fear of recrimination.

The dentist did not use a dental dam in line with guidance from the British Endodontic Society when providing root canal treatment. In instances where dental dam was not used, for example refusal by the patient, and where other methods could be used to protect the airway, we did not see that this was documented in the dental care record and a risk assessment completed.

Are services safe?

The provider did not have a recruitment policy and procedure to help them employ suitable staff. We looked at all staff recruitment records and saw that the provider followed had followed recruitment guidelines even though they did not have a policy.

We observed clinical staff were qualified and registered with the General Dental Council and had professional indemnity cover.

Staff ensured facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions, including electrical and gas appliances.

A fire risk assessment was carried out in line with the legal requirements, although limited in nature. We saw there were fire extinguishers throughout the building and fire exits were kept clear.

The practice had some arrangements to ensure the safety of the X-ray equipment. We saw some of the required radiation protection information was available; for example the relevant Health and Safety notification was not available. The company providing the radiation protection advisor service had recently changed and the practice had not yet engaged with the new radiation protection advisor.

We were unable to be shown evidence the dentists justified, graded and reported on the radiographs they took. The provider had not carried out radiography audits every year following current guidance and legislation.

Clinical staff completed continuing professional development in respect of dental radiography.

Risks to patients

The provider had implemented limited systems to assess, monitor and manage risks to patient safety.

The practice health and safety policies, procedures and risk assessments although limited in content; were reviewed regularly to help manage potential risk. The provider had current employer's liability insurance.

We looked at the practice arrangements for safe dental care and treatment. The staff did not follow the relevant safety regulation when using needles and other sharp dental items, for example the sharps boxes were located away from the treatment rooms and there were no safety sharps

equipment available, as recommended in guidance. A sharps risk assessment had been undertaken and was updated annually; but did not include specific information about the non-use of safer sharps equipment.

They had ensured clinical staff had received appropriate vaccinations, including vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked.

None of the clinical staff had sufficient knowledge of the recognition, diagnosis and early management of sepsis.

Staff knew told us they were not confident to use emergency medicines or equipment when responding to a medical emergency; although they had completed training in emergency resuscitation and basic life support every year. This demonstrated the provider did not have effective systems in place to ensure staff had understood the training they received and were competent to support patients in the case of an emergency.

Emergency equipment and medicines were not available as described in recognised guidance, for example' the oxygen cylinder was half the required size, no buccal midazolam was available which is used to treat a number of conditions including a seizure; needles and syringes had expired in 2011, and there was no automated external defibrillator (AED) available nor was a risk assessment in place to deal with the AED's absence. We found staff did not keep records or checks and the list used was not in line with current guidance.

A dental nurse worked with the dentist when they treated patients in line with General Dental Council Standards for the Dental Team.

We reviewed the Control of Substances Hazardous to Health (COSHH) Regulations 2002 file and saw that some material safety data sheets were out of date when newer versions were available, not all products had been risk assessed to minimise the risk that can be caused from substances that are hazardous to health.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at dental care records with clinicians to corroborate

Are services safe?

our findings and observed that individual records were written. The provider explained to us how examinations and treatment were conducted, however whilst what we were told was thorough, the patient care notes did not reflect what we had been told. Dental care records we saw were not complete. They contained insufficient detail concerning risk assessments, social history, consent processes, there were no basic periodontal examination details recorded or comprehensive periodontal evaluation records, no justification for radiographs either by way of grading or reporting of images and the records we reviewed were often illegible. Records were kept securely and complied with General Data Protection Regulation requirements.

The provider had systems for referring patients with suspected oral cancer under the national two-week wait arrangements. These arrangements were initiated by National Institute for Health and Care Excellence to help make sure patients were seen quickly by a specialist.

There was no central monitoring system for referrals as recommended in guidance.

Safe and appropriate use of medicines

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

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

We saw staff stored and kept records of NHS prescriptions, but improvements could be made to records to ensure these were as described in current guidance.

The dentist were not aware of current guidance with regard to prescribing medicines.

Antimicrobial prescribing audits were not carried out annually to confirm that the dentist was following current guidelines.

Track record on safety, and lessons learned and improvements

The provider had implemented systems for reviewing and investigating when things went wrong. There were comprehensive risk assessments in relation to safety issues. Staff monitored and reviewed incidents. This helped staff to understand the potential risks and led to effective risk management systems in the practice as well as safety improvements.

In the previous 12 months there had been no safety incidents. Staff told us that any safety incidents would be investigated, documented and discussed with the rest of the dental practice team to prevent such occurrences happening again.

The provider had a system for receiving and acting on safety alerts. Staff learned from external safety events as well as patient and medicine safety alerts. We saw they were shared with the team and acted upon if required.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

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

Helping patients to live healthier lives

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

The dentist prescribed high concentration fluoride products if a patient's risk of tooth decay indicated this would help them.

