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London City Dentists

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 29 June 2015 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 not providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this practice was not 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.

London City Dentists is located in the London Borough of Tower Hamlets. The premises consist of one treatment room which also houses the administrative/reception desk and a dedicated decontamination area. There are no waiting area facilities available. The practice shares the premises with a medical centre and dental patients have access to shared toilet facilities.

The practice provides private dental services and treats both adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers, crowns tooth whitening and oral hygiene.

The practice predominantly caters to the needs of the working professionals based in the City of London alongside their extended families and friends.

The staff structure of the practice is comprised of one principal dentist (who is the owner), two specialist dentists (with special interests in restorative dentistry), agency dental nurses and a contracted Business Manager.

The practice is open Monday to Friday from 7:45am to 5:00pm. We carried out an announced, comprehensive inspection on 29 June 2015. The inspection took place over one day and was carried out by a CQC inspector and a dentist specialist advisor.

We received 32 CQC comment cards completed by patients. Patients who completed comment cards, were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the staff.

Summary of findings

Our key findings were:

- The practice had some systems in place for the management of infection control and waste disposal and dental radiography.
- Staff understood their responsibilities in terms of identifying and reporting any potential abuse.
- Patients were able to make appointments when needed.
- The patient comment cards we reviewed indicated that patients were treated with kindness and respect by staff.
- There was a lack of suitable clinical governance systems in place.
- Risks such as those arising from incomplete staff recruitment checks had not been suitably identified and mitigated.
- The practice policies and protocols related to the safe running of the service were generic and not practice specific.
- The layout of the room in which dental treatment was being provided was not suitable as the reception desk was located in the same room and in close proximity to the dental chair.
- Patient confidentiality was not suitably protected as administrative functions took place in the same room as patient dental treatment and there was lack of appropriate facilities to ensure patients could have their discussions without being overheard.

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

- Establish an effective system to assess, monitor and mitigate the risks including and not limited to those arising from incomplete staff recruitment checks.
- Ensure audits of various aspects of the service, such as radiography are undertaken at regular intervals to help improve the quality of service.
- Ensure that the premises including the layout, are suitable for the service provided.
- Ensure that discussions about care, treatment and support only take place where they cannot be overheard.

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

- Review the practice's protocols for the receipt and dissemination of alerts and guidance such as those from the Medicines and Healthcare products Regulatory Agency (MHRA) and the National Institute for Health and Care Excellence (NICE).
- Review availability of medicines to manage medical emergencies giving due regard to guidelines issued by the British National Formulary.
- Review staff awareness of the location of the medicines to manage medical emergencies.
- 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'.
- Ensure the training, learning and development needs of individual staff members are reviewed at appropriate intervals and an effective process is established for the on-going assessment and supervision of all staff.
- Review audit methodology to ensure learning points are documented and the resulting improvements can be demonstrated.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

The practice had limited systems in place to minimise the risks associated with providing dental services. The practice had policies and protocols related to the safe running of the service however these were generic and not practice specific. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse. Equipment was well maintained and checked for effectiveness, however we found that the washer disinfector was not being checked regularly. The practice had systems in place for the management of infection control and waste disposal and dental radiography. However, reasonable efforts had not been made to ensure the administrative functions were appropriately located. Staff undertaking administrative functions were at risk of exposure to aerosols whilst patient dental treatment was being carried out. The practice had access to emergency medicines and equipment, however the practice staff were not aware of the location of some emergency medicines and were not involved in the checking of emergency equipment or stock control.

The practice had a recruitment policy in place, but had not carried out relevant checks for all staff members to ensure persons being recruited were suitable and competent for their roles.

Are services effective?

We found that this practice was not providing effective 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).

The practice could demonstrate they followed some relevant guidance, such as those issued by the National Institute for Health and Care Excellence (NICE). The practice monitored patients' oral health and gave appropriate health promotion advice. Staff explained treatment options to ensure that patients could make informed decisions about any treatment. There were systems in place for recording written consent for treatments however the record keeping for some patients was inconsistent.

