Dr. Christopher Bird

Dundee Court Dental Centre

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 7 September 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 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

Dundee Court Dental Centre provides only private general dentistry services to adults and children and is owned by Dr Christopher Bird. It is situated on an industrial estate just outside Kings Lynn and serves about 2,200 patients.

The practice has a team of two dentists, three dental nurses, a practice manager and a receptionist. There are three treatment rooms, two rooms for the decontamination of instruments, an office, two patient waiting areas and a reception area.

The practice opens on Mondays to Thursdays from 8.30am to 5pm, and on a Friday from 8.30am to 4pm.

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:

- We received consistently good feedback from patients about the quality of the practice's staff and the effectiveness of their treatment.
- There was appropriate equipment for staff to undertake their duties, and most equipment was well maintained.

Summary of findings

- 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.
- 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.
- Appointments were easy to book and emergency slots were available each day for patients requiring urgent treatment.
- Staff we spoke to felt well supported by the practice owner, despite his absence due to ill-health, and were committed to providing a quality service to their patients.
- The practice did not have access to an automated external defibrillator and the medical oxygen available on the premises was out of date.
- The practice did not have a structured plan in place to audit quality and safety beyond the mandatory audits for radiography
- Essential checks for gas safety and Legionella control had not been implemented.

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

- Implement robust processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.
- Ensure the 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.
- Ensure the safety and suitability of all areas of the premises and the equipment within it.
- Ensure the practice implements the recommendations of its Legionella risk assessment.
- Ensure audits of various aspects of the service such as infection control are undertaken at regular intervals to help improve the quality of service. The practice should ensure all audits have documented learning points and the resulting improvements can be demonstrated.
- Ensure that all staff undertake relevant training, to an appropriate level, in the safeguarding of children and vulnerable adults.
- 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.

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

- Review the storage of dental care products to ensure they are stored in line with the manufacturer's guidance and the fridge temperature is monitored and recorded.
- Review the practice's sharps handling procedures giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Review the protocol for completing accurate, complete and detailed records relating to employment of staff. This includes making appropriate notes of interviews and ensuring references are obtained.
- Review the practice's infection control procedures and protocols 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.
- Review appraisal protocols to ensure that all staff working at the practice have their performance monitored and assessed.

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?

Requirements notice 

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).

We found a number of significant shortfalls that compromised safe practice within the service. None of the staff had received accredited safeguarding training and their knowledge of local protection agencies was limited. Significant events were not always recorded and learning from them was not shared across the staff team. Risk assessment was poor and aspects of the practice's infection control processes did not meet national guidance. Essential checks for gas safety had not been undertaken, nor control measures for Legionella implemented. The practice did not have suitable emergency medical equipment in place and recruitment procedures were not robust.

Are services effective?

No action

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

Staff were appropriately qualified, trained and had current professional validation in place. Patients received a full assessment of their oral health, however not all the dentists used current National Institute for Health and Care Excellence (NICE) guidelines to determine how frequently to recall them. We found a limited application of guidance issued in the DH publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Staff had a basic understanding of the Mental Capacity Act 2005, and its relevance in obtaining full and valid consent for a patient who lacked the capacity to make decisions for themselves.

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. Staff understood the importance of maintaining patients' privacy and information about them was handled confidentially.

Summary of findings

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. Routine dental appointments were available, as were urgent on the day appointment slots. Patients told us it was easy to get through on the phone to the practice, and they rarely waited having arrived. The practice had made some adjustments to accommodate patients with a disability.

Are services well-led?

Requirements notice 

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 they felt well supported and were clearly committed to providing a good service to patients. However, we found a significant number of shortfalls in the practice's governance and leadership. Policies and procedures to govern the practice's activities had not been regularly reviewed or updated. Staff did not receive regular appraisal of their performance and did not have personal development plans in place. There were no staff meetings to discuss the running of the practice, significant events, and complaints or to share learning. The practice had failed to implement recommendations from its Legionella risk assessment and was not monitoring water temperatures. Other than radiography audits, no other audits were regularly undertaken ensure standards were maintained.

