Mr. Paul Sanders

Melbourn Dental Practice

Inspection Report

24a Orchard Road
Melbourn
Royston
Hertfordshire
SG8 6HH
Tel: 01763 262034
Website: www.melbourndentalpractice.co.uk

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Overall summary

The inspection took place on 14 January 2015 as part of our national programme of comprehensive inspections. We had previously inspected the service in 2012 when the provider was found to be meeting all five of the standards assessed.

Melbourn Dental Practice provides primary dental care and treatment to patients whose care is funded through the NHS and to patients who pay privately. The service is led by a principal dentist (also the registered manager) and two associate dentists, three registered dental nurses and a trainee dental nurse. A registered manager is a person who is registered with the Care Quality Commission to manage the service. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

The practice manager is also a registered dental nurse and dental health educator. They are supported by a receptionist.

Prior to our inspection we left some CQC comment cards for patients to complete about their experience of the practice. A total of 109 comments cards were received and we found that patients had made positive comments about the practice and were very satisfied with the care and treatment they received from the staff. Patients who said they were particularly nervous about visiting the dentist told us staff treated them with compassion and put them at ease. We spoke with four patients on the day of the inspection who also said that staff were kind and caring, explained about their care and treatment options and gave them valued advice about their dental health.

Our key findings were:

- The practice had effective systems in place to ensure the safety of equipment (including X-ray equipment), staff recruitment and for identifying and managing patient safety incidents. Staff managed the decontamination of dental instruments in line with published guidance. However improvements were required to strengthen environmental cleaning procedures and to ensure that emergency medicines were always available.
- Patients were given appropriate levels of information and involved in decisions about their treatment. Clinical records were well maintained and patients were referred for specialist treatment in a timely and efficient manner. Staff received appropriate training to meet the needs of patients.
- We received a large amount of comments cards from patients and spoke with others who gave very positive feedback about the caring and professional service they received from staff.

Summary of findings

- The practice provided a range of services that met the needs of their registered patients and were able to provide us with examples of how they had made changes to suit individual needs.
- The practice had a clear leadership structure and a learning culture was embedded. Risks were monitored and well managed. Regular audits were completed to ensure a continuous cycle of improvement.

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

- Review and document the environmental cleaning procedures so they are in line with national guidelines.
- Ensure that all hand wash sinks in the treatment rooms meet HTM 01-05 guidelines for the prevention and control of infection.

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:

- Ensure that any concerns or complaints received are recorded and monitored in line with the practice complaints policy.
- Improve staff training records held at the practice so that the provider has a clear record of planned and completed training for all team members.
- Ensure that appropriate emergency medicines are stocked and available for use at all times.

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?

The practice had a range of safety systems in place. Some improvements were required to strengthen infection control cleaning procedures and to ensure that emergency medicines were always available. There were systems to identify, investigate and analyse patient safety incidents and learning from them was cascaded to staff. Although facilities for decontamination of equipment were not ideal staff managed the process so that instruments were cleaned in line with published guidance. X-ray equipment at the practice had been serviced, maintained correctly and was only operated by qualified staff. Other items of equipment were serviced and maintained regularly. Staff recruitment procedures were effective.

Are services effective?

The dental care and treatment provided to patients followed current guidelines. Patients were given appropriate information to support them to make decisions about the treatment they received and to promote their oral health. The practice kept detailed clinical records of assessments and treatments carried out and monitored any changes in the patient's oral health. The practice had systems in place to ensure patients were referred for specialist treatment in a timely manner and that essential information was shared between dental practices.

Staff were supported by the practice in their continuing professional development (CPD) and were meeting the requirements of their professional registration.

Are services caring?

Patients told us they had very positive experiences of dental care provided at the practice. For example nervous patients told us they were treated with patience and compassion. Patients felt well supported and involved with the discussion of their treatment options which included risks and benefits. Staff displayed kindness and respect at all times.

Are services responsive to people's needs?