The principal dentist engaged in continuing professional development (CPD) and was meeting the training requirements of the General Dental Council (GDC).

Are services caring?

We found that this practice was not providing caring services 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 received feedback from patients through comment cards that they were treated with dignity and respect. They noted a positive and caring attitude amongst the staff. We found that patient records were stored securely; however we were not assured that patient confidentiality was always protected as a result of the reception/administrative area being located within the treatment room. Improvements could be made to ensure patients' privacy was respected while they were in the treatment room.

Are services responsive to people's needs?

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

Summary of findings

Patients had good access to appointments, including emergency appointments, which were available on the same day. There was a complaints procedure in place and information about how to make a complaint was available in a practice leaflet though it was not available on the practice website.

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).

There was lack of suitable clinical governance systems in place. The policies available were generic and not practice specific. There was lack of an effective system to assess, monitor and mitigate the risks which arise from recruitment of staff. The practice had not carried out relevant checks for all staff members to ensure persons being recruited were suitable and competent for their roles. There were no formal staff meetings or systems for obtaining staff feedback. Patient feedback was sought through the undertaking of patient satisfaction surveys. However, we saw no evidence of formal analysis of these surveys and any action taken by the practice to improve patients' experiences of coming to the practice.

London City Dentists

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 29 June 2015. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a dentist specialist advisor.

We reviewed information received from the provider prior to the inspection.

During our inspection visit, we reviewed policy documents and dental care records. We spoke with three members of staff including the dentist, dental nurse and business manager. The principal dentist was the sole permanent staff member of the practice. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We observed the dental nurse carrying out decontamination procedures of dental instruments and also observed staff interacting with patients.

We reviewed 32 Care Quality Commission (CQC) comment cards completed by patients. Patients who completed comment cards were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

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 formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There was a no formal system in place for reporting and learning from incidents. We saw evidence of three incidents which had been recorded in the past three years. However, there was no practice policy in place which described the actions that staff needed to take in the event that something went wrong or there was a 'near miss'.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any such incidents in the past 12 months.

Reliable safety systems and processes (including safeguarding)

The practice had a policy in place for child protection and safeguarding adults. This included contact details for the local authority safeguarding team.

The dentist was the lead in managing safeguarding issues and had completed Level 3 safeguarding training. Staff understood their responsibilities in terms of identifying and reporting any potential abuse; however we found no evidence that the specialist dentists, dental nurse or business manager had completed training in this area. There had been no safeguarding issues reported by the practice to the local safeguarding team.

We found no evidence of a practice policy or procedure for whistleblowing if staff had concerns about another member of staff's performance.

The practice had carried out some risk assessments. For example, a risk assessment had been carried out in 2013 which covered topics such as fire safety, and first aid arrangements, and in 2015 a risk assessment on biological hazards including blood and saliva had been undertaken.

The practice followed appropriate guidance by the British Endodontic Society in relation to the use of the rubber dam for root canal treatments. [A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth].

Medical emergencies

The practice had some arrangements in place to deal with medical emergencies. We saw evidence of training in emergency resuscitation and basic life support for the dentist and dental nurse; however, there were no training certificates available for the specialist dentists or business manager. All staff were aware of the location of the emergency equipment room where the majority of emergency equipment was stored.

The practice had access to suitable emergency equipment in accordance with guidance issued by the Resuscitation Council UK. The practice shared the emergency equipment which included emergency medicines, an automated external defibrillator (AED) and oxygen with the GP surgery on the premises. (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). There were face masks of different sizes for adults and children. The dental practice did not share responsibility for the testing of equipment and stock control. The emergency equipment was checked by staff at the GP surgery.

We checked the emergency medicines and could not locate any salbutamol aerosol inhalers (used for the relief of asthma and chronic obstructive pulmonary disorder conditions), midazolam (used to treat seizures) or glucagon (used to treat severely low blood sugar levels). The practice staff were not aware of the location of some emergency medicines. We raised this with the dentist who queried this issue with the GP practice. We were informed following our inspection that the GP practice had informed the dentist of the location of these items within the GP practice facilities.

