W & S K Ltd

The Hollies Dental Practice

Inspection Report

14 Park St, Chatteris, Cambridgeshire, PE16 6AF
Tel: 01354 692151
Website:

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Overall summary

We carried out an announced comprehensive inspection on 14 February 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 not 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

The Hollies is a well-established dental practice situated in the centre of the village of Chatteris. It provides private dentistry services to adults and NHS dentistry to children. The team consists of two full-time dentists, two part-time hygienists, a practice manager, four dental nurses and a receptionist. There are three treatment rooms, a room for the decontamination of instruments, a reception and waiting area and a number of staff and administrative offices.

The practice opens on Mondays from 8.30am to 7pm; on Tuesdays, Wednesdays and Thursdays from 8.30am to 5pm; and on Fridays from 8.30am to 2.30pm. The practice also opens on a Saturday morning once a month.

The practice manager is registered with the Care Quality Commission (CQC) as the registered manager. 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 had good facilities overall and was well equipped to treat patients and meet their needs.
- Information from 49 completed Care Quality Commission comment cards gave us a picture of a caring, empathetic and responsive staff. Patients received clear explanations about their proposed treatment and were actively involved in making decisions about it. They were treated in a way that they liked by staff

Summary of findings

- Patients' needs were assessed and care was planned and delivered in line with current best practice guidance from the National Institute for Health and Care Excellence (NICE) and other published guidance.
- Access to appointments was good: the practice opened late one evening a week, and on one Saturday a month. Emergency slots were available each day for patients requiring urgent treatment.
- There were sufficient numbers of suitably qualified and competent staff. Members of the dental team were up-to-date with their continuing professional development and supported to meet the requirements of their professional registration.
- The practice proactively sought feedback from staff and patients, which it acted upon.
- Some of the practice's infection control procedures and protocols did not meet guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'
- Staff were not aware of recent safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) that affected dental practice.
- The practice's recruitment process did not ensure that all relevant checks were undertaken before new staff started work.

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

- Ensure the practice's infection control procedures and protocols are suitable giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum

01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.

- Ensure effective systems and processes are established to assess and monitor the service against the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and national guidance relevant to dental practice. This includes monitoring significant events; responding to national patient safety alerts; improving staff recruitment and fire safety procedures; ensuring infection control audits are undertaken at regular intervals, implementing robust risk assessment, and ensuring policies and procedures are followed.

There were areas where the provider could make improvements and 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 the security of prescription pads in the practice and ensure there are systems in place to monitor and track their use.

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 (see full details of this action in the Requirement Notices at the end of this report).

There were sufficient numbers of suitably qualified and competent staff to meet patients' needs and the practice had arrangements in place for essential areas such as clinical waste, dental radiography (X-rays), the control of substances hazardous to health and the maintenance of equipment. However, untoward events were not analysed to prevent their reoccurrence and staff were unaware of recent safety alerts affecting dental practice. Fire safety, legionella management and infection control needed to be strengthened to ensure patients were protected. Recruitment procedures needed to be more robust to ensure only suitable staff worked at the practice.

Are services effective?

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

Consultations were carried out in line with best practice guidance from the National Institute for Health and Care Excellence (NICE) and the Faculty of General Dental Practice Guidelines. Patients received a comprehensive assessment of their dental needs including taking a medical history. Treatment risks, benefits, options and costs were explained to patients in a way they understood. Patients were referred to other services as needed.

The staff were able to access professional training and development appropriate to their roles; although they did not have development plans in place and not all received regular appraisal

Are services caring?

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

We collected 49 completed patient comment cards and obtained the views of a further three patients on the day of our visit. Patients commented on friendliness and helpfulness of the staff and told us dentists were good at explaining the treatment that was proposed. Patients told us that staff understood the importance of maintaining patients' privacy and most information about them was handled confidentially. Staff gave us examples of additional support they had provided for some patients.

