Belmont Lodge Limited

Belmont Lodge Dental Health Centre

Inspection Report

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Date of inspection visit: 24 March 2016
Date of publication: 06/07/2016

Overall summary

We carried out an announced comprehensive inspection on 24 March 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

Belmont Lodge Dental Health Centre is a small dental practice located on the outskirts of Maidenhead. It is located within a converted house and has provided services from the present location for over 10 years. Treatments are provided both via a small NHS contract and privately. The split between NHS and private treatment is approximately 50/50. The principal dentist employs three trainee dental nurses and two receptionists. There is a part time practice manager. An associate dentist also works at the practice. The principal dentist is approved as a trainer for qualified dentists undertaking their first year in general dental practice and there is a foundation year dentist working at the practice.

The practice is open from 9am to 5pm every weekday. Morning appointments are from 9am to 12.50pm and in the afternoon from 2pm to 4.50pm.

The practice manager is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'.

Summary of findings

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.

Forty nine patients provided feedback about the service. We spoke with three and 46 had completed CQC comment cards in the two weeks prior to our visit. All 49 were positive about the care they received. The common themes from patient feedback were focussed on how the dentists made patients feel at ease during their treatment, dispelling any fear patients had about dental treatment, and on the dentists giving good explanations of the care and treatment being undertaken.

Our key findings were:

- The practice was well equipped to deal with emergencies. An automated external defibrillator, medical oxygen and emergency medicines were available. Staff had received training in how to deal with an emergency.
- Patients' needs were assessed and care was planned and delivered in line with general professional and other published guidance.
- Patient feedback was consistently positive about the care and treatment received from the dentists.
- Appropriate arrangements were in place to protect patients from the risks posed by exposure to x-rays.
- Staff received training relevant to their roles and were supported in their continuing professional development.
- Prescription pads were held securely.

However,

- The practice conducted a range of audits including audits of x-ray quality, dental care records and control of infection. However, the audit of control of infection had failed to identify issues with general cleaning standards, disposal of clinical waste, demarcation of the decontamination room and uncovered computer keyboards in treatment rooms.
- Governance arrangements were in place but were operated inconsistently. For example the practice did not demonstrate they had a plan to effect repairs to equipment and had failed to complete a fixed wiring safety check of the premises. Premises checks had not identified issues of poor housekeeping.

We identified a regulation that was not being met and the provider must**:**

- Ensure the cleaning standards and frequency of cleaning are monitored to confirm consistent standards.
- Ensure the dental chairs are maintained in good order to reduce the risk of cross infection.
- Ensure appropriate segregation of clinical and sanitary waste and have clinical waste removed from the premises at suitable intervals to reduce the risk arising from storage.
- Institute robust checks of treatment rooms to ensure dental materials are appropriately stored to reduce risk of contamination.
- Ensure all current guidance to reduce the risk of cross infection is followed. Including the safe use of computer keyboards in treatment rooms and demarcation of clean and dirty areas in the decontamination room.

You can see full details of the regulation not being met at the end of this report.

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

- Ensure actions identified in the legionella risk assessment are completed. For example monitoring of hot and cold water temperatures.
- Complete a risk assessment to evaluate whether trainee dental nurses require a DBS check.

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 providing safe care in accordance with the relevant regulations.

The practice had systems in place for infection control but risk management was sometimes inconsistent. Some items of protective personal equipment were not available in the treatment rooms on the day of inspection. Standards of cleaning were inconsistent and clinical waste was kept awaiting collection for long periods of time. We found that the majority of equipment used in the dental practice was well maintained. However, two dental chairs required repair.

There were appropriate arrangements in place for the management of medical emergencies at the practice.

The practice recognised the importance of identifying, investigating and learning from patient safety incidents.

There were sufficient numbers of staff working at the practice. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. There was a strong focus on oral health and prevention of dental health problems.

The practice used current national professional guidance to guide their practice. The staff received professional training and development appropriate to their roles and learning needs.

Staff were registered with the General Dental Council and were meeting the requirements of their professional registration.

Are services caring?

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

Our observations of the practice showed staff to be kind and compassionate in their dealings with patients.

We received 43 CQC comment cards and spoke with three patients during the visit. All of the patients commented on the quality of care they received.