Staff recruitment

The practice staffing consisted of a principal dentist (who was also the owner), two specialist dentists, an agency dental nurse and a contracted business manager. We reviewed the staff files and saw that the practice had not carried out relevant checks for all staff members to ensure that the person being recruited was suitable and competent for the role. This included the checking of qualifications, identification, registration with the General Dental Council (where relevant) and checks with the Disclosure and Barring Service (DBS). We noted that the practice had evidence of DBS checks carried out for the dentist, the agency nurse and one of the specialist dentists but not for the second specialist dentist or business manager.

Are services safe?

There was no evidence available in the staff files for the specialist dentists for references. There was also no evidence available detailing the qualifications of one of the specialist dentists. There was no evidence of the Hepatitis B status of one of the specialist dentists.

The dentist subsequently sent us a reference, qualifications and the Hepatitis B obtained for one of the specialist dentists via email which was dated after the inspection.

We observed that the website provided information about two specialist dentists which were not the two dental specialist staff files we were provided with and checked. We found no evidence of qualifications, references, DBS checks or Hepatitis B status for the two specialist dentists advertised on the practice website.

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety action plan in place, however there was no date on this document or evidence of update. The practice had been assessed for risk of fire and we observed that fire extinguishers had been recently serviced.

There were effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. COSHH risk assessments where risks to patients, staff and visitors that were associated with hazardous substances had been identified and actions were described to minimise these risks. We saw that COSHH products were securely stored.

There was no formal process in place for the receipt and implementation of Medicines and Healthcare products Regulatory Agency (MHRA) alerts and National Institute for Health and Care Excellence (NICE) guidance . We discussed NICE guidance which indicated that antibiotic prophylaxis prescription for patients with heart disease was no longer required. The dentist was unaware of this guidance and had been prescribing these antibiotics for patients with heart disease. The dentist agreed to read the guidance on this following our inspection.

The practice had a Disaster Planning and Emergency Procedures policy in place to ensure continuity of care in the event that the practice's premises could not be used for any reason.

Infection control

There were some systems in place to reduce the risk and spread of infection. There was generic infection control policy which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. The dentist was the infection control lead. Staff files we reviewed showed the dentist and the dental nurse had undertaken training courses in infection control; however we found no evidence of infection control training in the staff files of the specialist dentists.

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)'. In accordance with HTM 01-05 guidance an instrument transportation system had been implemented to ensure the safe movement of instruments between treatment room and the decontamination area which ensured the risk of infection spread was minimised.

We examined the facilities for cleaning and decontaminating dental instruments. There was a dedicated decontamination room and the dental nurse showed us how they used this room and demonstrated a good understanding of the correct processes. The dental nurse wore appropriate protective equipment, such as gloves, masks and eye protection. Items were manually cleaned before being place in an ultrasonic cleaner. An illuminated magnifier was used to check for any debris during the cleaning stages. Items were placed in an autoclave (steriliser) after cleaning. Instruments were placed in pouches after sterilisation and a date stamp indicated how long they could be stored for before the sterilisation became ineffective.

The autoclave was checked daily for its performance, for example, in terms of temperature and pressure. A log was kept of the results demonstrating that the equipment was working well. The ultrasonic cleaner was also being checked daily for its performance. The ultrasonic cleaner was a new piece of equipment and therefore a 'foil' test had not been undertaken yet. The practice also had a washer disinfector however there were no recent maintenance certificates for this equipment. We discussed this issue with staff who informed us that this piece of

equipment was not frequently used. We advised that although this machine was occasionally used, a system was still required for the regular checking of this equipment.

The practice used a system of individual consignments and invoices with a waste disposal company. Waste was being appropriately stored and segregated. This included clinical waste and safe disposal of sharps. Staff demonstrated they understood how to dispose of single-use items appropriately. We observed posters in the decontamination room which described what to do in the event of a sharps injury.

