Douglas Lee Associates Limited

# Douglas Lee Dental Practice

## Inspection Report

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## Overall summary

We carried out an announced comprehensive inspection on 3 March 2017 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 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**

Douglas Lee Dental practice is located in Accrington, Lancashire and provides whole population private routine and preventative dental care. A practice manager, two dentists, two dental hygienists, a dental technician and two dental nurses work at the practice. The practice provides access and facilities for wheelchair users.

The practice is open Monday and Tuesday 09:00 – 17:30, Wednesday and Thursday 09:00 – 19:30 and Friday 09:00 – 13:00.

The practice owner is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) 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.

We reviewed 22 CQC patient feedback comment cards on the day of our visit. Patients spoke highly of the staff and the standard of care provided by the practice. Patients commented that they felt involved in all aspects of their care and found the staff to be helpful, respectful, and friendly, and said they were treated in a clean and tidy environment.

**Our key findings were:**

- The practice was well organised, visibly clean and free from clutter.
- An infection prevention and control policy was in place.

# Summary of findings

- The practice had a safeguarding policy and staff were aware on how to escalate safeguarding issues for children and adults should the need arise.
- Staff received annual medical emergency training. Equipment for dealing with medical emergencies reflected guidance from the resuscitation council (UK).
- Dental professionals provided treatment in accordance with current professional guidelines.
- A process was established to seek patient feedback about the service.
- Patients could access urgent care when required.
- Dental professionals were maintaining their continued professional development in accordance with their professional registration.
- A process was in place for managing complaints.
- The practice was actively involved in promoting oral health.
- The practice had systems for recording incidents, accidents and near misses. A near miss that occurred last year had not been recorded.
- A recruitment policy was not in place and recruitment checks were not robust.
- A programme of audit was not in place for the practice.

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

- 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 effective systems are developed to monitor and improve the quality and safety of the service, such as the undertaking of regular audits of various aspects of the service. The practice should also ensure all audits have documented learning points and the resulting improvements can be demonstrated.

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

- Review the practice's system for the recording and reviewing incidents or significant events to ensure that all incidents are recorded, including near misses.
- 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 the process for monitoring equipment requiring decontamination, in particular the dental treatment chairs, taking into account the guidelines issued by the Department of Health - Health Technical Memorandum 01-05.
- Review the practice's protocols for recording in the patient dental care records or elsewhere the reason 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.

# 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.

Equipment for decontamination procedures, radiography and general dental procedures were tested and checked according to manufacturer's instructions.

Emergency medicines and equipment were available and stored appropriately in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines.

Staff with were knowledgeable about safeguarding systems for adults and children.

A process for recording incidents, accidents and near misses was in place. A near miss that occurred last year had not been recorded.

A Disclosure and Barring Service (DBS) check had not been undertaken for staff and verbal references taken had not been recorded.

The upholstery to one of the dental treatment chairs was torn.

**Are services effective?**

No action

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

Dentists were following national guidance when providing oral health care to patients, which ensured treatment followed current recommendations.

Staff obtained consent from patients before providing treatment.

The practice followed the guidelines when using sedation as part of a treatment plan for patients.

Staff made referrals to other services in an appropriate and recognised manner.

Staff registered with the General Dental Council met the requirements of their professional registration by carrying out regular training and continuing professional development.

**Are services caring?**

No action

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

Patients we spoke with were very positive about the staff, practice and treatment received. We left CQC comment cards for patients to complete two weeks prior to the inspection. There were 22 responses all of which were very positive, with patients stating they felt listened to and included in making decisions about their care.

# Summary of findings

Dental care records were kept securely.

We observed patients being treated with respect and dignity during our inspection and privacy and confidentiality were maintained for patients using the service. We also observed staff to be welcoming and caring towards patients.

**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 ensured that patients requiring urgent dental care were seen on the day they contacted the practice.

Staff had access to an interpreter service for language and hearing if required.

The practice was fully accessible for people who were wheelchair users, including an accessible toilet.

**Are services well-led?**

**Requirements notice** 

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

The management of the practice had been inconsistent over the last year. A new practice manager had started in January 2017.

A range of policies were in place and systems were in place to manage risk.

A programme of audit to support continuous improvement was not in place for the practice. The required X-ray and infection prevention and control audits had not been completed. We were provided with the first of these completed audits shortly after the inspection.

Staff meetings took place and medical alerts, incidents, complaints and changes were discussed.

Staff said there was an open culture at the practice and they felt confident raising any concerns.

The practice had processes in place to seek feedback from patients about the service.

# Douglas Lee Dental Practice

**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 registered manager was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 3 March 2017. It was led by a CQC inspector and supported by a dental specialist advisor.

