Mr. Paul Wiltshire

Hanham High Street Dental Practice

Inspection Report

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Overall summary

We carried out this announced inspection on 30 May and 31 May 2017 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 CQC inspector who was supported by a specialist dental adviser, who was a dentist. The inspection was carried out over two days because there were two individual providers based on one site.

We told the NHS England area team and Healthwatch that we were inspecting the practice. They provided information which we took into account.

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Hanham High Street Dental Practice is in Hanham in South Gloucestershire and provides NHS and private treatment to patients of all ages.

Summary of findings

There is no level access for patients who use wheelchairs and there is no allocated parking for patients. Patients can use public transport services to attend the practice and there is a short stay car park nearby.

The dental team includes three dentists, five dental nurses and three receptionists. The practice has three treatment rooms.

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 45 CQC comment cards filled in by patients and spoke with five other patients. This information gave us a positive view of the practice.

During the inspection we spoke with three dentists, three dental nurses, a trainee dental nurse, two receptionists and the practice manager. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

- Monday and Wednesday 9am – 5pm
- Tuesday and Thursday 9am – 6pm
- Fridays 8am – 4pm

Our key findings were:

- The practice was clean and well maintained.
- The practice had infection control procedures which reflected published guidance.
- Staff knew how to deal with emergencies and appropriate medicines and life-saving equipment were available. Systems in place to check the emergency equipment must be improved.
- The practice had ineffective systems to help them manage risk.
- The practice had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- The practice must improve staff recruitment procedures.
- Through the review of patient records it was not always clear that clinical staff had followed current guidelines when providing care and treatment.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The appointment system met patients' needs.
- The provider needed to improve its leadership to ensure it improved upon patient safety and governance within the practice. Staff felt involved and supported by the practice manager and worked well as a team.
- The practice asked staff and patients for feedback about the services they provided.
- The practice dealt with complaints positively and efficiently.

We identified regulations the provider was not meeting. They must:

- Ensure an effective system is established to assess, monitor and mitigate the various risks arising from undertaking of the regulated activities. For example, completing actions from the fire safety risk assessment, ensuring emergency equipment was in working order, ensuring all staff reviewed the COSHH file, ensuring the consent policy included Mental Capacity Act and Gillick competency. Ensure there is an effective system in place to monitor staff training. Ensure there is an effective system in place to ensure staff maintain patient confidentiality at all times. Ensure there is an effective audit trail in place to monitor prescriptions upon entry to when they leave the practice. Ensure there is an effective system in place to respond to all patient comments including NHS choices.
- 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.
- Ensure that the practice is in compliance with its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000.

Summary of findings

- Ensure the practice's protocols for recording in the patients' dental care records or elsewhere the justification for taking the X-ray and quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.

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

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

- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society
- Review staffing arrangements to ensure all staff received appraisals and the support they required for their role.
- Review the storage of records related to people employed and the management of regulated activities giving due regard to current legislation and guidance.
- Introduce protocols regarding the prescribing and recording of antibiotic medicines in consideration of guidance provided by the Faculty of General Dental Practice in respect of antimicrobial prescribing
- Review dental care records so that they are maintained appropriately giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.

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?

No action

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

The practice had systems and processes to provide safe care and treatment. They used learning from incidents and complaints to help them improve.

Staff received training in safeguarding and knew how to recognise the signs of abuse and how to report concerns.

Staff were qualified for their roles. The practice needed to ensure there were safer recruitment checks in place to ensure patient safety.

Premises and equipment were clean and properly maintained. The practice followed national guidance for cleaning, sterilising and storing dental instruments.

The practice had arrangements for dealing with medical and other emergencies. Although, these needed to be monitored more effectively to ensure equipment was in adequate working order.

Are services effective?

No action

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

The dentists assessed patients' needs and provided care and treatment in line with recognised guidance. However, this was not always recorded appropriately or carried out with regard to recognised guidance.

Patients described the treatment they received as very good, excellent and pain free. The dentists discussed treatment with patients so they could give informed consent and two of three dentists recorded this in their records.

The practice had clear arrangements when patients needed to be referred to other dental or health care professionals.

The practice supported staff to complete training relevant to their roles and although their system to help them monitor this could be improved.

Are services caring?