The practice provided a range of dental services to NHS and Private patients. We found that patients were able to access treatment and urgent and emergency care when required. We found that patients with a disability or limited mobility were supported to access the service. Feedback from patients about the service was encouraged and acted upon so that further improvements could be made. There was an accessible complaints system in place so that concerns could be managed effectively.

Are services well-led?

There was an effective leadership structure led by the practice manager and principle dentist. Staff had clear roles and responsibilities and understood how they impacted on the quality of the service. Staff told us they felt supported and involved in service improvements through effective team communication. Risks to both patients and staff had been identified and these were monitored and reviewed. The practice assessed and monitored the services they provided through patient feedback, audits and monitoring complaints.

Melbourn 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 and to pilot a new inspection process being introduced by the CQC.

The inspection took place on 14 January 2015. The inspection team was led by a CQC Inspector with further support from a specialist advisor for dentistry.

Prior to the inspection we reviewed the information we already held about the service, requested some basic information from the provider and gathered information from their website. We informed the NHS England area team and the local Healthwatch that we were inspecting the practice; and we did not receive any information of concern from them.

During the inspection we spoke with the principle dentist, two other dentists, the practice manager, two dental practice nurses and the receptionist. We also spoke with four patients prior to or following their appointments.

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

Learning and improvement from incidents

The practice had a system in place for reporting, recording and reviewing incidents and accidents. The practice manager was responsible for leading this procedure. Records we checked showed that issues were raised at staff meetings, actions were discussed and learning was shared with the team to prevent any recurrence.

Staff we spoke with understood the process for accident and incident reporting. There was a policy in place for the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR) although there had not been a need to use it. We reviewed the accident reports and found that a risk assessment was always completed following an accident so that actions could be taken to prevent potential recurrences.

The practice followed national guidance in reporting any adverse reactions to medicines.

Reliable safety systems and processes (including safeguarding)

The practice had a named member of staff with lead responsibility for safeguarding issues. No safeguarding concerns had been raised about patients registered with the practice. We found that staff had received training in safeguarding adults and child protection and could demonstrate an awareness of the reporting procedures. This included access to local authority contacts. They had knowledge of the possible signs of abuse.

The practice did not have a specific chaperone policy in place. However, dental nurses covered this in their training. Patients were seen by a dentist when a dental nurse was present.

Staff told us they had clear checking procedures in place to prevent wrong site surgery taking place. This included confirming with the patient, checking the assessment records and radiography information.

Risks associated with sharps injury were fully assessed and staff followed a protocol to reduce any risks of sharps injuries. All employers are required to ensure that risks from sharps injuries are adequately assessed and appropriate control measures are in place. Legislation came into force in 2013 under the European Council Directive 2010/32/EU addressing this issue.

Staff could demonstrate they assessed patients appropriately for procedures to ensure that risks could be well managed for example by using rubber dams. A rubber dam is a thin, rectangular sheet, usually made of latex used to isolate the operative site from the rest of the mouth.

Infection control

We found the practice had followed the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 -Decontamination in primary care dental practices (HTM 01-05)' and the 'Code of Practice on the prevention and control of infections and related guidance'. The practice policy and procedures on infection prevention and control were accessible to staff.

We looked at the facilities for cleaning and decontaminating dental instruments at the practice. The decontamination area was within the practice manager's office. The provider recognised this was not an ideal arrangement and a plan had been drawn up to have a separate decontamination area. This has yet to be funded. We spoke with staff and found the dental nurses completed half of the decontamination procedure within the treatment room where manual washing of the instruments took place after the patients had left the room. The other half of the procedure took place in the decontamination room where equipment was situated for completing a thorough decontamination process and packaging the instruments. They followed clear zoning practice to prevent cross contamination of the instruments.

Staff followed procedures to ensure that safe practice was followed to promote the prevention and control of infection. This included the use of personal protective equipment such as eye protection, aprons, heavy duty gloves and a mask while handling used instruments.

