Mr. Robert Burkett

Dental Surgery

Inspection Report

199 Plumstead Road, Norwich, Norfolk, NR1 4AB
Tel: 01603 700435
Website:

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Overall summary

We carried out an announced comprehensive inspection on 4 October 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 not providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

The Dental Surgery is a small, well-established practice that provides mostly NHS general dentistry services to adults and children. Dr Robert Burkett, who is also the principal dentist, owns the practice.

The practice has a team of two dentists, three part-time dental nurses, and two part-time receptionists. There are two treatment rooms, a room for the decontamination of instruments, and a patient waiting and reception area.

The practice opens on Mondays to Fridays from 9am to 5pm, and on Saturdays by appointment. It is closed for lunch between 1 pm and 2 pm.

The practice owner is registered with the Care Quality Commission (CQC) as an individual. 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.

Our key findings were:

- We received consistently good feedback from patients about the quality of the practice's staff and the effectiveness of their treatment.
- There was appropriate equipment for staff to undertake their duties and equipment was well maintained.
- Appointments were easy to book and patients requiring urgent treatment were always seen on the same day.
- Staff we spoke to felt well supported by the practice owner, and there were regular practice meetings involving all staff.
- The practice listened to its patients and staff and acted upon their feedback.

Summary of findings

- Arrangements for monitoring safety and managing risk were not robust. This included the recording of significant events, the use of a safer sharps' systems, the use of rubber dams, the storage of dental care products, and the management of substances hazardous to health.
- The practice's recruitment process did not ensure that all relevant checks were undertaken before new staff started work.
- Essential information and evidence of some dental examinations and risk assessments was missing from patient dental care records.
- Some areas of the practice were not visibly clean.

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

- Ensure effective systems and processes are established to assess and monitor the service against the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and national guidance relevant to dental practice. This must include systems for monitoring safety and reducing risk to patients and staff; maintaining an hygienic environment, ensuring staff are up to date with essential training and ensuring dental care records are maintained appropriately giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Ensure the practice's recruitment policy and procedures are suitable and the recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.

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

- Review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role, and in particular to the needs of patients living with dementia.
- Review the practice's protocols and procedures for promoting the maintenance of good oral health giving due regard to guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'.
- Review the practice's responsibilities to the needs of people with a disability and the requirements of the Equality Act 2010. Review the availability of interpreting services for patients who do not speak English as their first language.

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?

Requirements notice 

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).

Risks to staff and patients had been identified and control measures put in place to reduce them. Emergency equipment was available and medicines were checked to ensure they did not go beyond their expiry dates. The decontamination of dirty instruments procedures met national guidance. However, none of the staff had received safeguarding training and their knowledge of local protection agencies was limited. Significant events were not always reported appropriately and learning from them was not shared across the staff team. Some clinical areas of the practice were not clean and recruitment practices were not robust. The dentists were not up to date with essential training in radiography, and did not use a safer sharps as recommended by national guidance.

Are services effective?

Requirements notice 

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

It was not possible for us to ascertain from the dental care records if patients' needs were fully assessed, and if care and treatment was delivered in line with current standards and evidence based guidance, as a lot of essential information about patients' treatment and examinations was missing. We also found a limited application of guidance issued in the DH publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. Staff did not have a clear understanding of the Mental Capacity Act 2005, and its relevance in obtaining valid consent for a patient who lacked the capacity to make decisions for themselves.

There was a small and established staff team at the practice who received regular appraisal of their performance. However, the clinical staff were not up to date with their continuing professional development and had not undertaken recommended training such as infection control, information governance, complaints handling, or health and safety.

Are services caring?

No action

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

Summary of findings

Patients spoke highly of the dental treatment they received, and of the caring and empathetic nature of the practice's staff. Patients told us they were involved in decisions about their treatment, and did not feel rushed in their appointments. Staff understood the importance of maintaining patients' privacy and information about them was handled confidentially.

Are services responsive to people's needs?