No action

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

We received feedback about the practice from 50 patients. Patients were positive about all aspects of the service the practice provided. They told us staff were kind,

Summary of findings

friendly and helpful. They said that they were given helpful, honest explanations about dental treatment, and said their dentist listened to them. Patients commented that they made them feel at ease, especially when they were anxious about visiting the dentist.

We saw that staff did not always protect patients' confidentiality when they were visiting or telephoning the practice. We saw staff maintained patient's privacy when being treated. Patients said staff treated them with dignity and respect.

Are services responsive to people's needs?

No action

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

The practice's appointment system was efficient and met patients' needs. Patients could get an appointment quickly if in pain.

Staff considered patients' different needs. This included providing facilities for families with children. The practice had access to telephone interpreter services and had arrangements to help patients with hearing loss.

The practice took patients views seriously. They valued compliments from patients and responded to concerns and complaints quickly and constructively. Although comments raised on NHS choices had not been responded to.

Are services well-led?

Requirements notice

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

The practice needed to ensure they had effective arrangements in place to ensure the safety of patients. These included systems for fire safety, medical emergency equipment, and audit trail for prescriptions.

Not all of the practice team kept complete patient dental care records which were clearly written. Patient records were stored securely.

The practice monitored clinical and non-clinical areas of their work to help them improve and learn. Although sometimes these methods were not effective.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had policies and procedures to report, investigate, respond and learn from accidents, incidents and significant events. Staff knew about these and understood their role in the process.

The practice recorded, responded to and discussed all incidents to reduce risk and support future learning.

The practice received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA). Relevant alerts were discussed with staff, acted on and stored for future reference.

Reliable safety systems and processes (including safeguarding)

Staff spoken with knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The practice had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw evidence that staff received safeguarding training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns. The practice had a whistleblowing policy. Staff told us they felt confident they could raise concerns with the practice manager without fear of recrimination.

We looked at the practice's arrangements for safe dental care and treatment. These included risk assessments which staff reviewed every year. The practice followed relevant safety laws when using needles and other sharp dental items. Dentists did not always use rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment. The dentist said they would risk assess the necessity of this following a review of the latest guidelines. The practice manager told us after the inspection they have now purchased an additional rubber dam kit and completed a risk assessment.

The practice had a business continuity plan describing how the practice would deal events which could disrupt the normal running of the practice.

Medical emergencies

Staff knew what to do in a medical emergency and completed training in emergency resuscitation and basic life support every year, except for two of the dentists.

Emergency equipment and medicines were available as described in recognised guidance. Staff kept records of their checks to make sure these were available and within their expiry date. Although we found the checks were not effective and found the oxygen was half full, which did not meet GDC standards and the resuscitation council guidance for primary dental care. The practice manager told us they had organised for the oxygen cylinder to be filled two days after our inspection.

Staff recruitment

The practice had a staff recruitment policy and procedure to help them employ suitable staff. This reflected the relevant legislation. We looked at two staff recruitment files. These showed the practice did not always follow their recruitment procedure. For example, the practice manager told us and we saw evidence that interview notes were not taken or held. One references had been sourced for one employee, even though their policy stated two references should be taken for all employees. The practice manager told us they would implement a new system to monitor recruitment of staff.

Clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover. Checks on GDC registration and performers list were not routinely taken and recorded for clinical staff.

Monitoring health & safety and responding to risks

The practice's health and safety policies were up to date and reviewed to help manage potential risk. These covered general workplace and specific dental topics. The practice had current employer's liability insurance and checked each year that the clinicians' professional indemnity insurance was up to date.

The practice had a fire risk assessment which had been completed by a fire safety company in April 2008. There was one low risk action from the risk assessment that had not been completed. This was to install emergency lighting in the building. The fire risk assessment had been reviewed by both the provider and the practice manager annually. The practice manager told us that the provider had not

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completed this due to funding. They did not have anything else available to aid patient's ability to see if a fire occurred. The practice manager informed us after the inspection that they had now organised for emergency lighting to be fitted.

Staff had not completed any training in fire safety and there was no competent person available in case of a fire that knew how to work the fire safety equipment or lead staff and patients out of the building safely. The practice manager had informed us since the inspection that fire safety training had been organised for July 2017.

Fire drills were completed on a weekly basis alongside the fire alarm check at the same time of day. The practice manager told us they would start completing six monthly or annual fire drills ensuring that all staff had been involved and completed when staff did not expect it.

