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Polscy Lekarze Dental Service

Inspection Report

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Date of inspection visit: 14 July 2015
Date of publication: 10/09/2015

Overall summary

We carried out an announced comprehensive inspection on 14 July 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

We found that this practice was 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 a well-led care in accordance with the relevant regulations.

This is the first inspection of Polscy Lekarze Dental Service which was registered with the CQC in September 2013. The practice provides a range of dental treatments on a private basis. Patients can register with the practice from anywhere in the country. Approximately 95% of patients who use the service are Polish speaking. There is one dentist at the practice supported by a dental nurse in training and the provider who takes the role of receptionist and administrative support. The practice offers appointments between 9.30am and 9pm every weekday and offers an emergency service at weekends. Appointments are available by calling the practice telephone number. The dentist, provider and nurse attend the practice when an appointment is booked but are not on site at all times providing a 'drop in' service.

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

Our key findings were:

- The practice provided flexible access to appointments and was available between 9.30am and 9pm every weekday.

Summary of findings

- The practice was clean and tidy and instruments were cleaned and decontaminated in accordance with current guidance.
- The small practice team of three worked closely together to offer a personalised and flexible service to their patients.
- Patients received both a detailed verbal description and a written treatment plan when a course of treatment was proposed.
- The systems in place for reviewing health and safety had not identified that control of infection audits had not been completed.
- The practice had not followed General Dental Council requirements because they did not hold all emergency equipment required.

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

- Ensure audits to assess the risks of cross infection are carried out every six months in accordance with current guidance.
- Ensure all staff, including the provider, are trained in basic life support and that immediate access to an Automated External Defibrillator (AED) is available.
- Ensure dental records include details of all examinations undertaken and advice given in respect of care and treatment.
- Ensure prescribed medication taken by patients is included in their medical history record.

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

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

- Undertake a written legionella risk assessment.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action by issuing Requirement Notices which can be found at the end of this report. The provider was not meeting regulations because they did not undertake control of infection audits at the required frequency. An automated external defibrillator (AED) (An AED is a portable electronic device that diagnoses life threatening irregularities of the heart and is able to deliver a shock to attempt to correct the irregularity) was not available for immediate use and there was no risk assessment completed to mitigate the risks. The provider had not undertaken training in basic life support. Systems were in place to report accidents and incidents, staff were aware of their responsibilities to safeguard children and vulnerable adults and X-ray procedures were operated safely.

Are services effective?

We found that this practice was not providing effective care in accordance with the relevant regulations. We have told the provider to take action by issuing a Requirement Notice which can be found at the end of this report. Patients were given information they understood to make decisions about their dental care and treatment. Advice was given to support patients maintaining their oral health but was not recorded. The results of soft tissue examinations and examinations of the ligaments supporting the teeth were not recorded and the medical history of patients did not include the medicines they were prescribed or taking. Referrals to other services were made when required and these were carried out in a timely manner. Staff received training relevant to their roles and responsibilities.

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations. Patients' privacy and dignity was maintained. Arrangements were made to support patients who were nervous and longer appointments were available for this group of patients. Patients received both a detailed verbal description and a treatment plan when a course of treatment was proposed.

Are services responsive to people's needs?

We found that this practice was providing responsive care in accordance with the relevant regulations. The practice offered appointments from 9.30am to 9pm each weekday and an emergency service was available at weekends. Patients were able to book appointments at short notice for a time that was convenient to them. Continuity of care was provided because patients always saw the same dentist.

Are services well-led?

We found that this practice was not providing well-led care in accordance with the relevant regulations. The systems in place for reviewing health and safety had not identified that control of infection audits had not been completed. The practice had not followed General Dental Council requirements because they did not hold all emergency equipment required. Omissions from patient dental records had not been identified in the audits of records undertaken on an annual basis.The small staff team worked closely together and a formal management structure was not required. Staff meetings were held at which both practical and practice development issues were discussed. Patient feedback was sought but patients had shown a reluctance to formalise either their satisfaction with the service or raise any concerns they had. The member of staff employed was being supported in their learning and development.

Polscy Lekarze Dental Service

Detailed findings

Background to this inspection

The inspection was led by a CQC inspector and a CQC specialist advisor who was a dentist. A second CQC inspector attended the inspection in an observer role.

We contacted NHS England area team and Slough Healthwatch. We did not receive any information of concern from them about this service.

The two patients who attended during our inspection declined to speak with us. We also attempted to call two patients on the telephone following the inspection and received two completed CQC comment cards. We met with the dentist, the provider and the member of staff on duty. The volunteer who assisted the practice in maintaining management records was also present and showed us a range of policies and procedures which the dentist used to manage the service. We saw how patients made their appointments and observed the processes for reducing the risk of cross infection.