Instruments were inspected to check for any debris or damage throughout the cleaning stages and staff used an illuminated magnifier in line with essential quality standards for the final check. Instruments were decontaminated using an autoclave (steriliser) and were then packaged in pouches after sterilisation and dated to indicated when they should be reprocessed if left unused.

Are services safe?

We found daily, weekly and monthly tests were performed to check the steriliser was working efficiently and a log was kept of the results. Regular servicing and maintenance of the equipment was in place.

The dental water lines were maintained in accordance with current guidelines to prevent the growth and spread of Legionella bacteria. This is a particular bacteria which can contaminate water systems in buildings. Flushing of the water lines was carried out in accordance with current guidelines and supported by a practice protocol. A Legionella risk assessment had been carried out by an appropriate contractor. This reduced the risk of legionella to patients and staff.

The practice had appropriate systems in place for the management of clinical, hazardous and general waste. We noted that the large yellow bin at the back of the premises for decanting clinical waste bags was locked.

General environmental cleaning of the premises was a shared responsibility between the dental nurses and an employed cleaner who cleaned three times a week. We found that cleaning equipment followed national guidance on colour coding equipment to prevent the risk of infection spreading.

Most areas of the practice were visibly clean and tidy. However, some elements of the environmental cleaning had not been completed to a satisfactory standard. This included items within the treatment rooms such as a hand wash sink, ventilation grill and a wall mounted screen. The provider agreed to take swift action to improve these.

Dental nurses responsibilities for cleaning were included as part of a daily checklist. A separate checklist was in place for the cleaner. We found this did not contain sufficient detail about the cleaning required in each area nor did it make reference to national cleaning guidelines to make the standard of cleaning clear. A cleaning schedule was in place listing parts of the environment, method of cleaning and the frequency or level of risk. However, it was not clear which areas these covered so the staff had guidelines that cross referenced with their cleaning checklists.

There was no record or guideline on the frequency of any deep cleans in the practice or when the toys in the waiting room should be cleaned. We raised this with the practice manager who agreed that improvements should be made.

Cleanliness checks of the environment had not been recorded since 2013 to demonstrate that cleaning standards were monitored.

Equipment and medicines

We observed that appropriate clinical equipment was available to support the service.

The emergency medicines were all in date and the drugs were securely kept along with emergency oxygen in a central location known to all staff. The expiry dates of medicines and equipment was monitored by the practice manager so that items that became out of date could be replaced in a timely manner.

Cleaning equipment was stored in a locked cupboard used for the storage of others items such as purified water and sharps boxes. This was not ideal due to the increased risk of cross contamination.

Monitoring health & safety and responding to risks

We found the practice had been assessed for risk of fire. Fire extinguishers had been recently serviced and staff were able to demonstrate to us they knew how to respond in the event of a fire.

We randomly checked electrical items and found that electronic safety testing had been carried out on most items. When we identified items that had no safety test stickers, we were told these items had been purchased within the last year and were included on an inventory for the next annual check.

The practice had carried out an assessment of risks to the health, safety and welfare of patients, staff and visitors to the premises. The practice manager described the risk management system that was in place to ensure that these risks were appropriately managed. Records confirmed that actions were taken to minimise risks. This included effective arrangements to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations.

Medical emergencies

There were arrangements in place to deal with foreseeable medical emergencies that were in line with the Resuscitation UK guidelines. A range of suitable equipment was available including an automated external defibrillator (AED) that was checked by a member of staff every two weeks to ensure it was in good working order and ready for use. This is a portable electronic device that analyses life

threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Oxygen was also available for use in a medical emergency and checked regularly to ensure it was fit for use.

We found there was no available medicine to treat hypoglycaemic attacks (low blood sugar levels) for diabetic patients in an emergency situation. Although the practice had placed this order, they did not have the item stocked and available for use at the time of the inspection. We also found there was no midazolam in stock. This item should be stocked for emergency use in line with guidelines in the British National Formulary (BNF).

The dentists and staff received annual training in basic life support including use of the AED. An external company had been used to facilitate team training in medical emergencies. It was practice policy to administer basic life support and call for emergency assistance using a 999 call.