A dental nurse worked with the dentists when they treated patients.

Infection control

The practice had an infection prevention and control policy and procedures to keep patients safe. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health. Staff completed infection prevention and control training every year.

The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM01-05. The records showed equipment staff used for cleaning and sterilising instruments was maintained and used in line with the manufacturers' guidance.

The practice carried out infection prevention and control audits twice a year. The latest audit showed the practice was meeting the required standards.

The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment.

We saw cleaning schedules for the premises. The practice appeared clean when we inspected and patients confirmed this was usual.

Equipment and medicines

We saw servicing documentation for the equipment used. Staff carried out checks in line with the manufacturers' recommendations.

The practice had suitable systems for prescribing and storing medicines. Although they did hold a medicine in a refrigerator that should be held securely.

The practice stored NHS prescriptions securely. They did not have a system in place to ensure there was an audit trail from delivery to the practice to when it was used to prescribe medicines as described in current guidance. The practice manager had started a system for recording prescription pads when they were delivered and when they were allocated to a dentist on the second day of the inspection. The provider told us they would now be logging the prescription numbers when they prescribed.

Radiography (X-rays)

The practice did not have suitable arrangements to ensure the safety of the X-ray equipment. We found ten X-rays which had no patient identification. We were told these were either had fallen out of patient records when the patient took them to reception or the dental nurse developing the X-ray had left them in the developing room. One X-ray seen demonstrated that the patient had caries and so the provider was unable to identify who this patient was or if they had been told. The owner told us they had implemented a monitoring system for the dental nurses to complete when they had an X-ray to develop and X-ray holders had been purchased to help contain records within their file.

Some X-ray chemicals used and unused had been stored in an unsecure room. These had been moved to an appropriate storage area by the second day of our inspection. Used X-ray chemicals were also not stored on appropriate trays to ensure any leakage was contained. The practice manager had ordered these by second day of the inspection.

We saw evidence that some records showed dentists justified, graded and reported on the X-rays they took. However, we found evidence that some records showed they did not record justification within patient notes for radiographs and found patients who had not had bite wing X-rays taken over the period of time recommended. For example, one patient had been seen since 2002 and there was no evidence of bite wing radiographs taken. The dentist told us that many patients refused to have a

Are services safe?

radiograph taken but this was not recorded in the notes. We found routine radiographs were not used as part of diagnosing and assessing caries risk and other problems that required treatment at an early stage.

The practice carried out X-ray audits every year following current guidance and legislation.

Dentists completed continuous professional development in respect of dental radiography. We found the provider was not using a collimator (a device that narrows a beam of particles or waves) when they took X-rays, so patients were exposed to more radiation than necessary. We were informed after the inspection that a spare collimator had been found and was now in use.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Most records showed the dentists kept detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. Most records showed the dentists assessed patients' treatment needs in line with recognised guidance. We saw some records that did not provide enough information to show an adequate assessment, diagnosis and process of any treatment carried out on the patient including treatment options provided. For example, one patients radiograph showed there were retained roots. The notes did not show whether this had been discussed with patient, what treatment if any was planned and whether the risk of infection was discussed.

We saw records where repeat antibiotics were prescribed but the situation did not follow current guidance for safe prescribing. We also saw evidence where a patient had been provided with private treatment which could have been provided through the NHS but no record on whether the patient was asked which service they had preferred.

We saw that two out of three dentists had audited patients' dental care records to check that the dentists recorded the necessary information. We were not shown evidence of the other dentists record audits. The practice manager told us they had completed one.

Health promotion & prevention

The practice believed in preventative care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentists told us they prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for children based on an assessment of the risk of tooth decay for each child.

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

Staffing

Staff new to the practice had a period of induction based on a structured induction programme. Although, induction records did not include a review of the Control of Substances Hazardous to Health file and there was no record to show they had read the file with signatures from staff. The practice manager assured us all staff had read the file and since the inspection they had informed us the induction procedure had been updated.

We confirmed clinical staff completed the continuous professional development required for their registration with the General Dental Council.

Staff told us they discussed training needs at annual appraisals. We saw evidence of completed appraisals. Although a senior member of staff did not receive an appraisal from the provider. We did discuss this with the provider who told us they would consider this.