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

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

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had a system for both reporting of accidents and incidents. There were log books for recording both accidents and significant events and near misses. We noted that the accident book did not meet the Health and Safety Executive (HSE) requirement and advised the provider of our findings. We received evidence the day after inspection confirming an HSE compliant accident report book had been purchased.

There were no records of either accidents or incidents taking place since the practice opened in September 2013. The dentist and provider confirmed there had not been any to report. The incident and near miss reporting log carried an information sheet at the front describing the types of event that should be recorded.

Reliable safety systems and processes (including safeguarding)

The practice had up to date Child Protection and Vulnerable Adult policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. Staff we spoke with were able to describe the types of abuse they might witness during the course of their duties. The policies were available to staff and they would either seek out the policy or discuss concerns with the dentist who was the lead for both child and adult safeguarding. We saw record confirming the dentist had received additional training to enable them to carry out their lead role. The contact details for the local authority's child protection and adult safeguarding teams were available to staff.

The dentist used rubber dams (a rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth), when undertaking root canal treatments. This ensured the treatment was carried out using up to date guidelines and increased the safety of the procedure for the patient.

Medical emergencies

The practice had arrangements in place to deal with some medical emergencies. The dentist had attended training for cardiopulmonary resuscitation (CPR) and the trainee dental nurse had this training included in their college course but had not yet completed this training. However, the provider who acted as receptionists and administrator had not undertaken this training. They would not be able to support the dentist if they experienced an emergency. We checked the medical emergency drugs kit and found all contents were in date and in accordance with national guidelines. We saw evidence that all emergency drugs were regularly checked and kept up to date. Medical emergency oxygen was available and we saw that the cylinder was regularly checked. There was a protocol in place to ensure correct maintenance of this piece of equipment. The practice did not have an Automated External Defibrillator (AED) (An AED is a portable electronic device that diagnoses life threatening irregularities of the heart and is able to deliver a shock to attempt to correct the irregularity). We did not find a risk assessment for the use of an AED. The General Dental Council (GDC) endorse the resuscitation council guidance requiring all dental practices to have, or have immediate access to, an AED. The practice was not meeting GDC guidance because it did not have immediate access to an AED.

Staff recruitment

The practice had a recruitment policy that included the requirement to obtain references, check qualifications and experience, be registered with an appropriate professional body and to obtain proof of identity. Checks were also made with the Disclosure and Barring Service to ensure staff were safe to work with children and vulnerable adults. We looked at the personnel records of the provider, the dentist and the trainee dental nurse files and found they contained the relevant documentation. We were able to confirm that all staff had undertaken criminal records checks and that the dentist was registered correctly with their professional body and had the necessary qualifications, skills and experience to work in their role.

Monitoring health & safety and responding to risks

A health and safety policy with supporting risk assessments was in place at the practice. The policy was easily available to the member of staff if they needed it. The policy described risks and the actions identified to mitigate risk. For example, it required all entrances and exits to be kept clear of obstructions.

There were also other policies and procedures in place to manage risks at the practice. These included infection prevention and control fire evacuation procedures and risks associated with hepatitis B. Processes were in place to monitor and reduce these risks so that staff and patients

Are services safe?

were safe. For example we saw records confirming that all staff had received their course of immunisations for hepatitis B. (Hepatitis B is a type of virus that can infect the liver. This virus can be contracted by health care personnel and others as a result of a needle stick injury if they have not been immunised against the virus).

Staff induction included briefing on health and safety procedures including what to do if there was a fire in the practice.

Infection control

The practice had an infection control policy. We reviewed the cleaning standards in the consulting room and general areas and found the practice clean and tidy. There was a cleaning checklist for the visiting contract cleaners to follow.

Clinical waste was managed in accordance with the required legislation. The clinical waste was collected directly, every week, from the consulting room because the practice only generated one bag of clinical waste each week. There was a contract in place for the disposal of all clinical waste and dental products. Records of collection of clinical waste by the approved contractor were signed and retained appropriately. However, we found that extracted teeth were placed in the clinical waste bag. The practice did not hold a 'tooth pot' for these items. We advised the provider and dentist of our findings. We received evidence on the day after the inspection confirming the practice had ordered a tooth pot.

We observed a member of staff cleaning the work area in the consulting room between treatments. The process followed current guidance for the cleaning and decontamination of dental practices and appropriate personal protective equipment (PPE) was worn throughout the procedure. Dental lines that carry water to the dental chair units were flushed through in accordance with best practice and a chemical application to reduce the risk of bacteria growing in the lines was appropriately applied.