Records showed that a Legionella test had been carried out by an external company in June 2015. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). The legionella test confirmed there were no legionella bacteria found in any of the samples taken. We also saw evidence that dental water lines were being flushed in accordance with current guidance in order to prevent the growth of Legionella. The water for the dental hand pieces was treated every month with suitable chemicals.

The premises appeared clean and tidy. However, reasonable efforts had not been made to ensure the administrative functions were appropriately located. Staff undertaking administrative functions were at risk of exposure to aerosols whilst patient dental treatment was being carried out as a result of the administrative desk being located within the treatment room.

There was a good supply of cleaning equipment which was stored appropriately. The practice had a daily infection prevention checklist which gave instructions for tasks to be carried at the start of each session, at the end of a session and at the end of the day when the practice was closed.

There were good supplies of protective equipment for patients and staff members including gloves, masks, eye protection and aprons. There were hand washing facilities in the treatment rooms, the decontamination room and the toilets.

We found evidence to show the dentist and agency dental nurse had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients; however we found no documentation in the staff files of the Hepatitis B status of the specialist dentists.

Equipment and medicines

We found that the equipment used at the practice, with exception to the washer disinfector was regularly serviced and well maintained. For example, we saw documents showing that the X-ray equipment had been inspected and serviced. Portable appliance testing (PAT) was completed in accordance with good practice guidance. PAT is the name of a process during which electrical appliances are routinely checked for safety.

Radiography (X-rays)

The practice kept a radiation protection file in relation to the use and maintenance of X–ray equipment. There were suitable arrangements in place to ensure the safety of the equipment. The procedures and equipment had been assessed by an external radiation protection adviser (RPA) within the recommended timescales. The dentist was the radiation protection supervisor (RPS). We saw evidence of a radiograph quality record audit undertaken for the period November 2014 – June 2015; however there was no evidence of analysis or write up of the findings.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We reviewed dental care records kept by the dentist. We found that the dentist regularly assessed patient's gum health and soft tissues (including lips, tongue and palate). The dentist was not aware of the Faculty of General Dental Practice (FGDP) guidance in relation to X-rays but was aware of the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) guidance. The dentist took X-rays at appropriate intervals and was able to describe how these were justified, graded and reported on.

The dental care records showed that an assessment of periodontal tissues was periodically undertaken using the basic periodontal examination (BPE) screening tool. (The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums.) Different BPE scores triggered further clinical action. We checked a sample of dental care records however and found that the BPE scores were not recorded for all of these patients.

The dentist always checked people's medical history and medicines prior to treatment.

The practice did not keep up to date with all current guidelines and research in order to continually develop and improve their system of clinical risk management. The practice did however, refer to National Institute for Health and Care Excellence (NICE) guidelines in relation to deciding appropriate intervals for recalling patients and wisdom teeth removal.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. Staff told us they discussed oral health with their patients, for example, the use of fluoride mouthwashes or dietary advice. The dentist identified patients' smoking status and recorded this in their notes. This prompted them to provide advice or consider how smoking status might be impacting on their oral health. The dentist also carried out examinations to check for the early signs of oral cancer. The dentist informed us that he also discussed the consumption of alcohol with patients and its effect on oral health.

Staffing

The principal dentist was the sole permanent staff member and we saw training certificates to demonstrate they received appropriate professional development and training. There was no induction programme for new staff to follow to ensure that they understood the protocols and systems in place at the practice.

There was no evidence within any of the staff files showed that staff had been engaged in an appraisal process. There were no formal meetings held which would identify staff training needs and career goals.

Working with other services

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients. The dentist used a system of onward referral to other providers, for example, for oral surgery or advanced conservation and to the in-house specialist dentists working at the practice. When patients had received their treatment they were discharged back to the practice for further follow-up and monitoring.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. Staff discussed treatment options, including risks and benefits, as well as costs, with each patient. The patient comment cards confirmed that treatment options, and their risks and benefits were discussed with them. However, our review of the dental care records found that these discussions were not consistently recorded.