No action 

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

Routine dental appointments were readily available, as were urgent on the day appointment for patients experiencing dental pain. Patients commented it was easy to get through on the phone to the practice, and they rarely waited once arrived.

The practice had made some adjustments to accommodate patients with a disability, although could not offer a service to wheelchair users due to limitations of the building.

Information about how to complain was easily available and the practice responded in a timely, empathetic and appropriate way to issues raised by patients.

Are services well-led?

Requirements notice 

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

Staff told us they felt well supported and there was a clear leadership structure. Feedback from staff and patients was actively used to improve the service provided. However, we found a significant number of shortfalls in three of the five key areas we inspected, indicating that the practice was not well-led. Policies and procedures to govern the practice's activities had not been regularly reviewed or updated to reflect current guidance, staff were not up to date with key areas of training, the quality of dental care records was poor, and the practice's own audits had been ineffective in identifying the shortfalls we found during our inspection. A lack of robust oversight meant that significant events had not been managed appropriately, levels of cleanliness had not been monitored and staff had not been recruited safely.

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 4 October 2016 and was conducted by a CQC inspector and a dental specialist advisor.

During the inspection we spoke with the practice owner, one dentist, two dental nurses and the receptionist. We received feedback from 47 patients who had completed our comment cards prior to our visit. We 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

Staff we spoke with had a satisfactory understanding of their reporting requirements under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) and details of how to report to this agency were available in the practice's policy. However, they had a limited understanding of what might constitute a significant event and how they should share learning from any. The practice did not have any policies regarding the reporting of significant events, or any process in place to ensure learning from them was shared formally. We were told of one incident where a patient's neck had become stuck in the dental chair's headrest. The patient had sustained slight bruising and a graze as a result. Although the event had been recorded in the accident book, it had not been reported to any other agencies, or the manufactures of the chair. The principal dentist was unaware of the event, and no discussion or action had been taken to prevent its reoccurrence. Another incident had occurred which involved a patient hurting their arm on some brickwork to the entrance of the practice; once again we found no evidence of learning from it.

National patient safety alerts were sent to the practice owner and actioned if required.

Reliable safety systems and processes (including safeguarding)

Policies were accessible to all staff and clearly outlined whom to contact for further guidance if they had concerns about a patient's welfare. We also noted a poster in the decontamination room providing guidance to staff on how to report any safeguarding concerns. However**,** none of the staff we spoke with had received accredited safeguarding training. The practice owner was the lead for safeguarding in the practice but he had not received any training for this role.

Staff spoke knowledgeably about action they would take following a sharps' injury and a sharps' risk assessment for the practice had been completed. There was a sharps' policy in place, although this did not include guidance about the need for staff to check patients' medical history. Only the dentists handled sharps, although they did not use a sharps' safety system, as recommended in Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Boxes for the disposal of sharps were wall mounted, although in one treatment room this was too low down for their safe disposal. Neither sharps' box had been labelled correctly.

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. Neither dentist routinely used rubber dams, or implemented additional safety measures to protect patients' airways.

Medical emergencies

All staff had received medical emergency training on 29 September 2016, although staff did not regularly rehearse emergency medical simulations so that they had a chance to practice what to do in the event of an incident.

The emergency equipment and oxygen were stored in a central location known to all staff and was checked regularly. Staff had access to oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines, although there was no automated blood glucose-measuring device. The practice had recently ordered an automatic external defibrillator (AED), which arrived on the day of our inspection. An AED is a portable electronic device that analyses life-threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.

The practice held emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice and those we checked were in date for safe use.

Staff recruitment

All but two of the staff had been employed at the practice for many years. We checked the recruitment file for a recently appointed member of staff and noted a number of shortfalls. For example, although there was a Disclosure and Barring Service certificate, this was dated some seven years before the staff member was employed and the practice had not undertaken a new check, or undertaken a risk assessment of the possible impact of this. Only one reference had been obtained from a previous work

colleague, despite the staff member having worked for a number of health services previously. There was no photographic proof of their identity. No record had been made of the staff member's interview to demonstrate it had been conducted in line with good employment practices.