Dental instruments were initially cleaned and placed in an ultrasonic cleaning bath in the consulting room (an ultrasonic cleaning bath is a device used in the initial stages of the decontamination of dental instruments). The instruments were then taken to a dedicated decontamination room. This was laid out appropriately with clear separation of the dirty instruments entering the room and the clean sterile instruments coming out of the autoclave (an autoclave is a piece of equipment that treats instruments at high temperature to ensure any bacteria are killed). A member of staff demonstrated the process for cleaning and sterilising instruments and the process followed current guidance and appropriate PPE was worn throughout the procedure. The equipment used for cleaning and sterilising was maintained and serviced as set out by the manufacturers. Daily, weekly and monthly records were kept of decontamination cycles and tests and when we checked those records it was clear that the equipment was in working order and being effectively maintained. We looked at the dental instruments which had been taken through the decontamination process and were ready for use in the dental consulting rooms. These were in date and ready for use.

We found hand washing guidance displayed above the wash hand basins in all consulting rooms, the decontamination room and toilets. There was an adequate supply of hand washing soap and paper towels adjacent to all hand wash hand basins.

The practice did not hold a written risk assessment for legionella (a particular bacteria which can contaminate water systems in buildings). We noted that hot and cold water was not held in tanks at the practice. The water for hand washing and other sinks was direct from the water mains. It was then heated to an appropriate temperature by individual water heaters below each sink. This meant the practice was of low risk for legionella. The risk level had not, however, been confirmed by a competent person undertaking an assessment.

Equipment and medicines

Records we reviewed showed the practice had a programme for servicing equipment. There were service records for pressure vessels, autoclaves and other items of dental equipment. Equipment was maintained in accordance with manufacturers' guidance and legal requirements and was safe for use.

We checked medicines held for use in an emergency and for day to day treatment and all were within their expiry dates and there was a system in place for monitoring the expiry dates and ensuring medicines were held safely and securely. Any medicine prescribed was supported by a prescription and an entry in the patient's record. The prescription pads were held securely and only accessible to the dentist and the provider.

Are services safe?

Radiography (X-rays)

The practice maintained a comprehensive radiation protection folder. A radiation protection advisor and a radiation protection supervisor had been appointed to ensure that the equipment was operated safely and by qualified staff only. The folder confirmed that the dentist was the only person, at the time of inspection, qualified to take X-rays and evidenced their training. Staff working at the practice had been required to sign to indicate that they understood the correct procedures and the local rules relating to the use of X-ray equipment. This kept staff and patients safe from unnecessary radiation exposure. The X-ray machine was situated in a suitable area and X-rays were carried out safely and in line with local rules that were relevant to the practice and equipment. We reviewed documentation that demonstrated that the X-ray equipment was serviced and calibrated at the recommended intervals.

The dentist entered the rating of the quality of the X-rays taken in the patient's record. However, we found one X-ray had been rated at the poorest quality grading and the dentist had not recorded the action they would take to avoid similar poor quality X-rays being taken in the future. We noted that the practice followed a policy of keeping exposure to x-rays to a minimum and followed national guidance on the frequency of taking routine X-rays. The justification for taking an X-ray was based on full dental examination.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Patients completed a medical history and were asked if there were any changes to medical conditions or medicines taken before any course of treatment was undertaken. However, the medical history form used did not detail any medicines the patients were prescribed. The five records we checked all contained medical history forms. These forms did not detail any medicines the patients were prescribed.

The practice used current guidelines when making decisions on treatment and clinical risk. For example the requirement to take x-rays and the frequency of recall was based upon a full oral examination. Each time the patient received a dental check their records were updated and decisions about their future treatment and check-up regime were noted.

The dentist showed us five patient records which they translated for us. The records did not contain details of examination of soft tissue or the assessment of the gum surrounding the tooth. The faculty of General Dental Practice recommends that these examinations are undertaken and recorded. The dentist told us they undertook the examinations but had not recorded the outcomes.

The practice conducted an annual audit of patient records. A random sample of ten records were reviewed. We looked at the results of the last audit. The dentist had identified that oral health advice had not been entered in the records and had recorded the need to include this information in the future. However, the five records we reviewed did not detail oral health advice being given.

Health promotion & prevention

There were health promotion leaflets available in the practice to support patients to look after their oral health. These included information about good oral hygiene. The dentist told us they offered oral health advice to patients but we did not find evidence of this recorded in the five records we checked.

There was a prominent poster displayed in Polish and in pictorial format that offered advice on a wide range of health promotion topics including healthy eating and smoking cessation. We heard that the practice had taken part in a local fayre in 2014. This enabled them to promote the importance of oral health to the local community.