Formal written consent was obtained using standard treatment plan forms. Patients were asked to read and sign these before starting a course of treatment.

The dentist was aware of the Mental Capacity Act (2005) and the responsibility to act in patients' best interests, if patients lacked some decision-making abilities. The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

From the CQC comments cards we received, patients commented positively on the staff's caring and helpful attitude. Patients were pleased with the level of care they received. Patients who reported some anxiety about visiting the dentist commented that the dental staff put them at ease and made them feel comfortable.

We observed staff were welcoming and helpful when patients arrived for their appointment. The business manager spoke politely and calmly to patients.

The door was always closed when patients were in the treatment room. Patients indicated they were treated with dignity and respect at all times. Due to the constraints of the building however, there was no facility for people to request to have a private discussion in an alternative room, if necessary. The treatment room also housed the reception and administrative facilities and we observed that this presented an issue for patient confidentiality. For example, the administrative computer screen was positioned in such a way that it could be seen by patients receiving treatment with the dentist. Telephone calls were also conducted and received in the same room as the patient treatment room and therefore telephone conversations could potentially be overheard by patients receiving treatment.

Dental care records were stored in a paper-based format and locked in a cabinet next to the administrative desk within the treatment room. Radiographs were stored electronically. The business manager showed us confidentiality agreements which had been signed by herself, the dentist and the agency dental nurse however we found no evidence of these agreements in the staff files of the specialist dentists.

Involvement in decisions about care and treatment

The practice website gave details of the private dental charges or fees.

Staff told us that they took time to explain the treatment options available. They spent time answering patients' questions and gave patients a copy of their treatment plan. There was a range of information on the practice website which described the different types of dental treatments available.

The patient feedback we received from the comment cards confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff. They told us that treatment options were well explained; the dentist listened and understood their concerns, and respected their choices regarding treatment. The practice had one on-going complaint with a patient which related to fees incurred for treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. The business manager gave a description about which types of treatment or reviews would require longer appointments and the dentist also specified the timings for some patients when they considered that the patient would need an appointment that was longer than the typical time.

Staff told us they had enough time to treat patients and that patients could generally book an appointment in good time. The feedback we received from patients confirmed that they could get an appointment within a reasonable time frame and that they had adequate time scheduled with the dentist to assess their needs and receive treatment.

Tackling inequity and promoting equality

The practice had recognised some of the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. We asked staff how they would accommodate patients whose first language was not English. Staff told us they would encourage patients to bring an interpreter with them to the appointment. We were told that the practice did not have access to a telephone translation service.

The building had wheelchair access, however the practice facilities did not fully accommodate wheelchair users. The door to the treatment room would not accommodate a wheelchair easily and there were no disabled toilets for patients accessing the dental practice to use. We discussed the limited disabled access with staff and we were told that if a patient with disabilities requested an appointment, the practice would encourage the patient to access an alternative dental provider with more suitable facilities for them.

Staff told us that in order to accommodate patients who were hard of hearing they would not play any music or reduce the volume of music during treatment which was normally played in the practice to relax patients.

Access to the service

The practice is open Monday to Friday from 7:45 am to 5:00pm and the opening hours were advertised on the practice website.

From the comment cards we received, patients did not have any concerns about accessing the dentist for an appointment. The business manager told us that she also kept a list of patients who wanted to be seen more quickly in the event that there were any late cancellations by other patients. She gave us an example of how she had used this list recently to enable some patients to access the dentist quickly following a cancellation.

We asked the business manager about access to the service in an emergency or outside of normal opening hours. They told us the answer phone message gave the principal dentist's mobile telephone number to access out of hour's emergency treatment. A same-day emergency service was offered to registered patients who contacted the practice before 10:00am. The dentist also had some gaps in their schedule at 12:30pm and 5:00pm on any given day which meant that any patients, who needed to be seen urgently, for example, because they were experiencing dental pain, could be accommodated.