Are services responsive to people's needs?

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

The practice had some good facilities and was well equipped to treat patients. Patients could access routine treatment and urgent care when required and the practice opened late one day a week, and one Saturday a month to meet the needs of patients. Appointments were easy to book and the practice operated a telephone appointment reminder service. The practice had made some adjustments to accommodate patients with a disability.

There was a clear complaints' procedure (although this could be better advertised to patients) and the practice responded appropriately to issues raised by patients.

Are services well-led?

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

Summary of findings

Staff told they felt well supported and enjoyed their work, and the practice proactively sought feedback from staff and patients, which it acted on to improve services to its patients. However, we found a number of shortfalls indicating that the practice was not well-led including the analyses of untoward events, the recruitment and development of staff, the management of legionella, the control and prevention of infection, and staff's adherence to the practice's own policies and procedures

The Hollies 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 practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 14 February 2017 and was conducted by a CQC inspector and a dental specialist advisor.

During the inspection we spoke with both dentists, the practice manager, a dental nurse and the receptionist. We received feedback from 49 patients who had completed our comment cards prior to our visit, and spoke with another three during our visit. We reviewed policies, procedures and other documents relating to the management of the service.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice did not have an incident reporting policy and staff we spoke with had a limited understanding of what might constitute an untoward event. Staff were also unsure of the requirement to record and report accidents under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). An accident book was kept, however records of three accidents we reviewed in the book were a little sparse in detail and did not contain any information of the action taken in their response. We noted two similar events that had occurred within in the space of a few months, which had caused injury to staff. There had been no analysis of the incidents (which had involved staff tripping on the step down into the decontamination room), to prevent their reoccurrence. This step continued to pose a risk as both inspectors stumbled on it during the inspection.

Reliable safety systems and processes (including safeguarding)

Some arrangements were in place to safeguard children and vulnerable adults from abuse. Policies were accessible to all staff and clearly outlined whom to contact for further guidance if they had concerns about a patient's welfare. Folders containing the local safeguarding contact details were in each treatment room, although not all staff were aware of this. Most staff had received regular training in safeguarding people, although this had not been updated for the practice's receptionist. There was no appointed lead within the practice for safeguarding and staff's knowledge of the agencies involved in protecting people was limited.

The practice had minimised risks in relation to used sharps (needles and other sharp objects, which may be contaminated). The dentists used a sharps safety system, which allowed them to discard needles without the need to re-sheath them. A sharps' protocol was on display in the decontamination room, but not in any of the treatment rooms where sharps were used. Sharps boxes were sited safely on work surfaces, although not wall mounted as recommended by national guidance. We viewed the accident record in relation to one sharps injury sustained by a nurse. The account of the incident lacked detail and gave no information if medical advice had been sought, or if the patient's medical history had been checked. There was no evidence to show that learning from the incident had been shared across the staff team.

The dentists did not use rubber dams. The British Endodontic Society uses quality guidance from the European Society of Endodontology recommending the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work.

Medical emergencies

The practice manager told us that all staff had received training in dealing with medical emergencies and CPR but could not find any evidence to demonstrate this to us. Staff did not regularly rehearse emergency medical simulations so that they had a chance to practise what to do in the event of an incident.

Staff had access to some medical emergency equipment but this was not in line with the Resuscitation Council UK guidelines. For example, there was no spacer device and no child's oxygen facemask. We found very out of date airways equipment that was no longer fit to use. The practice did not have its own automated external defibrillator (AED) but told us there was a community AED nearby: however, no risk assessment had been completed for its use. Following our inspection the practice manager sent us evidence that the missing equipment had been ordered.

The practice held most emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. However we found that there was no aspirin or buccal midazolam available, (although these were obtained following our inspection). Glucagon (a medicine used to treat hypoglycemia) was kept in a fridge, although the fridge temperature was not monitored to ensure it operated effectively. The medicines were checked weekly to ensure they were fit for use, but no checks were undertaken of the oxygen cylinder to ensure it was pressurised correctly.