Staffing

The dentist worked as a single practitioner on a flexible basis only attending the practice when patients were booked for treatment or review. The trainee dental nurse worked on a similar basis and attended the practice at the same time as the dentist. This member of staff was under the supervision of the dentist at all times.

The dentist was appropriately trained and registered with their professional body. The training records we reviewed showed they were maintaining their continuing professional development (CPD) to regularly update their skills. CPD is a compulsory requirement of registration as a general dental professional and its activity contributes to their professional development. Records showed details of the number of hours they had undertaken and training certificates were also in place. This showed all relevant training was attended. There was a record of the trainee dental nurse attending a college course to achieve their dental nurse qualification.

We saw that the dentist received an annual appraisal with the provider and this covered operational performance and identified training needs. The member of staff had been in post for three months and was not yet due an appraisal. We spoke with the member of staff and they told us about their college course and the support they received from the dentist in their learning and development.

Working with other services

We discussed with the dentist how they referred patients to other services. Referral letters and responses were held in the patients' records. These ensured patients were seen by appropriate specialists. Ninety-five per cent of the patients registered with the practice were Polish speaking. We found that if these patients returned to Poland they were able to request their dental records to take with them to their dentist in Poland. The dental records were written in Polish and were translated for us.

Patients transferring to another dentist in the United Kingdom were able to obtain their records to take to the new dentist. The records were translated into English free of charge.

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

We reviewed the records of five patients. We saw evidence that patients were presented with treatment options and treatment plans. We saw that in all five cases consent had been recorded for the treatment undertaken. The dentist was aware of the implications of the Mental Capacity Act 2005 (MCA). 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 had a MCA protocol which could be referenced if required. The dentist was also aware of and understood the use of Gillick competency in young persons. Gillick competence is used to decide whether a child (16 years or younger) is able to consent to their own medical treatment without the need for parental permission or knowledge.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We observed the dentist greeting patients and taking them to the consulting room. The consulting room door was closed during treatment and conversations between the dentist and the patient could not be overheard. We noted that the appointment system in operation resulted in only one patient at a time being present in the practice. Confidentiality between staff and patients was therefore maintained easily.

The comments from patients who completed comment cards were very positive about the service and both described the dentist as helpful and caring. The patients who attended on the day of inspection declined to speak with us. We also made attempts to contact two patients by telephone following the inspection but our calls were not answered.

A data protection and confidentiality policy was in place and confidentiality agreements linked to contracts of employment were signed. The policy covered disclosure of patient information and their conditions and the secure handling of patient information. Dental records were held securely in lockable filing cabinets. These cabinets were locked every evening and the keys held securely.

Involvement in decisions about care and treatment

We looked at some examples of written treatment plans which were translated for us and found that they explained the treatment required and outlined the costs involved. The dentist told us that they rarely carried out treatment the same day unless it was considered urgent. This allowed patients to consider the options, risks, benefits and costs before making a decision to proceed.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Information on the range of treatments available from the practice was available in both the practice information leaflet and on the practice notice board. The costs of treatments was also displayed on the reception notice board and included as an appendix in the practice leaflet. The information leaflet was available in both English and Polish.

Patients new to the practice were required to complete a patient questionnaire so that the practice could conduct an initial assessment and respond to their needs. This included a medical history form. The dentists undertook a full examination when patients attended for their first appointment. The five records we reviewed did not contain details of the soft tissue and gum examinations undertaken by the dentist during the initial consultation. When a patient booked their first appointment they were advised this would take 40 minutes and told the cost of the examination.

Continuity of care was ensured because only one dentist practiced. Decisions relating to the frequency of recall and the need for x-rays were based upon the findings of the initial assessment and then documented in the patient's records.

Tackling inequity and promoting equality

The practice was located on the first floor of a shared building. There was no lift access. An assessment required by the Disability Discrimination Act (DDA) 1995 had been undertaken and the practice was aware that the location made access difficult for patients who found it difficult to get up and down stairs. There was no opportunity to install a lift. If a patient with a mobility difficulty called to seek to register they were told the practice was on the first floor. They were offered advice about alternative dental practices in the area that offered ground floor access.

The majority of registered patients were of Polish origin. Staff at the practice spoke both English and Polish.

Translation services into other languages were not available but if a patient registered did not speak either English or Polish they were able to bring a friend or relative to translate for them.

Patients who were nervous about dental treatment could bring a friend or relative to accompany them during treatment. We received comments from patients that told us appointments were available outside of school hours.