Dundee Court Dental Centre

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 7 September 2016 and was conducted by a CQC inspector and a dental specialist advisor.

During the inspection we spoke with the owner, one dentist, a dental nurse and the receptionist. We received feedback from 23 patients who had completed our comment cards prior to 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 limited understanding of what might constitute a significant event and how they should share learning from any. The practice did not have any policies regarding the reporting of significant events, or any process in place to ensure learning from them was shared formally. There were two accident books in use at the practice leading to some confusion about which was the current one. Incidents recorded in the books were sparse in detail and did not contain any information of the action taken to prevent them for re-occurring. We were told of one incident where a patient had slid off a chair in the practice; no formal record had been made of this event.

Reliable safety systems and processes (including safeguarding)

None of the staff we spoke with had received accredited safeguarding training and their knowledge of reporting procedures and external agencies involved in the protection of children and vulnerable adults was limited. The practice owner was the lead for safeguarding in the practice but he had not received any training for this role. There was no information easily available around the practice regarding safeguarding and the dental nurse struggled to locate the practice's safeguarding policy.

Staff spoke knowledgeably about action they would take following a sharps' injury and a sharps risk assessment had been completed. A sharps' protocol was on display in the treatment rooms to guide staff about what to do if injured. Only the dentists handled sharps, although they did not use a sharps' safety system, as recommended in Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

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. We found inconsistent use of rubber dams within the practice with some dentists using them routinely and others not so. No rubber dam kits were available in the practice on the day of our inspection

Medical emergencies

All staff had received medical emergency training in April 2015 and although this training was now out of date, we saw evidence that training had been booked for 5 October 2016 for the staff. Other than this, emergency medical simulations were not regularly rehearsed by staff so that they had a chance to practice what to do in the event of an incident.

The emergency equipment and oxygen were stored in central locations known to all staff. However, there was no automatic electronic defibrillator (AED) within the practice and no arrangements in place with any location nearby who might have an AED. An AED is a portable electronic device that analyses life-threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. The practice had two oxygen cylinders, although we found one was completely empty of oxygen and had not been checked since it had been bought. It had expired on 28 August 2016.The second cylinder looked very old and there was no evidence of when it had been purchased or of its regular servicing. Therefore it was not safe to use. The practice's oxygen mask and tubing appeared old and were not compatible with the most recent oxygen cylinder. During our inspection the dental nurse ordered an AED and new oxygen cylinder.

Medicines were available to deal with a range of emergencies including angina, asthma, chest pain and epilepsy, and medicines were checked each week to ensure they were within date for use. The practice did not keep buccal Midazolam so it could be administered easily to patients experiencing an epileptic fit.

Staff recruitment

We reviewed recruitment files and found that most pre-employment checks had been undertaken for staff. For example, qualifications, registration with the relevant professional body and checks through the Disclosure and Barring Service (DBS). Insurance and indemnity checks were undertaken to ensure dental clinicians were fit to practise. However, no references were available for one dentist who had recently been employed, and no notes had been recorded of the interview held or the questions asked. None of the staff had been issued with an employment contract outlining the terms and conditions of their employment.

Monitoring health & safety and responding to risks

Are services safe?

There was a health and safety policy available with a poster on display in the staff kitchen, but this did not contain details of local health and safety representatives for staff to contact if needed.

Firefighting equipment such as extinguishers were regularly tested, evidence of which we viewed**.** However, there was no current fire risk assessment available for the practice. The practice owner told us he thought one had been completed in 1999 when he had acquired the premises, but that he could not find it. No regular evacuation drills were completed to ensure staff knew what to do in the event of a fire. A gas safety check had not been completed since 2013. Gas safety (Installation and Use) Regulations 1998, state a gas safety inspection certificate must be obtained every twelve months.

A legionella risk assessment had been carried out in November 2014. This assessment had identified that hot and cold water temperatures should monitored every month at sentinel points within the practice, but this recommendation had not been implemented by staff. Regular flushing of the water lines was carried out in accordance with current guidelines, at the start and end of each day, and between patients to reduce the risk of legionella bacteria forming.