Staff recruitment

The practice's staff recruitment policy stated that references and a Disclosure and Barring check must be

obtained for potential employees. However, recruitment information we checked showed that the policy was not being followed. For example, no references had been obtained for a newly recruited dental nurse, and the practice had not obtained a recent DBS check before employing her. There was no evidence to show that new staff had received an induction to their role.

A specialist visited the practice to provide conscious sedation to patients. The practice did not hold any information about them such as evidence of their GDC registration, DBS check, training certificates and hepatitis status to ensure they were suitable to work with patients.

Monitoring health & safety and responding to risks

There was a health and safety policy available with a poster, which identified local health and safety representatives. There was a general risk assessment, which covered a wide range of identified hazards in the practice, and detailed the control measures that had been put in place to reduce the risks to patients and staff. Panic buttons were available in each treatment room so that staff could call for assistance in an emergency if needed.

A fire risk assessment had been completed for the practice in 2006. It recommended that regular fire safety evacuation drills should be completed but this had not been implemented. Firefighting equipment such as extinguishers was regularly tested and fire alarms, torches and smoke detectors were checked weekly. However, we viewed the practice's fire logbook and there was no record made that staff had received any training or instruction in fire safety or that essential checks of fire exits, signage and escape routes had been completed as recommended.

It was not clear how the practice was managing the risk of legionella as it had not carried out a risk assessment. Staff did not monitor hot and cold water temperatures or conduct dip slide testing to monitor the microbial content of the water. Some staff's knowledge of the dental unit water line management was limited.

There was a comprehensive control of substances hazardous to health folder in place containing chemical safety data sheets for materials used within the practice.

The practice did have a business continuity plan in place for major incidents such as the loss of utilities or natural disasters. A copy of the plan was kept off site by the practice manager to ensure it was accessible in the event of an incident.

Infection control

Patients who completed our comment cards told us that they were happy with the standards of hygiene and cleanliness at the practice. The practice's waiting area, toilet, stairway and staff areas were clean and uncluttered. We checked the treatment rooms and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. The rooms had modern sealed work surfaces so they could be cleaned easily although some hand wash sinks that did not meet national guidance.

All dental staff had been immunised against Hepatitis B. We noted that staff uniforms were clean, long hair was tied back and arms were bare below the elbows to reduce the risk of cross infection. Our discussions with staff and review of the practice's policies showed that their knowledge and understating of national guidance in relation to infection control was limited. The practice had undertaken an infection control audit just before our inspection: prior to this, none had been completed. National guidance recommends that these audits be completed every six months. Equipment used for cleaning different parts of the practice was colour coded to reduce the risk of cross contamination, however the code used was not in line with national guidance and equipment was not stored correctly to reduce the risk of bacteria forming.

The practice did have a separate decontamination room for the processing of dirty instruments. A dental nurse demonstrated to us the decontamination process from taking the dirty instruments through to clean and ready for use again. We noted that she wore appropriate personal protective equipment during the procedure including heavy-duty gloves, visor and apron. However, we noted the following shortfalls which did not follow national guidance and compromised infection control:

- The same sink was used for both manually cleaning and rinsing instruments
- The temperature of the water used to manually clean instruments was not checked to ensure it was below 45 degrees Celsius.

Are services safe?

- Scrubbed instruments were transported in a dirty box to the steriliser.
- The same dirty area was used for different stages of the cleaning process and instruments were placed in the same area both before and after cleaning in the ultrasonic bath.
- There was no dedicated clean work surface for the pouching of instruments, and instruments were pouched on top of the steriliser.
- Instruments were stamped with the date of sterilisation, rather than the date by which they should be used as recommended by national guidance.