Staff recruitment

We reviewed personnel files for two members of staff and found that appropriate checks and assessments had been made to support safe recruitment procedures.

The practice had a policy to request a criminal records check through the Disclosure and Barring Services (DBS) for all staff. Some of the checks were four years old and the practice had no guidance on when to re-check this for staff.

We found the practice had appropriate numbers of staff to meet the needs of its registered patients. There was always a dental nurse to work with each dentist and one spare dental nurse to provide support to the dentists and the reception team. The practice manager also worked flexibly across the practice if required to do so.

There were no staff vacancies at the time of the inspection.

Radiography (X-rays)

The practice had a named radiation protection adviser (RPA) and radiation protection supervisor (RPS) to monitor safe practice and ensure that best practice guidelines were in place. The practice's radiation protection file contained the necessary documentation demonstrating the maintenance of the X-ray equipment. These included critical examination certificate for each X-ray set along with the three yearly maintenance logs in accordance with current guidelines. A copy of the local rules was displayed in each treatment room. An inventory of X-ray equipment used in the dental practice was displayed with each X-ray set.

Records confirmed that staff had completed appropriate training updates. Audits of dental X-rays had also been completed.

Are services effective?

(for example, treatment is effective)

Our findings

Consent to care and treatment

We spoke with two dentists who explained to us how valid consent was obtained for all care and treatment. The dentists checked each patients understanding and sought verbal or written consent before treatment was progressed. Records we checked showed that staff confirmed individual treatment options, risks, benefits and costs with each patient and documented this in a written treatment plan. Patients we spoke with confirmed they were given time to make informed decisions about the treatment they wanted.

The provider demonstrated a clear understanding of how the Mental Capacity Act 2005 applied in considering whether or not patients had the capacity to consent to dental treatment. The provider explained how they would consider the best interests of the patient and involve family members or other healthcare professionals responsible for their care to ensure their needs were met.

Monitoring and improving outcomes for patients

When patients attended the practice for a consultation we found they received a thorough assessment of their dental health needs. They were asked to supply information about their medical history such as any health conditions, current medicines being taken and whether they had any allergies. Patients were asked to review and update this information at routine examinations.

The dental assessments were completed in line with recognised guidance from the National Institute for Health and Care Excellence (NICE) and General Dental Council (GDC). This assessment included an examination covering the condition of a patient's teeth, gums and soft tissues and observation for the signs of mouth cancer. Dentists discussed the findings with patients including whether their oral health had changed since the last appointment. They also discussed treatment options, risks, benefits and costs.

Where relevant, preventative dental information was given in order to improve the outcome for the patient and this included smoking cessation advice, guidance on alcohol consumption and general dental hygiene. They were referred to the practice manager (dental health advisor) who provided advice on good oral hygiene if this was required.

The patient records were updated with the proposed treatment and reflected discussions with the patient. All of the records we checked contained clear and detailed information.

The practice kept up to date with current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, the practice referred to NICE guidelines in relation to deciding when to recall patients for examination and review.

Working with other services

When patients had more complex dental issues, the practice referred them to other healthcare providers. This included, for example conscious sedation, as the practice did not provide this service. It was practice policy to make same day referrals to reduce any delays of treatment for the patient and this was recorded in their records as well as on a referral log. Evidence we reviewed supported this.

The practice told us that patients did not always get their first choice of preferred specialist because of their location. (This was due to patients home postcodes and county borders)

Health promotion & prevention

The practice promoted the maintenance or good oral health as part of their overall philosophy and had considered the Department of Health publication 'Delivering Better Oral Health; a toolkit for prevention' when providing preventive oral health care and advice to patients.

Records showed patients were given advice appropriate to their individual needs such as smoking cessation or diet advice. We also saw that a patient with high risk of dental decay was prescribed a high concentration fluoride toothpaste. During discussion with staff, we found that two practitioners offered the application of fluoride varnish to children's teeth in line with current guidelines.