The dentist discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of dental products for sale and provided leaflets to help patients with their oral health.

The dentist described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients with preventative advice, taking plaque and gum bleeding scores and completing detailed charts of the patient's gum condition.

Records showed patients with severe gum disease were recalled at more frequent intervals for review and to reinforce preventative advice.

Consent to care and treatment

Staff showed a lack of awareness in obtaining consent to care and treatment in line with legislation and guidance.

The practice team did not fully understand the importance of obtaining and recording patients' consent to treatment. The staff were not aware of the need to obtain proof of legal guardianship or Power of Attorney for patients who lacked capacity or for children who are looked after. The dentist did not always record in patient care notes about the information they gave about treatment options and the

risks and benefits of these, so they could make informed decisions. We did not see this documented in patients' records. Patients confirmed their dentist listened to them and gave them clear information about their treatment.

The practice did not have a consent policy which included information about the Mental Capacity Act 2005. The team did not demonstrate that they understood their responsibilities under the act when treating adults who might not be able to make informed decisions. The policy should have referred to Gillick competence, by which a child under the age of 16 years of age may give consent for themselves in certain circumstances. Staff were unaware of the need to consider this when treating young people under 16 years of age.

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly, even though not recorded in patient care notes.

Monitoring care and treatment

The practice did not keep detailed dental care records containing information about the patient's current dental needs, past treatment, medical and social history. The dentist told us they assessed patient's treatment needs in line with recognised guidance, but this was not shown in patient care notes.

The provider had no quality assurance processes to encourage learning and continuous improvement. There were no records of audits, the resulting action plans and improvements.

Effective staffing

Staff new to the practice including locum staff did not have a structured induction programme. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council.

Co-ordinating care and treatment

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

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

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

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

Patients commented positively that staff were friendly, relaxed and helpful. We saw staff treated patients respectfully, appropriately and caringly; and were friendly towards patients at the reception desk and over the telephone.

Patients said staff were compassionate and understanding.

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

Information folders, patient survey results and thank you cards were available for patients to read.

Privacy and dignity

Staff respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting areas provided privacy when reception staff were dealing with patients. If a patient asked for more privacy, the practice would respond appropriately. The reception computer screens were not visible to patients and staff did not leave patients' personal information where other patients might see it.

Whilst the practice had an electronic patient care records system, they did not use it. Patients care records were in paper form, they stored paper records securely.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care. They were aware of the Accessible Information Standard.

The Accessible Information Standard is a requirement to make sure that patients and their carers can access and understand the information they are given. We saw:

- There were no interpreter services available for patients who did not speak or understand English.
- Staff communicated with patients in a way they could understand, and communication aids and easy-read materials were available.

Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Staff gave patients clear information to help them make informed choices about their treatment. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. A dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

The practice website and information leaflet provided patients with information about the range of treatments available at the practice.

The dentist described to us the methods they used to help patients understand treatment options discussed, these included X-ray which enabled images to be taken of the tooth being examined or treated and shown to the patient or relative to help them better understand the diagnosis and treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

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

Staff were clear about the importance of emotional support needed by patients when delivering care. They conveyed a good understanding of support which may be needed by more vulnerable members of society such as patients with dementia, and adults and children with a learning difficulty.

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

Two weeks before our inspection, CQC sent the practice 50 feedback comment cards, along with posters for the practice to display, encouraging patients to share their views of the service.

- 19 cards were completed, giving a patient response rate of 38%
- 100% of views expressed by patients were positive.

Common themes within the positive feedback were friendliness and helpfulness of staff, sympathetic staff and easy access to dental appointments.

We shared this with the provider in our feedback.

We were able to talk to three patients on the day of inspection. Feedback they provided aligned with the views expressed in completed comment cards.

The practice had made reasonable adjustments for patients with disabilities. This included step free access.

Staff had not carried out a disability access audit and formulated an action plan to continually improve access for patients.

Staff telephoned some patients on the morning of their appointment to make sure they could get to the practice.

Timely access to services

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

The practice displayed its opening hours in the premises and included it in their information leaflet and on their website.

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

The staff took part in an emergency on-call arrangement with the NHS 111 out of hour's service and patients were directed to the appropriate out of hours service.

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

Listening and learning from concerns and complaints

Staff told us the provider took complaints and concerns seriously and would respond to them appropriately to improve the quality of care.

The provider had a policy providing guidance to staff about how to handle a complaint. The practice information leaflet explained how to make a complaint.

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

The provider aimed to settle complaints in-house and invited patients to speak with them in person to discuss these. Information was available about organisations patients could contact if not satisfied with the way the provider had dealt with their concerns.

We looked at comments, compliments and complaints the practice had received. There had been no complaints in the previous year.

Are services well-led?

Our findings

We found 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). We will be following up on our concerns to ensure they have been put right by the provider.

