Kenneth Ng Surgery Ltd

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Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 11October 2016 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

Kenneth Ng Surgery Limited is a small, well-established practice that provides both NHS and private dentistry services to adults and children. Dr Kenneth Ng, who is the principal dentist, owns the practice. The practice has a team of two dentists and four dental nurses. There are three treatment rooms, a separate room for the decontamination of instruments, a reception area and two waiting rooms. The practice opens on Mondays to Fridays from 8.30am to 5.30pm, and on Saturdays by appointment.

The practice owner is registered with the Care Quality Commission (CQC) as an individual. 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:

- Patients commented on the effectiveness of their treatment, the professionalism of staff and the cleanliness of the environment. They reported that it was easy to get through on the phone and that they rarely waited long having arrived for their appointment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Appointments were easy to book and patients could access treatment and urgent and emergency care when required.
- Staff we spoke with felt supported by the practice owner, and there were regular practice meetings involving all staff. The practice listened to its patients and staff and acted upon their feedback.

Summary of findings

- Essential information and evidence of some dental examinations and risk assessments was missing from patient dental care records.
- The practice's recruitment process did not ensure that all relevant checks were undertaken before new staff began their employment.

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

- 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. For example, this includes the management of significant events and patient safety alerts; the storage of dental care products; the management of substances hazardous to health, and ensuring dental care records are maintained appropriately giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.

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

- Review the practice's system for the recording, investigating and reviewing incidents or significant events with a view to preventing further occurrences and ensuring that improvements are made as a result
- Review the practice's protocols for recording in the patients' 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.
- Review the practice's recruitment policy and procedures to ensure they are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 so that necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.
- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA).
- Review availability of medicines and equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.

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.

Most risks to staff and patients had been identified and control measures put in place to reduce them and the practice's decontamination procedures met national guidance. Arrangements were in place to safeguard children and vulnerable adults from abuse, and to respond appropriately to a range of medical emergencies. Equipment was well maintained. However, learning from significant events was not shared across the staff team to prevent their reoccurrence; emergency equipment and medicines did not meet national recommended guidelines, and there was no system in place to ensure that national safety alerts were disseminated and actioned appropriately.

Are services effective?

No action

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

There was a small and established staff team at the practice who received regular appraisal of their performance, and who were up to date with their continuing professional development. Staff had a good understanding of the Mental Capacity Act 2005, and its relevance in obtaining valid consent for a patient who lacked the capacity to make decisions for themselves. Patients were referred to other services appropriately. However, it was not possible for us to ascertain from the dental care records if patients' needs were fully assessed, and if care and treatment was delivered in line with current standards and evidence based guidance, as a lot of essential information about patients was not recorded.

Are services caring?

No action

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

Patients spoke highly of the dental treatment they received, and of the caring and empathetic nature of the practice's staff. Patients told us they were involved in decisions about their treatment, and did not feel rushed in their appointments.

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 had good facilities and was well equipped to treat patients and meet their needs. Routine dental appointments were readily available, as were urgent on the day appointment slots and patients told us it was easy to get an

Summary of findings

appointment with the practice. Good information was available for patients both in the practice's leaflet and on the web site. The practice had made adjustments to accommodate patients with a disability and the premises were fully wheelchair accessible.

Information about how to complain was not easily available to patients, although the practice responded in an empathetic and appropriate way to issues raised by them.

Are services well-led?

We found that this practice was not providing well-led 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).

Staff told us that they felt well supported and enjoyed their work. Staff received regular appraisal of their performance and there were regular practice meetings. Suggestions from staff and patients was used it to improve the service and patients' concerns were managed professionally and empathetically. However, we found a number of shortfalls indicating that the practice was not well-led. The quality of dental care records did not meet standards set by the FGDP, and the practice's own audits had been ineffective in identifying the shortfalls we found during our inspection. A lack of robust oversight meant that significant events had not been managed appropriately, staff had not been recruited safely, important safety alerts had not been actioned and medical consumables had not been checked.

Requirements notice 

Kenneth Ng Surgery Limited

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 11October 2016 and was conducted by a CQC inspector and a dental specialist advisor.