Patients in the waiting room had access to health promotion leaflets and posters were also displayed. Patients that we spoke with and comments cards we received gave us examples of information and health

Are services effective?

(for example, treatment is effective)

promotion advice patients had received to promote their oral health. We also found the practice had provided dental workshops for children at a local primary school and had received positive feedback about how useful the teachers and children had found it.

Staffing

The practice manager had a training log for all members of staff which demonstrated that training was supported and accessed by all staff. However, this was not fully complete because staff maintained their own professional portfolio's and did not always notify the practice manager when they had attended a training course.

The principal dentist held weekly tutorials once a week as a minimum. These were used for case discussion/ review and for looking at best practice guidelines and updates.

Staff received annual appraisals with a mid year review. On a more informal level, the practice manager had a weekly discussion with each member of staff to check that they were confident in their role and identify any issues or concerns they may have so that immediate support could be arranged. Staff we spoke with told us they felt supported and enjoyed working at the practice.

There was a process in place for managing staff induction so they were supported by experienced staff until they had sufficient knowledge and skills to perform their role at the practice. There was also a process for performance management of staff.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We observed that staff greeted patients in a friendly and welcoming way and were respectful. Reception staff told us they were mindful of each patient's right to privacy and therefore they did not disclose personal information that could be easily overheard. If a patient required a more confidential discussion, staff were able to use a room behind the reception desk.

Patients we spoke with told us they felt their privacy was respected; staff were welcoming, kind and helpful.

We received a total of 109 CQC comments cards completed by patients during two weeks leading up to the inspection. The cards were all very positive showing that patients valued the service they received. Six of the cards were from nervous patients who told us the dentists and staff were sensitive to their anxiety and helped them to feel calmer and more confident when they received care and treatment. We also received comments from two parents who told us their children enjoyed coming to the dentist and staff welcomed them, put them at ease and rewarded them with stickers.

Involvement in decisions about care and treatment

We received many comments on the CQC cards from patients who told us they received a good level of information about their treatment or general dental needs. They also felt able to make informed choices about their treatments.

We found that young people were seen alone if appropriate consent was given. This encouraged them to make decisions and take responsibility for their on-going oral health.

We spoke with one dentist who gave us examples of individualised care that enabled patients to make their own decisions. For example a hearing impaired patient is always seen with support of a relative who signs the specific information to them to ensure they can make informed decisions.

Records we checked showed that patients consent had been obtained before treatment plans were progressed.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patient's needs

The practice leaflet and website explained the range of services offered to patients. This included regular check-ups (including X-rays and teeth cleaning), fillings, extractions, root canal, dentures, bridges and crowns. The practice undertook NHS and private treatments. Costs were clearly displayed and were explained to patients during their consultation.

Staff reported that the practice always scheduled enough time with each patient to assess and undertake their care and treatment needs. Staff told us they never felt rushed or under pressure to complete procedures and always had enough time available to prepare for each patient. Our observation of the appointment system, of activities during the day and comments we received from patients supported this view.

Although the practice did not hold specific emergency appointment slots, they were able to fit in patients who needed an urgent appointment at the end of a morning or afternoon surgery. This was done on the day of the request if possible or the following day. Information received from patients supported this.

Tackling inequity and promoting equality

The front door to the practice had two small steps which could cause difficulty for patients who used a wheel chair to access the service. There was a door bell at low level, in working order to enable patients to call staff if they required assistance to access the building. In addition, the practice had purchased a metal ramp. They told us this was used on a regular basis to enable patients to access the service. Staff could prepare the ramp ahead of time when they were expecting a patient who required it.

Dentists we spoke with were able to give us examples of patients they had treated who required additional support needs. This included a patient who required urgent care. The patient was unable to transfer into the dentists chair for assessment and treatment. The dentist therefore agreed to see and treat them whilst in their own personal wheelchair.

The practice welcomed patients from all cultures and backgrounds although at the time of the inspection they did not have any patients with a limited understanding of the English language. However, they were aware of interpreting services should the need arise.