There was a comprehensive control of substances hazardous to health folder in place containing chemical safety data sheets for some materials used within the practice. We noted there were no safety data sheets available for a number of products used within the practice such as wasp killer and floor cleaner.

Infection control

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

According to the owner, the practice had scored 98% in its most recent audit, indicating that good standards were in place. This audit had only just been completed prior to our inspection (and was not available for us to view). No infection control audits had been undertaken prior to this since 2012. National guidance recommends that these audits be completed every six months.

The waiting areas, stairway and reception area were clean and uncluttered, although we noted some badly stained chairs in the downstairs waiting room. The patient toilets were clean and contained liquid soap and paper towels so that people could wash their hands hygienically. There was hand sanitiser available on the reception desk, making it easily available to patients. We checked two 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, however flooring was not coved up the wall and hand wash sinks did not meet national guidance. We noted that three chairs in one treatment room were badly ripped, thereby making them difficult to clean effectively. No action had been taken to repair them.

We noted that cleaning equipment had not been stored in line with national guidance and the same mop was used to clean the toilet and also the staff kitchen area, compromising good infection control.

The practice had two separate decontamination rooms for the reprocessing of dirty instruments which were mostly set out according to the Department of Health's guidance, Health Technical Memorandum 01- 05 (HTM 01- 05), decontamination in primary care dental practices. Neither room had a dedicated hand-washing sink and there was no ventilation input or extraction. We noted that some of the cabinetry was old and worn, exposing the chipboard underneath and making it difficult to clean.

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, although the water temperature was not checked beforehand to ensure it was kept below 45 degrees Celsius. Following inspection with an illuminated magnifying glass, instruments were then placed in an autoclave (a device used to sterilise medical and dental instruments). All pouches were dated with an expiry date in accordance with current guidelines. The dental nurse demonstrated that systems were in place to ensure that the autoclaves used in the decontamination process were working effectively.

All dental staff had been immunised against Hepatitis B. 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.

Are services safe?

The practice used an appropriate contractor to remove dental waste and we saw the necessary waste consignment notices.

Equipment and medicines

Staff told us they had suitable equipment to enable them to carry out their work and that repairs were undertaken quickly. 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 September 2016; the compressor in August 2016 and portable appliances had been tested in December 2015.

Dentists we spoke with were aware of on-line reporting systems to the British National Formulary and of the yellow card scheme to report any adverse reactions to medicines. We saw from a sample of dental care records that the batch numbers and expiry dates for local anaesthetics were always recorded in patients' clinical notes. However, the practice did not have a separate fridge for the storage of medicines, which required cool storage, and we found medical consumables stored alongside milk and food in the staff kitchen. The temperature of the fridge was not monitored to ensure it operated effectively. We also noted that medicines such as antibiotics were stored in a cupboard in the decontamination room. The temperature of the room was not monitored to ensure it did not exceed 25 degrees Celsius. This was of particular concern as the cupboard was near the autoclave and there was no venting or air conditioning in the room to keep it cool. No stock log was kept of the antibiotics and no checks were undertaken to ensure they were in date for safe use.

There was no system in place to ensure that relevant patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Authority were received and actioned and staff were unaware of recent alerts affecting dental practice. However, the practice owner signed up to receive these alerts during our inspection.

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 the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. Staff who operated the equipment had undertaken appropriate training.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Our discussion with two dentists and review of ten sets of dental care records demonstrated that patients' dental assessments and treatments were not always carried out in line with recognised guidance from the National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC) guidelines. For example, patients' recall frequencies were not always undertaken in line with national guidance and one dentist routinely saw patients every six months without considering any risk factors. Patients' social and dental histories were not always recorded and guidelines were not always followed for the frequency of radiographic examination. No audits were undertaken of dental care records to ensure they met good practice guidelines in clinical examination and record keeping.