During the inspection we spoke with the practice owner, one dentist and two dental nurses. We received feedback from 15 patients who had completed our comment cards prior to our inspection, and spoke with another four 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

Staff we spoke with had a satisfactory understanding of their reporting requirements under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences). Any significant events that occurred in the practice were recorded in a small notebook and we viewed recent events including a mercury spillage and a patient who had fainted. Although these had been recorded, there was no evidence that they had been formally discussed with staff, or of any action that had been taken to prevent their reoccurrence.

National patient safety alerts were sent to the practice owner, however these were not distributed to the associate dentist and neither dentist was aware of recent alerts affecting dental practice.

Reliable safety systems and processes (including safeguarding)

Arrangements were in place to safeguard children and vulnerable adults from abuse. These reflected relevant legislation and local requirements. Policies were accessible to all staff and clearly outlined whom to contact for further guidance if staff had concerns about a patient's welfare. All staff had completed relevant training in safeguarding patients. Contact details of agencies involved in protecting vulnerable people and a flow chart showing reporting procedures were available in the reception area. Staff we spoke with demonstrated their awareness of the different types of abuse, and understood the importance of safeguarding issues.

Staff spoke knowledgeably about action they would take following a sharps injury and a sharps risk assessment for the practice had been completed. Protocols of what to do in the event of an injury were on display in areas where sharps were used. Dentists used a safer sharps' system and boxes for the disposal of sharps were wall mounted, and labelled correctly to ensure their safety.

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. The dentists we spoke with confirmed that they used rubber dams routinely, and we viewed appropriate kits in place.

Medical emergencies

There were arrangements in place to deal with foreseeable emergencies. Emergency

equipment as recommended by the Resuscitation Council (UK) was stored securely in clearly marked locked cupboard. This included oxygen and an automatic external defibrillator, although the practice did not have a full set of airways or automated blood glucose measuring device as recommended. All staff had access to this cupboard and records showed that the equipment and medicines were checked routinely. We noted laminated posters in treatment rooms from the Resuscitation Council with advice on how to respond to a range of medical emergencies.

Staff medical emergency training was slightly out of date but training had been organised for the day following our inspection. Staff did not regularly rehearse emergency medical simulations so that they had a chance to practice what to do in the event of an incident.

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, although there was no glucagon injection available to treat patients with very low blood sugar. Medicines we checked were in date for safe use.

Staff recruitment

We checked the file for a recently appointed member of staff and noted a number of shortfalls in their recruitment. For example, although the practice had obtained a Disclosure and Barring Service (DBS) check for the employee, information about their inclusion on the children's barring list had not been requested. No references had been obtained for the staff member despite her having worked previously as a dental nurse. No record had been made of her interview to demonstrate it had been conducted in line with good employment practices. The practice owner told us he had not requested references for any current members of staff, but was in the process of obtaining new DBS checks for them.

Monitoring health & safety and responding to risks

Are services safe?

The practice had a range of policies and risk assessments, which described how it aimed to provide safe care for patients and staff. The risk assessments we viewed were satisfactory and covered wide range of identified hazards in the practice and the control measures that had been put in place to reduce the risks to patients and staff. They had been regularly updated.

A fire risk assessment had been recently completed in October 2016 and in response to this, the practice owner was about to install smoke detectors and a range of other measures as recommended. Firefighting equipment such as extinguishers were regularly tested, evidence of which we viewed**.** However we found no evidence that staff had received any fire training and no fire marshals had been appointed. Regular fire evacuation drills were not completed, so it was no clear how the practice would manage in a fire when patients were present.

A legionella risk assessment had been carried out in October 2016, and the practice was in the process of implementing its recommendations to monitor water temperatures and conduct regular dip slide testing. Dental unit water lines were managed correctly to reduce the risk of legionella bacteria forming.

There was a control of substances hazardous to health folder in place containing chemical safety data sheets for some materials used within the practice. However we noted there were no safety data sheets available for a number of products regularly used within the practice such as disinfectant and window cleaner. We also noted an unmarked bottle containing a light green fluid in one treatment room. We were told it contained a surface cleaner but there was no way of verifying this.

A mercury spillage kit was available so that any amalgam could be dealt with safely, although the practice did not have a bodily fluid spillage kit.

Infection control

Patients who completed our comment cards told us that they were happy with the standards of hygiene and cleanliness at the practice.

Periodic infection control audits were completed using a nationally recognised tool. Such an audit had been completed immediately prior to our inspection with the practice achieving a compliance score of 93%. As a result of this audit, long handled brushes for manually cleaning instruments and lidded instrument transport boxes had been implemented.