The practice's arrangements for segregating, storing and disposing of dental waste reflected current guidelines from the Department of Health. The practice used an appropriate contractor to remove dental waste from the practice, which was stored in locked bins outside the practice.

Equipment and medicines

The equipment used for sterilising instruments was checked, maintained and serviced in line with the manufacturer's instructions. Appropriate records were kept of decontamination cycles to ensure that equipment was functioning properly. All equipment was tested and serviced regularly and we saw maintenance logs and other records that confirmed this. For example, the autoclaves had been serviced in November 2016, and portable appliance testing had been completed in February 2016.

The practice had two fridges but their temperatures were not monitored to ensure they operated effectively. We found very out of date medical consumables in one of the fridges.

We saw from a sample of dental care records that the batch numbers and expiry dates for local anaesthetics were recorded in patients' clinical notes. Prescription pads were not logged to ensure their security.

We were told that relevant patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Authority were emailed to the practice. However there was no system in place to ensure that these were checked and actioned if needed. Staff were unaware of recent alerts affecting dental practice and there was no evidence to show that appropriate action had been taken in response to them.

Radiography (X-rays)

Training records showed all staff where appropriate had received training for core radiological knowledge under IRMER 2000 Regulations. We viewed the practice's radiography file that contained the names of the Radiation Protection Advisor; the Radiation Protection Supervisor and the local rules for each unit. Evidence of the servicing of x-ray equipment was sent to us following our inspection and demonstrated it was safe and suitable for use. However, rectangular collimation was not used to confine x-ray beams and reduce dosage to patients.

Dental care records we viewed showed that the reason for taking any X-rays had been justified, although the actual grade of the quality of the x-ray was not recorded. The practice's radiograph audit did not actually assess the quality and grade of the radiograph as recommended by the Faculty of General Dental Practice guidance.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

All new patients to the practice were asked to provide their medical history including any health conditions, current medication and allergies and these were updated every six months to ensure the dentists were aware of any health concerns. Our discussion with both dentists and review of dental care records demonstrated that patients' dental assessments and treatments were carried out in line with recognised guidance from the National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC) guidelines. Assessments included an examination covering the condition of the patient's teeth, gums and soft tissues. Antibiotic prescribing for patients at risk of infective endocarditis, wisdom tooth extraction and patients' recall frequencies also met national guidance. Patients' basic periodontal examinations were recorded with appropriate referrals made to the practice's hygienists if needed.

A GMC registered doctor visited the practice to undertake conscious sedation for patients. No record of the doctor's qualifications or training was kept by the practice to ensure they were suitable for the role, however evidence of this was obtained and sent to us following our inspection. Neither the dentist nor nurse who assisted the doctor had received training for this. We looked at the notes for one patient who had been sedated. These demonstrated the procedure had been undertaken in line with national guidance; 'Standards for Conscious Sedation in the Provision of dental care' in relation to patient assessment, consent , monitoring throughout the procedure and post-operative care.

We saw a range of clinical audits that the practice regularly carried out to help them monitor the effectiveness of the service. These included the quality of patients' dental care records, referrals, medical histories, the reasons patients did not attend and the quality of written estimates undertaken.

Health promotion & prevention

A number of oral health care products were for sale to patients including interdental brushes, mouthwash and floss. Free samples of toothpaste were also available. We noted a folder in the waiting area that contained good oral health information for patients on issues such as tooth brushing, plaque removal, using interdental brushes and fluoride advice. There was also a specific folder dedicated to smoking cessation. The practice manager told us she was about to liaise with 'Camquit'- (a local anti-smoking local charity) to target patients who smoked with advice about quitting.

Knowledge of guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' was limited amongst the dental clinicians

Staffing

The practice employed two full time dentists, two part-time hygienist and four dental nurses. The practice manager was also a qualified dental nurse. Staff told us they were enough of them for the smooth running of the practice and a nurse worked with the hygienists. Each dentist saw about 20 patients a day and both staff and patients told us they did not feel rushed during appointments.