The staff member concerned told us she had received a full induction to her role which included working supernumerary to staff until she felt confident to work on her own.

Monitoring health & safety and responding to risks

The practice had a range of policies and risk assessments, which described how it aimed to provide safe care for patients and staff. The risk assessments we viewed were satisfactory and covered wide range of identified hazards in the practice and the control measures that had been put in place to reduce the risks to patients and staff. They had been regularly updated.

A fire risk assessment had been completed in June 2016 and firefighting equipment such as extinguishers were regularly tested, evidence of which we viewed**.** Regular fire evacuation drills were completed, although these did not include patients so it was not clear how the practice would manage in a fire when patients were present.

A legionella risk assessment had been carried out for the practice and tap water temperatures were checked monthly. However a record was made just that the check had been completed, and not of the actual temperature of the water tested. Regular flushing of the water lines was carried out, at the start and end of each day to reduce the risk of legionella bacteria forming. Staff we spoke with were not following national guidance as to how long this should be done for.

There was a comprehensive control of substances hazardous to health folder in place containing chemical safety data sheets for some materials used within the practice. However we noted there were no safety data sheets available for a number of products used within the practice. We also noted an unmarked bottle containing a green fluid in one surgery. We were told it contained a surface cleaner but there was no way of verifying this.

A mercury spillage kit was available so that any amalgam could be dealt with safely, although the practice did not have a bodily fluid spillage kit.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure, loss of dental records or staff shortages. The plan included emergency contact numbers for key staff and utility companies.

Infection control

Patients who completed our comment cards told us that they were happy with the standards of hygiene and cleanliness at the practice.

We observed that most areas of the practice were visibly clean and hygienic, including the waiting area, stairway and corridors. The toilet was clean and contained liquid soap and paper towels so that people could wash their hands hygienically. There was plenty personal protective equipment available for both staff and patients. Staff uniforms were clean, long hair was tied back and staff's arms were bare below the elbows to reduce the risk of cross infection. All dental staff had been immunised against Hepatitis B.

We checked both treatment rooms and noted a number of shortfalls in cleanliness. Treatment room walls were covered in wooded chip paper, making them difficult to clean effectively. Drawer handles and insets were sticky and dirty and had not been cleaned in some time. We noted some loose and uncovered items in drawers within the splatter zone that risked becoming contaminated over time. We found two single use matrix bands that had been reprocessed so that they could be used again. There were a number of cracks in surfaces that needed to be filled, and some cabinetry was worn exposing chip work underneath. A chair in one treatment room was ripped and no action had been taken to repair it. Paintwork round the chair base was flaking and old, and electrical leads were sticky and dirty. The practice's cleaning equipment did not meet with national guidance and the same mop was used to clean the toilet and also the treatment areas, compromising good infection control.

The practice had a dedicated decontamination room that was set out according to the Department of Health's guidance, Health Technical Memorandum 01- 05 (HTM 01-05), decontamination in primary care dental practices. The dental nurse demonstrated the decontamination process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments

Are services safe?

followed a well-defined system of zoning from dirty through to clean. The dental nurse used a system of manual scrubbing for the initial cleaning process. Following inspection with an illuminated magnifying glass, instruments were then placed in an autoclave (a device used to sterilise medical and dental instruments). When the instruments had been sterilized, they were pouched and stored until required. However, the pouches were not marked with the date by which they should be used. The dental nurse told us instead she reprocessed all pouched instruments once a month on a specific day. However this did not follow HTM01-05 guidance.

The dental nurse demonstrated that systems were in place to ensure that the autoclaves used in the decontamination process were working effectively.

The practice used an appropriate contractor to remove dental waste and we saw the necessary waste consignment notices. Clinical waste was stored in a locked downstairs cupboard, prior to being removed from the practice.