There was plenty personal protective equipment available for both staff and patients. A range of infection prevention and control guidance was displayed for staff, including reminders about correct hand washing techniques and the management of needle-stick injuries. We noted that staff uniforms were clean, long hair was tied back and staff's arms were bare below the elbows to reduce the risk of cross infection. All dental staff had been immunised against Hepatitis B.

Prior to our inspection, we received concerns that the practice owner routinely treated family members with the same instruments, without cleaning them between consultations. The practice owner admitted to us this had been his practice, but that he had stopped it following a patient complaint about the matter. Other staff we spoke with confirmed this was the case. The practice owner told us he would implement an instruments audit for a period of three months so he could evidence he no longer did this.

We observed that most areas of the practice were visibly clean and hygienic, including the waiting area, stairway and corridors. The toilets were clean and contained liquid soap and paper towels so that people could wash their hands hygienically. We checked the treatment rooms and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. However a chair in one room was ripped and no action had been taken to repair it. Treatment room drawers were messy and cluttered and we noted some loose and uncovered items within the splatter zone that risked becoming contaminated over time. We viewed a number of uncovered and rusty looking steel burs in the drawers. Lime scale had built up around sink taps and plugholes, making them difficult to clean. The practice's cleaning equipment did not meet with national guidance and was not stored correctly. There were no cleaning schedules or accountability sheets in place for the practice's cleaner.

The practice had a dedicated decontamination room that was set out according to the Department of Health's guidance, Health Technical Memorandum 01- 05 (HTM 01-05), decontamination in primary care dental practices. The dental nurse demonstrated the decontamination process from taking the dirty instruments through to clean and

ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean. The dental nurse used a system of manual scrubbing for the initial cleaning process, before placing instruments in an ultrasonic bath. Following this, instruments were inspected with an illuminated magnifying glass, then placed in an autoclave (a device used to sterilise medical and dental instruments). When the instruments had been sterilized, they were pouched, dated and stored until required. The dental nurse demonstrated that systems were in place to ensure that the autoclaves and sonic baths used in the decontamination process were working effectively.

The practice used an appropriate contractor to remove dental waste and we saw the necessary waste consignment notices. Clinical waste was stored in a locked basement cellar, prior to being removed from the practice.

Equipment and medicines

Staff told us they had enough equipment for their job and that repairs were actioned swiftly by the practice owner.

We found that there were adequate numbers of instruments available for each clinical session to take account of decontamination procedures. 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 other equipment was tested and serviced regularly and we saw maintenance records that confirmed this. For example, a full service of dental equipment had been completed in October 2016, portable appliances had been tested in August 2016 and the compressor had been serviced in July 2016.

Dentists were aware of reporting systems to the British National Formulary and of the yellow card scheme to report any patient adverse reactions to medicines. The batch numbers and expiry dates for local anaesthetics were recorded in patients' clinical notes; although prescription numbers were not recorded so they could be tracked effectively from pad to patient.

The practice had a dedicated fridge for medicines which required cool storage. However, the fridge's temperature was not monitored to ensure it was operating effectively. We found a number of very out of date medical consumables in the fridge that were no longer fit for safe use.

Radiography (X-rays)

We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation relating to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for each X-ray set along with the maintenance logs and a copy of the local rules. A copy of the local rules was also kept in each treatment room where x-rays were taken. Both dentists had received training for core radiological knowledge under IRMER 2000 Regulations

Dental care records showed that dental X-rays had been reported on; however neither their justification nor grading had been recorded, as recommended by the Faculty of General Dental Practice.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Dentists we spoke with were aware of National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC) guidelines in relation to antibiotic prophylaxis, wisdom tooth removal and dental recall intervals.

We were shown a sample of eight dental care records and found that soft tissue, jaw joint and dental charting had been completed for patients. Basic periodontal examinations had been recorded and results acted on to help patients manage their gum disease. However other essential information and evidence of dental assessment was missing. For example, the reason for patients attending and their social history was not always recorded; medical histories were not signed by both the patients and the dentist, and had not been updated regularly. Risk assessments for caries and periodontal disease had not been recorded. Radiographs had been recorded but not their justification or grading. We were told that smoking cessation advice was given verbally to patients, but there was no record of this in the notes we saw.