Leadership capacity and capability

At the conclusion of our inspection the provider and staff identified that there was a need to implement a new management system; that the practice would be implementing an external contractor to supply this system, as soon as was practicable.

Staff told us they worked closely with the provider to make sure they prioritised compassionate and inclusive leadership.

Culture

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

Staff did not discuss their training needs at an annual appraisal. We saw no evidence of completed appraisals in the staff folders. The provider did not have a system in place to monitor staff understanding of training and therefore was not able to ensure they were competent in applying training they had undertaken.

We saw the provider had systems in place to deal with poor staff performance.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of, and had systems, to ensure compliance with the requirements of the Duty of Candour.

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

Governance and management

Staff had clear responsibilities, roles and systems of accountability.

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

The provider had a limited system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff and were reviewed regularly. There were a number of policies which the provider was unable to show us[EY3]; these included recruitment, prescriptions, consent, referrals, business continuity plan, incident reporting, environmental cleaning, whistleblowing, hand hygiene, training or induction procedures.

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

Appropriate and accurate information

Quality and operational information, for example a rolling patient satisfaction survey was used to ensure and improve performance.

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

Engagement with patients, the public, staff and external partners

Staff involved patients to support the service. For example by arranging a rolling feedback system and constantly reviewing the results. The survey confirmed that patients were happy with the service the practice provided.

The provider used patient surveys and a comments book to obtain patients' views about the service.

Patients were encouraged to complete the NHS Friends and Family Test. This is a national programme to allow patients to provide feedback about NHS services they have used.

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

Continuous improvement and innovation

Are services well-led?

The provider had limited quality assurance processes to encourage learning and continuous improvement. There were no audits of dental care records, radiographs and infection prevention and control. As there were no audits there were no resulting action plans and improvements.

The principal dentist valued the contributions made to the team by individual members of staff, an example of this was helping a member of staff requalify as a dental nurse after a period away from the nursing profession; where registration with the General Dental Council had lapsed.

Staff completed 'highly recommended' training as stated in the General Dental Council professional standards. The provider supported and encouraged staff to complete continuing professional development.

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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014</p> <p>Regulation 12</p> <p>Safe care and Treatment</p> <p>Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>The registered person had systems or processes in place that were ineffectively operated in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:</p> <ul style="list-style-type: none">• The provider must ensure that arrangements for transporting, cleaning, checking, sterilising and storing instruments are in line with HTM 01-05.• The provider must provide evidence of procedures to reduce the possibility of legionella or other bacteria developing in the water systems, and a legionella risk assessment provided in line with guidance.• The provider must ensure usage of a dental dam in line with guidance from the British Endodontic Society when providing root canal treatment. In instances where dental dam is not used this must be documented in the patient dental care record and a risk assessment completed.• The provider must ensure that the required radiation protection information is available for inspection.• The provider must ensure that safer sharps guidelines are followed; and where guidance is not followed this is recorded and risk assessed.

Requirement notices

- The provider must ensure that emergency equipment and medicines are available as described in recognised guidance. Where guidance is not followed this must be recorded and risk assessed. The provider needs to have processes in place to ensure staff are knowledgeable in how to manage emergency situations, equipment and medicines.

Regulation 12

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulation 17

Good governance

Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered person did not maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. In particular:

- The provider must ensure that dental care records are completed in line with guidelines and include risk assessments, social history, consent processes, basic periodontal examination details or comprehensive periodontal evaluation records, justification for radiographs either by way of grading or reporting of images and are legible.

The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

Requirement notices

- The provider must ensure that the Control of Substances Hazardous to Health (COSHH) Regulations 2002 file contains the relevant information for all substances where risk can be caused to health.
- The provider must ensure staff are aware of guidelines in prescribing medicines.
- The provider must ensure the practice team fully understand the importance of obtaining and recording patients' consent to treatment. The staff must be aware of the need to obtain proof of legal guardianship or Power of Attorney for patients who lacked capacity or for children who are looked after.
- The provider must produce evidence of a consent policy which includes information about the Mental Capacity Act 2005. The policy should refer to Gillick competence, by which a child under the age of 16 years of age may give consent for themselves in certain circumstances.
- The provider must ensure that detailed dental care records containing information about the patient's current dental needs, information about treatment options and the risks and benefits of these, passed treatment, medical and social history are kept.
- The provider must improve clinical governance and include policies, protocols and procedures that were accessible to all members of staff; including recruitment, prescriptions, consent, referrals, business continuity plan, incident reporting, environmental cleaning, whistleblowing, hand hygiene, training or induction procedures.
- The provider must implement a system to oversee that staff received their annual appraisal .
- The provider must implement a quality assurance processes to encourage learning and continuous improvement. These were no audits of dental care records, radiographs and infection prevention and control.

Regulation 17