The last infection control audit at the practice had been undertaken in December 2015, some nine months prior to our visit. National guidance recommends that these audits be completed every six months. This audit had identified two areas for improvement, but no action had been taken to implement them.

Equipment and medicines

We found that there were adequate numbers of instruments available for each clinical session to take account of decontamination procedures. The equipment used for sterilising instruments was checked, maintained and serviced in line with the manufacturer's instructions. Appropriate records were kept of decontamination cycles to ensure that equipment was functioning properly. All other equipment was tested and serviced regularly and we saw maintenance records that confirmed this. For example, fire equipment had been serviced in September 2016, a gas safety check had been completed in June 2016 and portable appliances had been tested in October 2015. We checked a range of medical consumables in the practice's stock room area and found that they were all within date for safe use.

There was a system in place to ensure that relevant patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Authority were received and actioned and staff were aware of recent alerts affecting dental practice. Dentists were also aware of reporting systems to the British National Formulary and of the yellow card scheme to report any patient adverse reactions to medicines.

The batch numbers and expiry dates for local anaesthetics were not recorded and prescriptions were mot managed so they could be tracked effectively. The practice did not have a separate fridge for the storage of medical consumables which required cool storage, and fridge temperatures were not monitored to ensure they were operating effectively.

Radiography (X-rays)

We viewed the practice's radiography file that contained the names of the Radiation Protection Advisor the Radiation Protection Supervisor, and the necessary documentation regarding the maintenance of the X-ray equipment. Local rules were available in the file, but not in the treatment rooms where x-rays were undertaken. Although the principal dentist assured us that the Health and Safety Executive had been informed of the practice's use of radiology, evidence of this was not available. Neither dentist had received recent training for core radiological knowledge under IR(ME)R 2000 Regulations, although both signed up to a course on 9 November 2016 during our inspection. Rectangular collimation or aiming devices were not used to minimise x-ray beam scatter, although these were fitted during our inspection.

Dental care records we viewed showed the justification for x-rays being taken, although their quality was not graded as recommended by the Faculty of General Dental Practice.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Dentists we spoke with were aware of National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC) guidelines in relation to wisdom tooth removal and patient dental recall intervals. However, they were not aware of recent guidance in relation to the use of antibiotic prophylaxis and were prescribing antibiotic cover in contravention of the guidance. We were shown a sample of 10 patients' dental care records and found them to be of poor quality generally. Although there was evidence that gum disease and dental decay risk assessments had been undertaken for patients, other essential information and evidence of examinations was missing. For example, patients' medical histories were not always updated annually, or signed by them; lymph gland and jaw examinations were not recorded; patients' tooth surface loss was not recorded; patients' social and dental histories were not routinely recorded, nor was any record of the treatment options discussed with them. Soft tissue examinations were recorded but not in great detail. We were told that smoking cessation advice was given verbally to patients, but there was no record of this in the notes we viewed. As a result, it was not possible for us to ascertain from the dental care records if patients' dental needs were fully assessed, and if care and treatment was delivered in line with current legislation, standards and evidence based guidance.

Health promotion & prevention

The practice did not sell any oral health care products such as interdental brushes, mouthwash, or floss. Free samples of toothpaste were available and one dental nurse told us she regularly gave them to patients. General information about oral health care for patients was limited and there were no leaflets or displays available in the waiting area about oral health care.

One dental nurse had undertaken training in smoking cessation advice and patients were asked about their smoking habits and alcohol intake when they completed their medical histories. However, there was no record of smoking cessation advice having been recorded in patients' notes that we viewed. There was no information or leaflets available for patients wanting to give up smoking. Staff were not aware of guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' was limited. This is an evidence-based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Staffing

There was a stable and established staff team at the practice, most of who had worked there for many years. Staff told us the staffing levels were suitable for the small size of the service and the dentists worked with a dental nurse. They reported that patients were given plenty time and that appointments were never rushed.

Staff told us they received a yearly appraisal of their performance, which they found useful.