Access to the service

The practice offered appointments between 9.30am and 9pm every weekday. An emergency service was available at weekends. Appointments were accessed by calling a mobile telephone which if not answered immediately gave the patient the option for a call back. The practice operated a system of short notice appointments and we were told this was preferred by patients. We observed the process during our inspection. A patient called requesting an appointment and was seen one hour after they called. The opening hours enabled patients to choose an appointment time that fitted was convenient to them.

The opening hours were displayed on a notice board and detailed in the practice information leaflet. The practice also advertised in the local press and in the Polish community. When the practice was closed a recorded message gave patients advice on how to access emergency dental services.

Concerns & complaints

The practice had a complaints handling policy and procedure and we noted that this required the dentist to investigate and respond to complaints. A complaints log was available. However, we were told the practice had not received any complaints since it opened.

A suggestions box and a 'concerns' book were available near the reception desk for patients who wished to make comments about the service they received. We could see the practice encouraged feedback and had systems in place to receive any feedback. Neither the suggestions box or concerns book contained any entries.

Are services well-led?

Our findings

Governance arrangements

The dentist was also the registered manager for the service holding responsibility for all clinical and administrative functions at the practice. A formal management structure was not therefore required. The dentist was assisted in the day to day management of the practice by the provider who was always present at the practice when patients were being seen. One of the provider's relatives assisted in maintaining management records in a voluntary capacity.

The dentist and provider had policies and procedures in place to govern the practice and we saw that these covered a wide range of topics. For example, control of infection, health and safety and maintenance of equipment.

The systems in place to monitor the safe and effective delivery of treatment were not operating effectively. The practice had failed to identify that they had not followed the current guidance to complete audits of infection control on a six monthly cycle. (A Health Technical Memorandum HTM01-05 contains detailed guidance for dental practices to follow). They were not following GDC requirements in regard to holding the full range of equipment needed to deal with medical emergencies. The audit of patient records had not recognised that dental records were not completed in full. For example, the results of soft tissue examinations were not recorded. Although the practice had identified the medical history record in use had some information missing they had not amended it to include the missing sections.

We noted that management policies were kept under review and had been updated in the last year. The member of staff employed at the practice knew where the policies and procedures were held and we saw that these were easily accessible if anyone needed to refer to them.

Leadership, openness and transparency

The practice had a statement of purpose and this focused on providing safe personal treatment. We reviewed the minutes of two team meetings held in 2015 which the dentist led. The minutes showed a range of topics were discussed. For example, new products to be used in treatment and how they should be used and on promoting the practice to attract more patients. The team of three worked together whenever patients attended for appointments. Raising any concerns or ideas was therefore straightforward. There were job descriptions for both the dentist and trainee dental nurse and they were clear on the duties that were expected of them.

The member of staff we spoke with told us they were encouraged to discuss their progress. They also told us they would have no hesitation in raising concerns about conduct in the practice. They knew there was a whistleblowing policy and where they could find this if they needed to refer a matter outside of the practice.

Management lead through learning and improvement

The dentist maintained their continuing professional development (CPD) as required by the General Dental Council (GDC). Training was completed through a variety of media and sources including attendance on training courses and online learning materials.

There was evidence that the trainee dental nurse was enrolled on a dental nurse training programme. They were supported in their day to day learning by the dentist. They told us the dentist was very helpful.

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

The practice was open to receiving patient feedback and had offered patients a number of opportunities to offer their views on the service they received. There was a suggestion box and a concerns book which were prominently displayed. We were told that patients were asked to formalise their feedback by completing a satisfaction form and leaving it in the suggestion box. However, neither the suggestion box or concerns book had been used. We noted that some patients travelled long distances to access the service because they felt it met their needs. For example, there was one patient who lived in Portsmouth who used 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 12 HSCA (RA) Regulations 2014 Safe care and treatment (1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include – (c) ensuring that persons providing care or treatment to service users have the qualifications, competence , skills and experience to do so safely (f) where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs and (h) assessing the risk of, and preventing, detecting and controlling the spread of, infections including those that are health care associated. · The provider and a member of staff were not trained in basic life support thus colleagues and patients were at risk in the event of an emergency. · An automated external defibrillator AED was not accessible for immediate use in the case of an emergency. · Control of infection audits had not been undertaken at the required frequency to identify assess and manage any risks of cross infection. · A legionella risk assessment was not in place to confirm the level of risk in the practice.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

(2)Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to –

(c) maintain securely, an accurate, complete and contemporaneous record in respect of each service user, including a record of care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

The results of soft tissue examinations and periodontal examinations were not entered onto patient records. Medical history records did not detail medicines prescribed and oral hygiene advice was not entered onto patient records.