Concerns & complaints

Information about how to make a complaint was available for patients in a leaflet. There was no information about the complaints procedure on the practice website. There was a generic complaints policy describing how the practice would handle formal and informal complaints from patients. At the time of our inspection the practice had one on-going complaint which had not been fully resolved. The dentist was responsible for leading investigations and responding to complaints.

The majority of the feedback collected during the past year from patient satisfaction surveys indicated a high level of satisfaction. This was corroborated with the 32 patient comment cards we received.

Are services well-led?

Our findings

Governance arrangements

The practice did not have good governance arrangements in place. They practice had recently contracted a business manager to support the development of governance arrangements. There was a lack of practice specific relevant policies and procedures in place. The vast majority of policies and procedures available were generic and had not been reviewed and updated. There was no assurance that staff working at the practice were aware of any policies and procedures and acted in line with them. There were no suitable arrangements in place for identifying, recording and managing risks through the use of scheduled risk assessments and audits. There were no formal practice meetings held to discuss key governance issues.

Leadership, openness and transparency

Staff we spoke with said that they felt comfortable about raising concerns with the principal dentist and felt they were listened to and responded to when they did so.

There was no system of staff appraisals in place to support staff in carrying out their roles to a high standard. The dental nurse and business manager had temporary employment with the practice and therefore had not received an appraisal.

Management lead through learning and improvement

We saw evidence that the dentist was working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the General Dental Council (GDC); however we found no evidence of CPD hours completed for the specialist dentists.

The practice had undertaken clinical audits such as infection control, clinical record keeping and X-ray quality. The audits showed a generally high standard of work, but identified some areas for improvement. For example, the dental care records audit for the dentist showed that they could improve the completion of patient records. During our inspection we checked a sample of five dental care records and found that the record keeping was inconsistent for these patients. The audits had all been initiated in 2013 and 2014 and we found no evidence of an audit programme to repeat these audits after a year to determine if any changes implemented had led to an improvement in performance.

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

The practice gathered feedback from patients through the use of a patient satisfaction survey during the past few years. We noted from reviewing a sample of the completed surveys that the overwhelming majority of feedback had been positive. However, we saw no evidence of formal analysis of these surveys and any action taken by the practice to improve patients' experiences of coming to the practice, in response to this feedback.

There was no system in place to gather feedback from staff as a result of formal meetings being held and no appraisals being undertaken.

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 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: The provider did not have effective systems in place to ensure the privacy of the service users. Reasonable efforts had not been made to make sure that discussions about care, treatment and support only took place where they could not be overheard. Administrative functions took place in the same room as patient dental treatment and there were no separate facilities to ensure patient confidentiality. Regulation 10(2)(a) ensuring the privacy of the service user.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: The provider premises, including the layout where care and treatment were delivered were not appropriate. Reasonable efforts had not been made to ensure the reception desk was appropriately located. Staff undertaking administrative functions were at risk of exposure to aerosols whilst patient dental treatment was being carried out. Regulation 15 (1) (c) All premises and equipment used by the service provider must be suitable for the purpose for which they are being used. Premises, including the layout, must be suitable for the service provided and be big enough to accommodate the potential number of people using the service at any one time.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures 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 have effective systems in place to: • enable them to identify and assess risks to the health, safety and/or welfare of people who use the service. • minimise the likelihood of risks and to minimise the impact of risks on people who use services. Regulation 17 (1)(2)(b) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: The provider did not have an effective recruitment procedure in place to assess the suitability of staff for their role. Not all the specified information as required in the Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to persons employed at the practice was obtained for staff at the time of recruitment. Regulation 19 (1), (2) Persons employed for the purposes of carrying on a regulated activity must be of good character and have the qualifications, competence, skills and experience which are necessary for the work to be performed by them. Recruitment procedures must be established and operated effectively.