We informed NHS England area team that we were inspecting the practice; we did not receive any information of concern from them. We also reviewed information held by CQC about the practice and no concerns were identified.

During the inspection, we spoke with the practice manager, the registered manager, a dentist and two dental nurses. We reviewed policies, protocols, certificates and other documents as part of the inspection. We also had a look around the building.

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**

A serious incident policy, safety incident reporting policy and adverse reaction to drugs policy were in place. They took into account a range of incidents, including never events and near misses. An accident reporting book was also in use. Staff told us there had been no incidents to report and the last staff accident recorded was in February 2015. We were informed of an event that happened last year and that met the criteria for a near miss. This had not been recorded and reported through the incident process and we discussed this with the registered manager at the time of the inspection.

The staff we spoke with were clear about what needed to be reported in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 2013 (RIDDOR).

The registered manager received safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) and Department of Health Central Alerting System (CAS). These alerts identify problems or concerns relating to medicines or equipment. If the alert was relevant to the operation of the practice then it was shared with the staff.

The registered manager and staff we spoke with were aware of the need to be open, honest and apologetic to patients if anything should go wrong; this was in accordance with the Duty of Candour principle which states the same. A duty of candour policy was available for the practice.

**Reliable safety systems and processes (including safeguarding).**

We spoke with staff about the use of safer sharps in dentistry as per the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. A sharps policy was in place and the registered manager advised us that the practice used a safe sharps system. A procedure was in place for staff to follow in the event of a sharps injury that included occupational health contact details. We saw evidence in the accident reporting that the procedure for managing sharps injuries had been followed.

The registered manager told us rubber dam was not routinely used when providing root canal treatment to patients in accordance with guidance from the British Endodontic Society. They said an alternative safe approach was used. 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 and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use a rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured. The registered manager said they did not record in the patient's dental record the rationale for not using rubber dam.

A child and vulnerable adult safeguarding policy and procedure were in place. The practice manager was the designated lead for safeguarding. Staff were knowledgeable about abuse and were aware of how to report any concerns in relation to abuse. Local safeguarding contact numbers were available for should staff have a concern they wished to report. All staff working at the practice had undertaken safeguarding training within the last two years.

The registered manager provided us with an example of a safeguarding concern they had identified at the practice and the action they took, including seeking advice from the local area safeguarding team.

The practice had a whistleblowing policy. Staff could raise concerns within the practice or could raise concerns externally. Staff told us they felt confident they could raise concerns about colleagues without fear of recriminations.

Employer's liability insurance was in place for the practice. Having this insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969 and we saw the practice certificate was up to date. Professional indemnity was in place for all staff.

**Medical emergencies**

A medical emergency policy was available for the practice and it took account of the guidance from the Resuscitation Council UK and had sufficient arrangements in place to deal with medical emergencies. Procedures were in place for staff to follow in the event of a medical emergency and all staff had received medical emergency training from an external company in the last 12 months, including the use of an Automated External Defibrillator. An AED is a portable electronic device that analyses the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.

# Are services safe?

The practice kept medicines and equipment for use in a medical emergency. These were in line with the Resuscitation Council UK and British National Formulary guidelines. All staff knew where these items were located.

Emergency equipment and medicine checks were undertaken to ensure equipment was available and did not require replacing. We saw that the practice kept records that indicated the emergency equipment, emergency medical oxygen cylinder, emergency drugs and AED were regularly checked. This supported with ensuring the equipment was fit for use and the medication was within the manufacturer's expiry dates. We checked the emergency medicines and found they were of the recommended type and were all in date. A blood spillage kit was in place in the event that staff should need to use it.

**Staff recruitment**

A recruitment policy was not in place for the practice. We discussed recruitment with the practice manager and looked at two staff recruitment files and confirmed the required recruitment checks had not been completed in accordance with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A full employment history, references, an appropriate DBS check and identification, including a recent photograph were missing some from recruitment files. A DBS check helps employers to make safer recruitment decisions and can prevent unsuitable people from working with vulnerable groups, including children. The immunisation status was available for all the staff.

The practice manager advised us that agency staff were being used due to a staff shortage. There was no information available to show what checks had been undertaken when the staff were recruited. Shortly after the inspection the practice manager advised us they had received information from the agency to confirm the agency staff had been appropriately recruited.

**Monitoring health & safety and responding to risks**

A general health and safety policy was available for the practice. A practice risk assessment was completed in January 2017 and it addressed the environment (slips, trips and falls), equipment, fire waste and bodily fluids. A risk assessment is a system of identifying what could cause harm to people and deciding whether to take any reasonable steps to prevent that harm.