Health promotion & prevention

A number of oral health care products were available for sale to patients in the reception area including interdental brushes, toothpaste and dental floss. Free samples of toothpaste were also available. However, information about oral health care for patients was limited and there were no leaflets or displays available in the waiting area about oral health care.

Patients were asked about their smoking habits and alcohol intake when they completed their medical histories; however, there was no information or leaflets available for patients wanting to give up smoking and staff were unaware of local smoking cessation services. Knowledge of guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' was variable, with one dentist fully aware of it and the other not.

Staffing

There was a stable and established staff team at the practice, most of who had worked there for many years. Staff told us the staffing levels were suitable for the small size of the service and the dentists always worked with a dental nurse. However due to the owner's long-term ill health the practice had been relying on a locum dentist to maintain the service in the last year. This locum had recently left the practice and a more permanent dentist had just started employment at the practice when we inspected it.

Files we viewed demonstrated that clinical staff were appropriately qualified, trained and where required, had current professional validation. The practice had appropriate Employer's Liability insurance in place. However, the receptionist had only undertaken training in basic life support and had no formal training in customer skills, information governance or safeguarding people. None of the staff had ever received an appraisal so it was not clear how their performance was assessed or their training needs identified.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves. However, a log of the referrals made was not kept so they could be could be tracked and monitored and patients were not given a copy of their referral for their information.

Consent to 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 before agreeing to a particular treatment.Patients were also provided with a plan, which clearly outlined the proposed treatment, and the costs involved. Feedback from the practice's own survey completed by nearly 40 patients indicated that dental procedures were explained to them in a way that they understood before they agreed to 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. We spoke to two dentists on duty on the day of our visit; both of whom had a satisfactory understanding of patient consent and MCA issues. Evidence of patients' consent to treatment had been recorded in the dental care records we reviewed.

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. Patients told us that staff listened to them and respected their wishes. One patient commented that the dentist had rung them after a difficult procedure, something that they had greatly valued.

We observed the receptionist interact with about 10 patients both on the phone and face to face and noted she was consistently polite and helpful towards them, and created a welcoming and friendly atmosphere. She worked hard to ensure that patients got appointment times that were suitable for them. Staff gave us examples of where they had gone out their way to support patients. For example, when an elderly patient had experienced fall on the way to the practice, the receptionist had driven him home and rung his daughter to inform her. Staff had also delivered antibiotics to a patient to save them from having to come to the surgery, and had picked up another patient from their home, when their taxi had failed to arrive.

Staff were aware of the importance of providing patients with privacy and maintaining their confidentiality. Patients' notes were held securely in locked fireproof filing cabinets and the receptionist told us she always placed notes on the desk face downwards so that patients' details could not be viewed. Both the practice's patient waiting areas were separate to the main reception area allowing for good confidentiality. 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 involved in decision making about the care and treatment they received. They reported that they felt listened to and supported by staff and had sufficient time during consultations. A plan outlining the proposed treatment was given to each patient so they were fully aware of what it entailed and its cost. Leaflets explaining procedures were also given to patients. Feedback from the practice's own survey of 40 patients indicated that their questions about treatments were addressed and that fees were explained clearly to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Access to the practice was easy and there was ample parking available for patients. Although the practice did not offer any extended hours opening, patients commented that appointments were easy to get, and they rarely waited long once they arrived. Feedback from the practice's own patient survey aligned with these views. We looked at the practice's appointment book for patients and found that patients were given adequate time slots for the type and complexity of treatment. As the practice was not computerised, it was unable to offer patients a text or email messaging service to remind them of their appointments.

The practice opened Mondays to Thursdays from 8.30pm to 5pm, and on Fridays from 8.30am to 4pm. Emergency slots were available each day for patients experiencing dental pain and they could also be seen at the end of the day if these slots had been taken. Information about emergency out of hours 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.

Tackling inequity and promoting equality

There was good access to the practice for wheelchair users. There was a specific disabled parking spot close to the entrance and ramp access to the front door. There was a disabled friendly toilet, and any patients with limited mobility who attended the dentist who worked upstairs, could be seen by him in one of the downstairs surgeries. There was no wide seating or chairs of different height in the waiting room to accommodate those with mobility problems and no 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, braille or audio. Staff had not undertaken any training in equalities and diversity to help them better understand the diverse needs of patients.