Regular audits were undertaken to assess standards in radiography and the quality of clinical notes. However the radiographic audits and recording keeping audits undertaken by staff showed high levels of compliance with national guidelines, which was not demonstrated by the eight sets of records we reviewed as part of our inspection.

Health promotion & prevention

The practice sold some dental oral health care products such as toothbrushes, interdental brushes and mouthwash. Free samples of toothpaste were also available for patients.

Staff were aware of guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'. This is an evidence-based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. Dental nurses told us the dentists regularly provided smoking cessation advice to patients; although there was no record of the advice having been recorded in the patients' notes that we viewed. Staff with were not aware of local smoking cessation services and there was no information or leaflets available for patients wanting to give up smoking.

Dentists confirmed that they prescribed high concentrated fluoride toothpaste to keep patients' teeth in a healthy condition if needed. The practice owner told us a hygienist was about to start work at the practice to assist patients with the prevention of decay and gum disease.

Staffing

The practice had experienced a recent turnover of staff, with one dental nurse leaving permanently. In addition to this, agency staff had been used regularly in the previous 18 months to cover another three staff members who had gone on maternity leave. A permanent dental nurse had recently been employed and staff reported that staffing levels were suitable for the small size of the service. Dental nurses told us that patients were given plenty time from the dentists and that appointments were never rushed. One nurse felt there should be a dedicated decontamination nurse to ensure that instruments were reprocessed swiftly and not allowed to mount up.

Records we reviewed showed all staff were appropriately qualified, trained and where appropriate, had current professional validation. The practice owner had undertaken an MSc in Implant dentistry and held a PG Certificate in dental education. Staff told us they received good training which was paid for by the practice owner. They stated they were given time to complete their training within their working hours. Staff told us they received a yearly appraisal of their performance, which they found useful.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves and there were clear referral pathways in place. We viewed a small sample of referrals letters and found they contained appropriate information about the patient. A log of the referrals made was not kept so they could be could be tracked, and patients were not offered a copy of the referral for their information.

Consent to care and treatment

Are services effective?

(for example, treatment is effective)

Patients told us that they were provided with information during their consultation and that they had the opportunity to ask questions before agreeing to a particular treatment. Patients told us they were also provided with a treatment plan that they signed.

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. The staff we spoke with had a satisfactory knowledge of the act and its relevance when dealing with patients who might not have capacity to make decisions for themselves.

We viewed a small sample of patients' treatment plans that clearly outlined the prosed treatment, any alternative treatments available and their estimated costs. Detailed information was given to patients about implant treatment so that they could give informed consent to the procedure.

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 caring, friendly and considerate of their needs. Patients told us that staff listened to them and respected their wishes. Staff gave us examples of where they had gone out their way to support patients, such as delivering antibiotic prescriptions to one patient's house and walking another patient to the correct dental surgery, nearby.

The practice's reception area was separate from the patients' waiting room, ensuring that conversations could not be overheard. Staff had a good understanding of confidentiality. One nurse told us that she never gave out information to anyone other than the patient themselves, and did not leave any personal information on patients' answerphones but always asked them to call back. Patients' paper records were kept in filing cabinets by the reception desk, although these were not locked to ensure their safety.

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.

Involvement in decisions about care and treatment

Patients told us that their dental health issues were discussed with them and they felt well informed about the options available to them. They told us that they were offered treatment choices. A plan outlining the proposed treatment was given to each patient so they were fully aware of what it entailed and its cost. One dental nurse told us that as well as giving written post-operative instructions to patients, she always read them aloud to ensure they understood what was required.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice offered a full range of NHS treatments and also provided private treatment including periodontics, endodontics, dental implants and teeth whitening. There was free Wi-Fi access in all areas and the practice used an operating microscope to facilitate more accurate and precise treatment.

The practice's web site contained useful information for patients about its staff, opening hours and the range of treatments on offer. The practice opened on Mondays to Fridays from 8.30am to 5.30pm, and on Saturdays by appointment. Patients who completed our comment cards stated that it was easy to get an appointment and that they rarely waited long having arrived for their appointment. Emergency appointments were available each day for patients experiencing dental pain. Information about emergency out of hours services was available on the practice's answer phone message, and on the front door should a patient come to the practice when it was closed.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to help prevent inequity for patients that experienced limited mobility or other issues that hamper them from accessing services. There was level access to the front door and treatment rooms on the ground floor for those patients with limited mobility, as well as parents and carers using prams and pushchairs. There was also a disabled friendly toilet. The practice served a large multi-cultural population group and had access to interpreting services if needed. However, information about the practice was not available in any other languages or formats such as large print, braille or audio. No portable hearing loop was available to assist patients with hearing aids.