Working with other services

Dentists confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide. This included referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist. The practice monitored urgent referrals to make sure they were dealt with promptly.

Consent to care and treatment

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentists told us they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions. Patients confirmed their dentist listened to them and gave them clear information about their treatment.

The practice's consent policy did not include information about the Mental Capacity Act 2005. The practice had information about the Mental Capacity Act but no evidence to show staff had read this. Although, we did see evidence of discussions about this in team meetings. The practice manager had since informed us the policy had been updated. The policy also did not have any information in relation to Gillick competence. Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff we spoke with were aware of their responsibility to respect patient's diversity and human rights.

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

Nervous patients said staff were compassionate and understanding. Patients could choose whether they saw a male or female dentist.

Staff were aware of the importance of privacy and confidentiality. Although we observed receptionists discussing confidential personal information to a level that other patients would know who had an appointment and what treatment they required. Receptionists used appointment books and it was observed that patients could view these books and see other patient information. We also observed a member of clinical staff discussing X-ray results with a patient in the waiting/reception area rather than taking them back into the treatment room. The practice manager told us they had spoken to staff about this to remind them of confidentiality. The layout of reception and waiting areas was unable to provide full privacy when reception staff were dealing with patients.

The practice was a solely paper record practice and did not use computers. We saw they stored paper records securely within the reception area.

There were magazines and a television in the waiting room for patients entertainment whilst they were waiting to be seen.

Information about practice policies was available for patients to read and fees of NHS treatment were displayed. Although there were no specific treatment leaflets available for patients. For example, to explain root canal treatment or crowns.

Involvement in decisions about care and treatment

The practice gave patients clear information to help them make informed choices. 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.

Patients told us staff were kind and helpful when they were in pain, distress or discomfort. We heard patients comment they received pain-free treatment.

The practice did not have a website to inform patients of information about the range of treatments available at the practice.

One dentist told us they only verbally explained treatment and did not find it necessary to use other aids such as moulds, X-rays and pictures to help aid understanding. They told us for patients that may need some additional support they used a carer or family member to assist them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

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

The practice had an efficient appointment system to respond to patients' needs. Staff told us that patients who requested an urgent appointment were seen the same day. Patients told us they had enough time during their appointment and did not feel rushed. We heard from staff that often appointments ran late for one dentist and some patients said they didn't mind waiting to see the dentist.

Staff told us that they currently had some patients for whom they needed to make adjustments to enable them to receive treatment. Where patients were unable to use the stairs they were asked if they would like to use the ground floor room. The ground floor room was also only suitable for patients who could manage a couple of steps without aid. The patients preferred dentist would move rooms to accommodate this. Otherwise patients were referred to a local practice which could meet their needs.

Staff told us and we heard staff phoning all patients the day before their appointment to remind them.

Promoting equality

The practice made reasonable adjustments for patients with disabilities. Patients had access to a translation line service and a hearing loop.

The practice building meant they were restricted in providing services for all mobility's. The practice was on two levels and additional steps on each level which meant patients who used a wheelchair were unable to use the practice. Receptionists made patients aware of this when they called and referred patients to other local practices that could meet their needs. If patients preferred to see their dentist in the ground floor surgery, which had a couple of steps upon entry, then they would swap surgeries to accommodate them.

Access to the service

The practice displayed its opening hours in the premises, in their information leaflet and through the NHS choices website. We were told the practice kept waiting times for routine appointments around two to three weeks. Cancellations were kept to a minimum and locums were rarely used.

The practice was committed to seeing patients experiencing pain on the same day and kept 20 minute appointments free for same day appointments. They took part in an emergency on-call arrangement with some other local practices. The information leaflet and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open. Patients confirmed they could make routine and emergency appointments easily and were rarely kept waiting for their appointment.

Concerns & complaints

The practice had a complaints policy providing guidance to staff on how to handle a complaint. The practice information leaflet explained how to make a complaint. The practice manager was responsible for dealing with these. Staff told us they would tell the practice manager about any formal or informal comments or concerns straight away so patients received a quick response.

The practice manager told us they 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 practice dealt with their concerns.