Files we viewed demonstrated that clinical staff were appropriately qualified and trained (although not for assisting with sedation), and the manager had completed a BTEC Professional Diploma in dental practice management. The lead nurse was in charge of monitoring staff training and ensuring they kept up to date with their continuing professional development. We noted dental journals readily available in the staff room and staff told us they always completed the monthly training sessions recommended in these journals. However, apart from training in safeguarding some years ago the receptionist had not received training on topics such as customer care, complaints handling, or health and safety.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves. Written referrals were made to the practice's own hygienists. A log of the referrals made was kept so they could be could be tracked, although patients were not routinely given a copy of their referral for their information

Consent to care and treatment

The Mental Capacity Act 2005 (MCA) provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Patients' consent to treatment had been recorded in the dental care records we reviewed, along with evidence that treatment options had been discussed

Are services effective?

(for example, treatment is effective)

with them. Additional consent forms were used for treatments such as for implants and tooth whitening. However, not all dental nurses we spoke with had a satisfactory understanding of patient consent and MCA issues.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patients told us they were treated in a way that they liked by staff and many comment cards we received described staff as professional, caring and empathetic to their needs. One patient told us that staff always remembered them at each visit and another that dentist was always cheerful.

We observed the receptionist interact with about six patients both on the phone and face to face and noted she was consistently polite, friendly and helpful towards them. She had worked at the practice many years and had built up a good rapport with many of the patients whom she knew well. Staff gave us examples of where they had gone out their way to support patients such as taking older patients home, guiding patients onto the road from the car park and looking after children when their parents were in surgery. One of the dentists told us of the particular care he had provided to a patient with a learning difficulty.

The main reception area itself was not particularly private and those waiting could easily overhear conversations between reception staff and patients. However, staff assured us that they were careful not to give out patients' personal details when speaking on the phone. Treatment rooms doors were closed at all times when patients were with dentists and conversations between patients and dentists could not be heard from outside the rooms. Blinds were hung on windows to prevent passerbys looking in.

Involvement in decisions about care and treatment

Patients told us that they were provided with good information during their consultation and that they had the opportunity to ask questions. One patient reported that he was always provided with understandable guidance about treatment and another that their concerns were listened and responded to well by staff

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

In addition to a full range of general dentistry services, the practice also offered a variety of cosmetic orthodontic, implant and tooth whitening treatments. It employed two hygienists to support patients with the management of gum disease, one of whom could be accessed without the need of a dentist's referral.

The practice offered extended hour opening for patients. It opened on Mondays from 8.30am to 7pm; on Tuesdays, Wednesdays and Thursdays from 8.30am to 5pm; and on Fridays from 8.30am to 2.30pm. The practice also opened on a Saturday morning once a month, with both a dentist and hygienist available that day. Patients told us it was easy to get an appointment at a time that suited them. Each dentist held a half an hour each day for emergency appointments and a rota system was in place with other local practices to provide out of hours cover. Information about emergency out of hour's services was available on the practice's answer phone message, although none was available on the front door should a patient come to the practice when it was closed.

The waiting area provided good facilities for patients including a children's play area, interesting magazines and a water machine. There was plenty information available about different types of treatment as well as their cost.

Tackling inequity and promoting equality

The practice had made some adjustments to help prevent inequity for patients that experienced limited mobility and there was level access entry to the building. There were downstairs treatment rooms and toilet, although the toilet was not accessible to wheelchair users. There was no wide seating or chairs of different height in the waiting room to accommodate those with mobility problems and no portable hearing loop to assist patients who wore hearing aids. Information about the practice was not available in any other languages or formats such as large print or audio.

Concerns & complaints

The practice had a policy and a procedure that set out how complaints would be addressed, the timescales and other organisations that could be contacted for support. There was no information on the practice's web site or waiting area informing patients how they could raise concerns. The receptionist told us she did not have any written information she could give patients about the practice's complaints procedure.