Files we viewed demonstrated that clinical staff were appropriately qualified, insured and where required, had current professional validation. The practice had appropriate Employer's Liability insurance in place. However, apart from one certificate showing that the dental nurses had received training in decontamination procedures, there was no other evidence available that any staff had undertaken key training in radiology, infection control, safeguarding, complaints handling, information governance, and health and safety. Staff's fitness to practice was not regularly checked by the practice owner.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves. The dentists referred cases of suspected oral cancer swiftly and told us of four instances in the last year that had been identified and managed well. However, a log of the referrals made was not kept so they could be could be tracked, and copies of the referral were not kept on patients' notes. Patients were not offered a copy of the referral for their information.

Consent to care and treatment

Patients told us that they were provided with information during their consultation and that they had the opportunity to ask questions before agreeing to a particular treatment. Patients were also provided with a plan, which clearly outlined their proposed treatment. However, there was little evidence that written information about various treatments was routinely given to patients to help aid their full understanding and consent to it.

Are services effective?

(for example, treatment is effective)

The Mental Capacity Act 2005 (MCA) provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The practice did not have a policy in relation to the MCA and none of the staff had received any training, despite the practice. The staff we spoke with had a limited knowledge of the act and its relevance when dealing with patients who might not have capacity to make decisions for themselves. This was of concern given lead dental nurse told us the practice served an aging population group, some of whom lived with dementia.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patients told us they were treated in a way that they liked by staff and many comment cards we received described staff as professional, caring and empathetic to their needs. Patients told us that staff listened to them and respected their wishes. They also commented that they received good follow up and after care from the dentists. One patient praised the principal dentist in particular for the caring way he worked with her son who had considerable mental health difficulties. All the respondents to the practice's own survey, (completed by about 100 patients) stated that staff were courteous and supportive to them.

Staff gave us examples of where they had gone out their way to support patients. For example, patients regularly dropped off their dentures for repair at one dental nurse's house to save them travelling a long way to the practice. The receptionist told us she regularly helped older patients and parents with small children manage the steep stairway to the practice.

The receptionist had a good understanding of patient confidentiality and told she never discussed patients' medical histories in the waiting area, never left patients' notes out unattended, and offered to take patients' to a different room if they wanted to discuss matters privately. Patients' paper records were kept in lockable fireproof filing cabinets behind the reception desk.

Treatment rooms doors were closed at all times when patients were with dentists and conversations between patients and dentists could not be heard from outside the rooms.

Involvement in decisions about care and treatment

Patients told us that their dental health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They reported that they felt listened to and supported by staff and had sufficient time during consultations. A plan outlining the proposed treatment was given to each patient so they were fully aware of what it entailed and its cost.

Feedback from the practice's own survey indicated that treatment was explained to adequately patients.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

In addition to general dentistry, the practice offered a number of cosmetic treatments, including tooth whitening, veneers and crowns. Although no hygienist was available at the practice, the dentists provided all oral health and gum disease advice and treatment to patients.

There was good information available in the waiting room for patients explaining both NHS and private dental fees, staff's General Dental Council (GDC) registration certificates, how to raise a complaint, and also the patients' information leaflet. Information about emergency out of hours services was available on the practice's answer phone message, and on the front door should a patient come to the practice when it was closed.

The practice opened on Mondays to Fridays from 9am to 5pm, and on Saturdays by appointment. Patients who completed our comment cards stated that it was easy to get an appointment and that they rarely waited long having arrived for their appointment. Although no specific emergency appointment slots were held aside each day, the lead nurses told us that all patients experiencing dental would be seen the same day and the practice offered a 'sit and wait' service. As the practice was not computerised, it was unable to offer patients a text or email messaging service to remind them of their appointments, something that four patients commented that they would like.