We looked at comments from the NHS choices website and complaints the practice received in the last 12 months. We noted there had been one formal complaint which had been acted on and addressed within the same day. The practice responded to the complaint appropriately and discussed outcomes with staff to share learning and improve the service. On NHS choices 18 patients had commented about the care and treatment received in the last 12 months, six comments were negative about the treatment received. It was noted that all of these comments had not received a response from the practice. The practice manager told us they had attempted to respond but had some technical difficulties, so were unable to respond.

Are services well-led?

Our findings

Governance arrangements

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

The practice needed to improve its policies, procedures and risk assessments to support the management of the service and to protect patients and staff;

- The consent policy did not have any information included in relation to the Mental Capacity Act and Gillick competency.
- There was no record to show staff had read and understood the Control of Substances Hazardous to Health file.
- The practice manager did not have an efficient system in place to ensure all staff had received required training within the required timescale.
- The fire safety risk assessment that had been completed in 2008 had an action that required attention. The risk assessment had been reviewed annually by the practice manager and provider but no action taken to address this.
- Staff had not been trained in fire safety and this had not been assessed as a risk by the provider.
- The emergency equipment had been regularly assessed but it had not been recognised that the oxygen was not at the required level appropriate if there was an emergency requiring oxygen.
- Prescriptions were not effectively monitored upon delivery to when they left the building to ensure there was an adequate audit trail.
- There was not an effective system in place to respond to patients who commented on NHS choices.
- The recruitment policy did not reflect current regulations and records reviewed did not follow their own practice policy.
- Patient records did not always reflect what had been diagnosed during their consultation and sometimes decisions were made without due consideration to current guidelines.

The practice had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information. Although staff had been made aware that this should be further improved in the reception area when reminding or booking patients in for their appointments. Some staff records were held within an open plan area of the building. The practice manager informed us they would review what was stored and ensure all records were held securely.

Leadership, openness and transparency

The practice manager was not aware of the duty of candour and its requirements to be open, honest and to offer an apology to patients if anything went wrong. They told us they would gain some advice and produce a policy to ensure all staff were aware of this. We have been shown since the inspection a duty of candour policy.

Staff told us there was an open, no blame culture at the practice. They said the practice manager encouraged them to raise any issues and felt confident they could do this. They knew who to raise any issues with and told us the practice manager was approachable, would listen to their concerns and act appropriately. The practice manager discussed concerns at staff meetings and it was clear the practice worked as a team and dealt with issues professionally.

The practice held meetings where staff could raise any concerns and discuss clinical and non-clinical updates. Immediate discussions were arranged to share urgent information.

Learning and improvement

The practice had ineffective quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, X-rays and infection prevention and control. They had clear records of the results of these audits. However, we saw some audit results did not correspond to what we found in regards to radiographs and patient records and so could be further improved to ensure audits were effective. We also saw antibiotic prescribing logs which showed entries did not correspond with patient records reviewed.

Are services well-led?

The principal dentist showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff. The dental nurses and receptionists had annual appraisals. They discussed learning needs, general wellbeing and aims for future professional development. We saw evidence of completed appraisals in the staff folders. We noted a senior member of staff did not have an appraisal and felt this would be beneficial to further their development in their role. This was discussed with the provider who said they would consider this.

Staff told us they completed some mandatory training, including medical emergencies and basic life support, each year. There was no fire safety training available for staff and fire drills were carried out by staff who had not received any training. Staff had not been shown by a competent person how to use the fire extinguishers. Three members of staff had not completed level two child protection training as required and two out of three of the dentists had not completed their annual basic life support training. The General Dental Council requires clinical staff to complete continuous professional development. Staff told us the practice provided support and encouragement for them to do so.

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

The practice used patient surveys to obtain patients' views about the service. We saw examples of suggestions from patients the practice had acted on. For example, patients had commented about having more toys for children to play with whilst they were waiting to be seen. The practice manger had purchased more toys for children. The other patient comments were made about the payment facilities as there was no method of paying by a debit or credit card. Only cash and cheque payment. This caused an inconvenience for patients particularly for the larger payments made. The provider had decided against this because of funding.

Patients were encouraged to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on NHS services they have used. We saw results from this were high for recommending friends and family to the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HCSA 2008 Regulations 2014 Good governance** How the regulation was not being met: • The provider must assess, monitor and improve the quality and safety of the services provided • The provider must assess, monitor and mitigate the risks relating to health, safety and welfare of service users and others who may be at risk