Access to the service

The practice offers a range of dental services and treatments that includes preventive care, prosthetics, implants and protective dental health. The practice treats both NHS and private patients and opens weekdays from 9am until 6pm. The practice operated a system to remind patients about their appointment details by email or text messaging if the patient had given permission for this.

Patients received information about obtaining emergency care out of hours if they telephoned the practice. Patients may find it useful to have this information on the practice website.

Out-of-hours cover is provided by the NHS 111 service or by Camdent for private patients.

Concerns & complaints

The practice had an appropriate complaints policy in place and the practice manager was responsible for dealing with any complaints received. Information on how to raise a complaint and how it would be dealt with was available on the website and available in written format in the waiting room.

There had been two complaints received within the last year. We found that one issue had been resolved by the practice in line with their complaints policy. The other complaint had been made through NHS England and was being investigated by them. The practice had responded to information requested by NHS England but the practice were not aware of an outcome.

The practice did not have a system to ensure that the stages of the complaint, outcomes, learning and the actions taken could be clearly evidenced.

Patients we spoke with told us they would raise any concerns they had with the dentist treating them or to the practice manager or receptionist.

Are services well-led?

Our findings

Leadership, openness and transparency

There was a clear leadership structure in place and staff were very clear about their roles and responsibilities. Staff told us there was an open culture at the practice and they felt well supported by the practice manager and principle dentist. There were arrangements for sharing information across the practice on a daily basis and through regular practice meetings. Staff told us this helped them keep up to date with new developments and policies. It also gave them an opportunity to make suggestions and provide feedback to the practice manager.

Governance arrangements

The practice had a comprehensive risk assessment file and was able to demonstrate that these were regularly reviewed. Risk assessments included the use of sharp instruments, hazardous substances and window blind cords. New risk assessments were often completed in response to an incident so that risks could be managed and reduced. For example a new risk assessment was completed when the metal access ramp was purchased.

The practice completed annual audits to ensure that staff followed best practice and identify further improvements. These included audits of patient records, radiography, and infection control. Outcomes were discussed at the staff meetings and training sessions.

The principle dentist attended a local dental forum to maintain other professional links and share good practice. This had become a training practice in 2008 and had a strong commitment to continuing professional development which was evidenced through observation, talking to staff and reviewing training records.

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

The practice manager and principle dentist took responsibility for monitoring feedback about the service through incidents, comments and complaints. For example they conducted a disability assessment and invited patients views following an incident at the practice.

There was a comments box with pen and paper situated in the waiting room and the provider had included some comments on the website. The staff were proactive in asking patient's to complete the CQC comments cards by giving them out to patients following their consultation. This had resulted in a high number of comments cards being completed.

A file placed in the waiting room contained the results of the patient survey in 2014. The information listed a range of positive comments received. It did not contain any detail about overall findings or any survey outcomes to inform patients how the information was being used.

Management lead through learning and improvement

Each dentist at the practice was supported by a qualified dental nurse. The dental nurses worked a rotation system so that they were familiar with working with each dentist and learning could be shared.

Staff told us they had good access to training which was monitored by the practice manager to ensure essential training was completed each year. In addition, staff working at the practice were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC).

All dentists and dental nurses at the practice were registered with the GDC. The GDC registers all dental care professionals to make sure they are appropriately qualified and competent to work in the United Kingdom. The practice manager kept a record to evidence that staff were up to date with their professional registration.

The practice audited areas of their practice as part of a system of continuous improvement and learning. For example infection control and patient record audits were completed every six months and there was evidence of actions taken.

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 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Regulation 12 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Cleanliness and Infection Control. This corresponds to Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who use services and others were not always protected against the risks associated with infection control and prevention by the maintenance of appropriate standards of cleanliness and hygiene in relation to the premises. Sinks in one treatment room did not meet HTM 01-05 guidelines. Regulation 12(c) (corresponding to Regulation 12 (2)(h))