Concerns & complaints

The practice had a policy and a procedure that set out how complaints would be addressed, and the receptionist spoke knowledgeably about how she would handle a patient's concerns. Information about the procedure was available in both patient waiting rooms; however, it did not contain details of other agencies that could be contacted such as the dental complaints service or the General Dental Council.

Staff told us they had not received any formal complaints from patients in the last few years. However, the practice owner told us he was currently dealing with two recently received complaints, concerning appointment cancellations. It was not possible for us to assess how these complaints were being managed as the paperwork was unavailable on site.

Are services well-led?

Our findings

Governance arrangements

We identified a number of shortfalls in the practice's governance arrangements**.** The owner's ill health had left a vacuum of leadership within the practice and there had been no clear delegation of management responsibilities in his absence. There was an appointed practice manager, but staff told us this was in name only, as she only attended the practice one day a week to do the accounts. She had no managerial responsibility for the service, or oversight of the day-to-day running of the practice. There were no leads within the practice, other than the practice owner.

Although the practice had a number of policies and procedures in place to guide staff, many of these had not been reviewed in the last two years. Others had not been dated at all so it was not clear if they were up to date and still relevant to the practice. The practice did not always follow its own policies. For example, the quality assurance policy stated that there would be on-going staff appraisal and regular staff meetings, however neither of these happened. Apart from an audit of the quality of its radiographs, the practice did not undertake any other audits (such as the quality of dental care records, its prescribing, patient waiting times etc.) to help them monitor the effectiveness of the service for patients.

None of the staff had received an annual appraisal so it was not clear how their performance was assessed. None had a training or personal development plan in place and the practice did not keep a record of staff training. There were no staff meetings to discuss the running of the practice, significant events, and complaints or to share learning.

Risk assessment within the practice was generally poor and even when risks had been identified control measures had not been implemented. For example, the practice had failed to implement recommendations from its Legionella risk assessment and was not monitoring water temperatures.

There was no detailed plan in place to detail how the provision of its decontamination procedures would move towards best practice.

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. They told us they felt supported and valued in their work and reported there was an open culture within the practice. One dental nurse told us that the dentist always thanked her for her work: a small thing but one she greatly appreciated. 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. Although he had been absent due to ill health, staff reported he was readily available by phone for advice or guidance.

The practice owner honestly acknowledged to us that his long-term ill health had affected the running and oversight of the practice, but he was clearly keen to improve the practice and welcomed many of our recommendations.

We viewed a letter that the practice owner had written to patients explaining the reason for his long-term absence, thanking them for their patience and giving a commitment to keep them informed on any future developments and changes. This demonstrated an open, transparent and honest approach by him to the practice's patients.

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

The practice had conducted a patient satisfaction survey which asked them for feedback about appointment times, the friendliness of reception staff, if they were seen on time and if procedures were explained well. About forty patients had responded and all had rated the practice as excellent in all areas. However, there was little evidence that the practice had implemented patients' suggestions from the survey such as the need for reading material and better chairs in the waiting room, and for the reception area to be 'freshened up'. No information had been provided to patients about the results of the survey or how their suggestion would be implemented.

Staff told us that the practice owner listened to them and implemented their suggestions. For example, their suggestion to rearrange appointment times and their request for a different design of suction tips had been implemented. It was not clear how the practice collected formal feedback from staff given there were no staff meetings, no staff appraisal or staff survey.

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 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 safety within the service. Risk assessment was poor and control measures to reduce risk were not always implemented. Infection control procedures did not meet national guidance and recruitment procedures were not robust. Regulation 12 (1)

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 ensure compliance with the regulations. The provider did not have effective systems in place to assess and monitor the quality of clinical care. This included the auditing of its service, the appraisal of staff, providing robust leadership in the practice and acting upon suggestions of patients **Regulation 17 (1)**