We looked at the Control of Substances Hazardous to Health (COSHH) file. COSHH files are kept to ensure providers retain information on the risks from hazardous substances in the dental practice. The practice manager was responsible for ensuring the COSHH file was up-to-date. They confirmed the COSHH file was reviewed in July 2016 and would be reviewed if any new products were introduced. We found the practice had in place risk assessments for the COSHH products and safety data sheets; information sheets about each hazardous product, including handling, storage and emergency measures in case of an accident.

A fire risk assessment was carried out in April 2016. The practice manager confirmed that the staff team had received fire training in July 2016 and that two fire marshals were identified for the practice. A fire evacuation procedure was in place. Arrangements were in place to check the smoke alarms and firefighting equipment on a weekly basis.

**Infection control**

The practice manager was the lead for infection prevention and control (IPC) was identified for the practice. A member of staff took us through the process about how instruments were decontaminated in the dedicated decontamination room. They outlined the practice's process for cleaning, sterilising and storing dental instruments and reviewing relevant policies and procedures. This was in accordance with the Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices. Produced by the Department of Health, this guidance details the recommended procedures for sterilising and packaging instruments.

We observed that the decontamination and treatment rooms were clean. Drawers and cupboards were well organised and clutter free with adequate dental materials available. A checklist was in place for the cleaning of the decontamination room and this was completed each day. There were hand washing facilities, liquid soap and paper towel dispensers in each of the treatment rooms, decontamination room and toilets.

We observed a tear in the upholstery of a dental chair. The registered manager advised us that a programme was in place to re-upholster all the dental chairs and it had started on 12 January 2017. They confirmed with the company

carrying out the work that all chairs would be re-upholstered by 27 March 2017. Shortly after the inspection the practice manager advised us they had put a temporary cover on the tear in the chair.

The dental unit water lines were maintained to prevent the growth and spread of Legionella bacteria. Legionella is a term for particular bacteria which can contaminate water systems in buildings. Staff described the method used and this was in line with current HTM 01-05 guidelines. A Legionella risk assessment had been carried out in April 2016. The water temperature checks of water outlets, including the sentinel taps (nearest and furthest taps from the water distribution source) was carried out on a monthly basis.

A contract was in place for the removal and disposal of clinical waste. Waste consignment notices were available for the inspection. Clinical waste was disposed of in accordance with Health Technical Memorandum 07-01: Safe management of healthcare waste.

Schedules were in place for the cleaning of the premises and checklists were completed daily to confirm the premises had been cleaned. We observed the building was clean, tidy and clutter-free. Environmental cleaning equipment was labelled to identify the area it should be used in.

Regular IPC audits had not been undertaken at the practice. The practice manager had started working at the practice in January 2017 and identified that IPC audits were needed. They had started to complete an audit and shortly after the inspection sent us the completed version. They confirmed that IPC audits would be completed every six months going forward. We will check at a follow up inspection to ensure these checks are effective. .

**Equipment and medicines**

Equipment checks were regularly carried out in line with the manufacturer's recommendations.

We saw evidence of up-to-date examinations and servicing of sterilisation equipment, X-ray machines, autoclave and the compressor. Portable electrical appliances had been tested to ensure they were safe to use.

Local anaesthetics were stored appropriately and a log of batch numbers and expiry dates was in place. Antibiotics were stored securely at the practice. A log was kept when they were issued and they were checked regularly to ensure they had not exceeded their expiry date.

If patients required a prescription for any medication not held by the practice the dentist wrote a letter on practice headed paper to the pharmacy. The letter included a record of the patient details, the dentist's name and GDC registration number. Details were recorded in the patient's clinical records.

**Radiography (X-rays)**

The practice demonstrated compliance with the Ionising Radiation Regulations (IRR) 1999 and the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000. The practice kept a detailed radiation protection file, including the names of the Radiation Protection Advisor, the Radiation Protection Supervisor and Health and Safety Executive notification. Maintenance certificates were contained in the file. Local rules were located next to the equipment.

We saw that the dentists were up-to-date with their continuing professional development training in respect of dental radiography. A radiological audit had not been completed in accordance with the IR(ME)R 2000 guidance. The practice manager had identified this when they started working at the practice in January 2017 and said they planned to do this audit. Shortly after the inspection they sent us a completed radiological audit. It was based on a review of 10 random radiographs for each of the two dentists.