Concerns & complaints

The practice had a policy and a procedure that set out how complaints would be addressed. This included other agencies such as the General Dental Council and Dental Complaints Service that patients could contact, and the timescales within which their concerns would be responded to. However there was no information in the waiting areas or the practice's web site about how patients could raise their concerns, despite the policy stating that the procedure would be clearly displayed for patients.

We reviewed the paperwork in relation to three recent complaints and found they had been managed in a professional and empathetic way. An apology and refund had been given to the patient if required. It was clear that the practice learned from complaints. In response to one patient's complaint the practice had undertaken a specific audit to assess the quality of post-operative instruction given to patients following surgical procedures. Complaints were also regularly shared at staff meetings. For example, the complaint from a patient who had turned up for an appointment and found the practice closed had been discussed at the meeting of 27 July 2016, and a complaint about wisdom tooth extraction had been discussed at the meeting of 4 May 2015.

Are services well-led?

Our findings

Governance arrangements

During our inspection we found a number of shortfalls which indicted that oversight and leadership in the practice was lacking. For example recruitment processes were not robust; learning from significant events was limited; national patient safety alerts were not disseminated appropriately, the some aspects of the environment was not hygienic and dental care records had not been maintained adequately. We saw a range of clinical and other audits that the practice carried out to help them monitor the effectiveness of the service. These included the quality of clinical record keeping, the quality of dental radiographs, infection control and the quality of post-operative advice. However, the accuracy and effectiveness of these audits was limited, given the shortfalls we found in the justification and grading of X-rays, and the quality of dental care records.

The principal dentist had responsibility for the day-to-day running of the practice and acknowledged that he was finding some aspects of managing and overseeing the practice difficult in the absence of a practice manager. He told us he had plans in place to appoint a dedicated manager as a result. He had also purchased an on-line governance tool to assist him in the running of the practice

The practice had policies and procedures to support its work and provide guidance to staff and the practice owner regularly updated these using advice sheets from the British Dental Association.

Communication across the practice was structured around regular practice meetings, minutes of which we viewed. Staff told us the meetings were useful and provided a good forum for communication. Staff also received regular appraisal of their performance from the practice owner. Their appraisals were comprehensive and covered areas such as staff's communication, punctuality and administration skills

The practice owner told us he had completed an information governance audit tool. Results of this were not available, so it was not clear if the practice was meeting the requirements of legislation in how it managed patient information.

Leadership, openness and transparency

Staff told us they enjoyed their work and the small size of the practice, which meant that communication between them was good. Staff told us that they had the opportunity to, and felt comfortable, raising any concerns with the owner of the practice who was approachable and responsive to their needs.

We found that the practice owner was open and honest with us about the concerns we had received in relation to the practice. We also found that, if appropriate, he offered a full apology to patients when this had gone wrong. This demonstrated he understood duty of candour requirements.

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

The practice had introduced the NHS Friends and Family Test as a way for patients to let them know how well they were doing. There was also a suggestion box in the waiting area for patients to leave any comments. Patients' feedback was regularly discussed at the practice meetings, evidence of which we viewed, although not shared with patients so that they were aware of how their suggestions had been implemented by the practice. In response to feedback left, the practice had removed its music centre as patients had complained that they could not always hear the dentists speaking as a result. Squeaking door hinges had been oiled as suggested by one patient. It was clear that the practice learned from complaints and used them to improve the service.

Staff told us that the practice owner listened to them and implemented their suggestions. For example, their suggestion to replace an old sofa in the practice and to use different cleanings products had been implemented by the practice owner. Non slip strips had been applied to flooring in one treatment room, following a suggestion by the associate dentist.

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
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not operate effective systems and processes to assess, monitor and mitigate risks to the health and welfare of people who used the service. This included maintaining complete records of care provided, ensuring the safe recruitment of staff, responding to national safety alerts and undertaking robust audits of the service provided. **Regulation 17 (1)**