Tackling inequity and promoting equality

The practice was sited on a first floor, reachable only by a steep staircase, making it inaccessible to wheelchairs. However it had arrangements in place with a nearby by practice who could accommodate wheelchair users. There was no disabled toilet to accommodate those with mobility problems or hearing loop to assist patients who wore hearing aids. Information about the practice was not available in any other languages or formats such as large print, braille or audio. There was no information available about interpreting services that patients could access and staff were not aware of any. Staff had not undertaken any training in equalities and diversity to help them better understand the diverse needs of their patients. The practice's equal opportunities policy was very out of date and referred to legislation that no longer existed.

Concerns & complaints

The practice had a policy and a procedure that set out how complaints would be addressed, and the receptionist spoke knowledgeably about how she would handle a patient's concerns. Information about the procedure was available in the patient waiting room and contained details of other agencies that could be contacted if necessary. We viewed details of two recent complaints and found they had been investigated in a timely and thorough way, and an apology given where appropriate. It was clear that the practice learned from complaints and in response to one had implemented a range of measures to ensure that all patients felt safe within the practice.

Are services well-led?

Our findings

Governance arrangements

The principal dentist had responsibility for the day-to-day running of the practice, supported by the lead dental nurse. Communication across the practice was structured around monthly practice meetings, minutes of which we viewed. Staff told us the meetings were useful and provided a good forum for teamwork and communication.

During our inspection we found a significant number of shortfalls, which indicted that oversight and leadership in the practice was lacking. For example, staff had not received essential safeguarding and radiology training, and significant events were not managed well. Recruitment practices were not robust and did not ensure that only suitable staff were employed at the practice. Water temperatures were not adequately recorded and some areas of the practice were not clean.

The practice had policies and procedures to support its work and provide guidance to staff. However some of these had not been reviewed regularly; others had not been dated at all so it was not clear if they were still relevant, and others referred to locations not relevant to the practice, or to out of date legislation. Although the practice manager had signed these policies, there was no evidence that other staff had signed them to indicate that they had read, understood and had agreed to abide by them.

Regular audits were undertaken to assess standards in radiography, infection control and the quality of clinical notes. However, infection control audits were not undertaken as frequently as recommended and identified shortfalls had not been addressed. The practice's dental care records audit had not been effective in addressing many of the shortfalls we discovered following our review of them.

The practice's information governance tool kit had not been completed fully, so it was not clear whether it was meeting the requirements of legislation in how it managed patient information.

Leadership, openness and transparency

Staff told us they enjoyed their work and the small size of the practice, which meant that communication between them was good. They told us they felt supported and valued in their work and reported there was an open culture within the practice. Staff told us that they had the opportunity to, and felt comfortable, raising any concerns with the owner of the practice who was approachable and responsive to their needs.

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

The practice had introduced the NHS Friends and Family Test as a way for patients to let them know how well they were doing. There was also a suggestion box in the waiting area for patients to leave any comments. Patients' feedback was regularly discussed at the practice meetings, evidence of which we viewed at the meeting of 2 August 2016. It was also displayed in the waiting area so that patients were aware of how their suggestions had been implemented by staff.

In response to a patient's complaint, the practice had introduced an additional survey, asking patients if staff explained treatment adequately, if they were given a treatment plan and if staff were courteous and supportive. We viewed about 50 responses all of which provided a very positive view of the practice.

Staff told us that the practice owner listened to them and implemented their suggestions. For example, their suggestion to operate a denture repair 'collect and return' service had been implemented, thereby helping the practice's older patients. Staff's suggestion to introduce a yearly planning tool had also been actioned.

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 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HCSA 2008 Regulations 2014 Good Governance** How the regulation was not being met: The provider did not operate effective systems and processes to assess, monitor and mitigate risks to the health and welfare of people who used the service. This included ensuring that relevant national guidance was followed, maintaining complete records of care, maintaining an hygienic environment and ensuring staff received essential training. **Regulation 17 (1)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Regulation 19- Fit and proper person employed** How the regulation was not being met: The provider did not have robust recruitment systems in place to ensure that only fit and proper staff were employed by the practice. **Reg 19 (1)**