# Are services effective?

(for example, treatment is effective)

## Our findings

**Monitoring and improving outcomes for patients**

We spoke with the dentists and determined that they were following guidance and procedures for delivering dental care. They outlined how a thorough examination was carried out to assess the dental hard and soft tissues, including an oral cancer screen. They also used the basic periodontal examination (BPE) to check patient's gums. This is a simple screening tool that indicates how healthy the patient's gums and bone surrounding the teeth are. The dental records we looked at showed that BPE scores were recorded at each. Medical history forms were checked at each visit and were confirmed with the patient. We noted from the records that patients were advised of the findings, treatment options and costs.

The dentists were familiar with the current National Institute for Health and Care Excellence (NICE) guidelines for recall intervals, wisdom teeth removal and antibiotic cover. Recalls were based upon individual risk of dental diseases.

The dentists advised us that they used their clinical judgement and guidance from the Faculty of General Dental Practitioners (FGDP) to decide when X-rays were required. The records we saw showed that the findings of X-rays were not always recorded. We also saw that not all X-rays were graded for quality assurance purposes.

**Health promotion & prevention**

We found the practice was proactive about promoting the importance of good oral health and prevention. There was evidence in the dental records we looked at that the dental team applied the Department of Health's 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive care and advice to patients. Preventative measures included providing patients with oral hygiene advice such as tooth brushing technique, fluoride varnish applications and dietary advice. Smoking and alcohol consumption was also checked where applicable.

**Staffing**

An induction programme was in place and the two staff recruited within the last 18 months advised us that had an induction when they first started.

Staff told us they were supported by the registered manager to participate in regular training to and to maintain their continuous professional development (CPD) required for registration with the GDC. The GDC highly recommends certain core subjects for CPD, including medical emergencies and life support, safeguarding, IPC and radiology. Training records showed that staff were up-to-date with these training topics.

Staff received annual immediate life support training to ensure they were suitably qualified to manage any emergencies associated with the use of sedation. In addition, the staff involved in providing sedation to patients had undertaken the required training.

The practice manager confirmed that staff had not had a review of their performance and they intended to introduce an appraisal process for staff. Shortly after the inspection the practice manager sent us an action plan confirming that appraisals would be completed by June 2017.

**Working with other services**

The registered manager confirmed that patients could be referred to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. Referral letters were used to send all the relevant information to the specialist. Details included patient identification, medical history, reason for referral and X-rays if relevant.

The practice also ensured any urgent referrals were dealt with promptly such as referring for suspicious lesions under the two-week rule. The two-week rule was initiated by NICE in 2005 to enable patients with suspected cancer lesions to be seen within two weeks.

**Consent to care and treatment**

We spoke with the staff about how they implemented the principles of informed consent. Informed consent is a patient giving permission to a dental professional for treatment with full understanding of the possible options, risks and benefits. Staff explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. Photographs and other visual aids were used to support the consent process. The patient then was provided with a copy of the plan and a copy would be retained in the patient's dental care record.

# Are services effective?

## (for example, treatment is effective)

The risks associated with sedation were discussed with patients who were then given time to consider the information provided before making a decision. Once sedation was agreed then the patient provided written consent. The sedation policy provided guidance on consent.

The staff were clear on the principles of the 2005 Mental Capacity Act (MCA) and the concept of Gillick competence. The registered manager provided us with an example of how the principles of the MCA were applied when they were assessing a patient to ensure they were able to give informed consent to treatment. The MCA is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. Gillick competence is a term used to decide whether a child (16 years or younger) is able to consent to their own medical or dental treatment, without the need for parental permission or knowledge. The child would have to show sufficient mental maturity to be deemed competent.

# Are services caring?

## Our findings

**Respect, dignity, compassion & empathy**

We provided the practice with CQC comment cards for patients to fill out two weeks prior to the inspection. There were 22 responses all of which were very positive with compliments about the staff, practice and treatment received. Patients commented they were treated with respect and dignity, and that staff were sensitive to their specific needs. They said time was taken to explain treatment options and patients who were anxious felt reassured by the information they were given.

The registered manager continued to provide dental care to a patient who had moved into care home by visiting them at the care home. This showed commitment to providing patients with continuity of dental care.

We observed staff maintaining the privacy and confidentiality for patients on the day of the inspection.

Practice computer screens were not overlooked in reception and treatment rooms which ensured patient's confidential information could not be viewed by others. We saw that doors of treatment rooms were closed at all times when patients were being seen. Conversations could not be heard from outside the treatment rooms which protected patient privacy.

Dental care records stored electronically secure as computers were password protected. Paper records were stored appropriately and securely. Staff were confident in data protection and confidentiality principles.

**Involvement in decisions about care and treatment**

From our review of the CQC comment cards and our observation of dental records it was clear that patients were involved in decisions about their care. Information showing treatment costs was available in the waiting area.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting patients' needs**

We noted that information was available for patients in the reception area, including the practice opening hours, emergency out-of-hours contact details, fire procedures, the complaint procedure and treatment costs.