We viewed the practice's complaints log for 2016, and the paperwork in relation to two recent complaints and found they had been dealt with in a timely and professional way. Complaints were also a standing agenda item at the regular staff team meetings. Minutes we viewed from September 2016 showed that recent complaints had been discussed so that learning from them could be shared across the staff team.

Are services well-led?

Our findings

Governance arrangements

The practice manager had day to day responsibility for the running of the service supported by a receptionist and the dental nurses. We identified a number of shortfalls in the practice's governance arrangements including fire safety, the analyses of untoward events, the management of legionella, the recruitment of staff, and the control and prevention of infection which impacted on the overall safety of the service.

There were a number of policies and procedures in place to guide staff however, we found examples where staff were not following them. For example, the recruitment policy stated that references would be sought for prospective employees but we found this had not been done. The practice's Equality and Diversity policy stated that it would provide information in a variety of languages and that translation services were available but we found no evidence of this. The practice's infection control policy stated staff should use a rinse sink, but the practice did not have one. Some polices gave incorrect guidance for staff. For example, the practice's infection control policy stated that instruments should be rinsed under running water following being cleaned in the ultrasonic bath. Guidance about the length of time instruments could be stored for before requiring reprocessing was also incorrect.

Communication across the practice was structured around monthly practice meetings that all staff attended. We viewed minutes from these meetings which were detailed and included action points for staff. Copies of minutes were distributed to staff who could not attend. Staff told us the meetings provided a good forum to discuss practice issues and they felt able and willing to raise their concerns in them.

Most staff had received an appraisal but the practice manager told us this only occurred every two years. Neither she, nor the hygienists had ever received an appraisal so it was not clear how their performance was managed. None of the staff had personal development plans. There was no system was in place to monitor the continuing professional registration of staff and their fitness to practise. Staff assisting in the sedation of patients had not received training.

We noted good audits were in place to assess the quality of record keeping, referrals, the recording of patient consent. However, an infection control audit had only been undertaken for the first time just prior to our visit which was not in accordance with national guidelines and a radiography audit did not meet FGDP guidelines

Leadership, openness and transparency

Staff told us they enjoyed their work, and felt well supported by the dentists and practice manager**.** They reported that they were able to raise their suggestions and concerns with them, and frequently did so.

The practice had recently implemented a policy in relation to its requirements under the Duty of Candour, although not all staff were aware of it.

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

Patients were asked to complete a survey that asked them for their views on a range of issues including the friendliness of staff, the length of wait for their appointment and if the cost of their treatment was explained to them. The results had been analysed and shared with staff at their meeting, although they had not been shared with the patient themselves. There was also a suggestion box in the waiting room with forms available for patients to complete. In response to feedback from patients, the waiting room carpet had been replaced with new laminate flooring and the number of hygienist appointments had been increased to better meet patient demand.

The practice gathered feedback from staff generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues. We were provided with examples of where staff's suggestions had been implemented such as providing a water machine for patients; providing staff car parking and introducing a referral book for orthodontic and implant treatment.

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 How the regulation was not being met: The provider did not have robust systems in place to ensure that care and treatment was provided in a safe way for service users. • Significant events were not analysed or used as a tool to prevent their reoccurrence. • Fire safety, legionella management and infection control were not effective enough to ensure that patients were protected. • Staff recruitment was not robust and essential pre-employment checks were not completed to ensure staff were suitable to work with patients.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not have effective systems in place to ensure that the regulated activities at The Hollies Dental Surgery were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

- There was no system to ensure regular updating of the practice's policies and procedures and for checking staff adhered to them. Some polices were not being followed and others contained incorrect guidance for staff.
- Not all staff received regular appraisal of their performance and none had personal development plans in place.
- Risk assessment was not robust. For example there was no assessment in place for the reliance on a community defibrillator to manage medical emergencies.