The registered manager confirmed that patients needing an urgent appointment were usually seen on the day they contacted the practice. Even if no appointments were available the patient requiring the urgent appointment would be invited to come in and wait.

**Tackling inequity and promoting equality**

The registered manager had made adjustments to the premises to prevent inequity to patients with a disability. A disability access audit was not available on the day of the inspection but the practice manager sent this to us shortly after the inspection. This audit is an assessment of the practice to ensure it meets the needs of people with a disability. Portable ramps for wheelchair access were available for access through the front door. An accessible toilet was located on the ground floor and the ground floor treatment room could accommodate wheelchairs and patients with limited mobility.

Staff had access to a translation service for both language and hearing should the need arise.

**Access to the service**

Opening hours were available in the practice information leaflet. Patient feedback indicated there was good access to routine and urgent dental care. There were clear instructions on the practice's answer machine for patients requiring urgent dental care when the practice was closed.

**Concerns & complaints**.

The practice manager was the lead for complaints. A complaints policy was in place which provided guidance on how to handle a complaint. The policy was in accordance with current guidance as recommended by the GDC. Information for patients about how to make a complaint was displayed in the waiting area.

The practice had a system in place to log complaints. There had been one complaint received about the practice in the last 12 months.

# Are services well-led?

## Our findings

**Governance arrangements**

The registered manager explained there had been an inconsistency with the management of the practice over the last 12 months. Two practice managers had left. The departure of the last manager happened suddenly and the registered manager had taken on responsibility for the day-to-day running of the practice in addition to their clinical work. The practice manager in post at the time of our inspection had started working at the practice full time in January 2017.

The registered manager acknowledged that improvements needed to be made to service and that the newly recruited practice manager was working towards making these improvements. Many of the improvements required we identified through the inspection. Shortly after the inspection the practice manager provided us with an improvement plan that included a progress report and timeframes when each action would be met. We also noted from the minutes of the staff meetings for January and February 2017 that the practice manager had discussed the improvements required with the staff team.

The practice was a member of a practice accreditation scheme. Accreditation schemes require a commitment by a practice to provide dental care to nationally recognised standards.

Governance arrangements included a framework of operational policies and procedures, and risk management systems. The policies had been sourced externally and were up-to-date in accordance with national guidance and best practice. They had recently been put in place and some had not yet been modified to reflect the practice specifically. The practice manager said they planned to do this.

Risk management processes were in place to ensure the safety of patients and staff members. They were regularly reviewed particularly if any changes had been made at the practice. For example, we saw risk assessments relating to the environment, equipment, clinical waste and fire. These had been reviewed in January 2017.

A business continuity policy and disaster plan was in place that set out how the service would be provided if an incident occurred that impacted on its operation.

**Leadership, openness and transparency**

Staff told us there was a supportive culture within the practice. They said the management and leadership had improved since the new practice manager started. We also heard that there was an open culture and staff were encouraged to share their views and to challenge poor practice. Staff told us regular practice meetings were now being held each month.

**Learning and improvement**

Quality assurance processes were not routinely used at the practice to encourage continuous improvement. There was no clinical audit programme in place, such as an X-ray audit and infection prevention and control audit as required. The outcome of an investigation into a complaint identified that clinical record keeping needed to improve yet a dental record audit had not been undertaken to check the specific improvements that needed to be made. We also identified that clinical record keeping was not consistent.

Shortly after the inspection the practice manager sent us completed IPC, X-ray and dental record audits. This demonstrated a commitment to making improvements in a timely way. Because they were the first audits undertaken, it was too early to show the impact they would have on encouraging continuous improvements.

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

The practice also carried out its own patient satisfaction survey every year. The survey we saw was completed in April 2016 and the feedback from patients was positive.

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<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**Regulation 17 HCSA 2008 Regulations 2014 Good governance**<br>The registered person did not have effective systems in place to ensure that the regulated activities were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.<br>How the regulation was not being met:<br>The registered provider failed to ensure a programme of audit was established to monitor and improve the quality and safety of the service. These included a bi-annual Infection prevention and control audit and a radiology audit.<br>Regulation 17(1) |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br>**Regulation 19 HCSA 2008 Regulations 2014**<br>**Fit and proper persons employed**<br>How the regulation was not being met:<br>The registered provider failed to ensure recruitment procedures were established, including ensuring all the necessary checks to ensure that persons employed met the conditions as specified in Schedule 3. These included seeking appropriate DBS checks.<br>Regulation 19(2)(3) |