There had been four formal compliments logged and two positive experiences of care posted on NHS choices in the last year.

Are services responsive to people's needs?

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

The practice was aware of the needs of the population served. Patients could access treatment and urgent care when required.

The practice provided patients with written information about how to prevent dental problems.

Two of the dental treatment rooms were on the ground floor enabling ease of access for patients with mobility difficulties and families with prams and pushchairs.

Summary of findings

Are services well-led?

We found that this practice was not providing well-led care in accordance with the relevant regulations. The processes to identify, assess and manage risk were not carried out consistently.

Staff told us that they felt supported by the principal dentist and could raise any issues with them. Although team meetings were held staff felt the information sharing at meetings could be improved.

Management of systems to reduce the risk of cross infection was inconsistent. For example, the practice had not identified the risk of holding clinical waste on site for long periods of time and not appropriately segregating waste.

We have told the provider to take action. The details of this action are shown in the Requirement Notice at the end of this report.

Belmont Lodge Dental Health Centre

Detailed findings

Background to this inspection

We undertook a comprehensive inspection of Belmont Lodge Dental Health Centre on 24 March 2016. The inspection was undertaken by a CQC lead inspector and a dental specialist advisor.

We informed NHS England area team that we were inspecting the practice and did not receive any information of concern from them.

During the inspection we:

- Spoke with two dentists, two trainee dental nurses and a member of the reception staff.
- Spoke with three patients.
- Undertook a review of records relevant to the management of the service.
- Asked the dental specialist advisor to look at a number of anonymised dental care records to corroborate that the dentist carried out their consultations, assessments and treatment in line with general professional guidelines.
- Carried out observations around the service.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had a system in place for the reporting and recording of significant events and near misses. We reviewed three significant event reports from the last two years. The practice demonstrated that significant events were followed up and learning was shared with relevant staff to reduce the risk of the same thing happening again in the future. For example, the principal dentist conducted a tutorial with an associate dentist following and incident with a dental instrument.

The principal dentist took responsibility for receipt and action arising from national patient safety and medicines alerts received by the practice. We saw that alerts received were checked and signed off by the dentist to confirm that action had been taken.

Reliable safety systems and processes (including safeguarding)

We spoke with the principal dentist, the associate dentist, two trainee dental nurses and the receptionist. All the staff we spoke with were able to describe the types of abuse they might witness or suspect during the course of their duties. Staff records showed us that appropriate training in safeguarding; both children and vulnerable adults had been undertaken by all staff. The practice had a safeguarding protocol in place and the principal dentist was the safeguarding lead for the practice.

Details of the local safeguarding agency were held both in the manager's office and in the staff room. Staff we spoke with knew where to find the protocol and the safeguarding authority contact details and told us they would report any safeguarding concerns in line with the protocol.

Our discussion with the principal dentist, and review of dental care records showed that a rubber dam was used in all cases of 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 treatment).

Staff were able to describe the action they would take if they suffered a needlestick injury. The dentists took personal responsibility for dealing with needles used to deliver local anaesthetic.

Medical emergencies

The practice had an automated external defibrillator (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].We checked this during the inspection and found that both child and adult pads were available and were in date. Medical oxygen was held at the practice and we found that the cylinder was full with oxygen. There were adult and child masks available and these were within their expiry date. Both the AED and medical oxygen were checked on a regular basis. However, the room where the oxygen cylinder was kept was not identified with an approved oxygen hazard notice. We discussed this with the practice manager and principal dentist and they addressed the matter within 24 hours of our inspection.

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The practice held emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice. We saw records to show that the medicines were checked every week. All medicines were within their expiry date.

Staff had received training in how to deal with a medical emergency including basic life support (BLS) training. We saw records to confirm that training in BLS was undertaken on an annual basis.

Staff recruitment

We reviewed the recruitment files of seven staff and found that most of the appropriate pre-employment recruitment checks had been undertaken. For example, proof of identity, references and application forms were retained. The practice had not completed Disclosure and Barring Service (DBS) checks for the trainee dental nurses when they were appointed. (A DBS check identifies whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice could not identify a risk assessment detailing why they chose not to conduct DBS checks for staff working with patients on a daily basis.

Monitoring health & safety and responding to risks

The practice had some arrangements in place to monitor health and safety and deal with foreseeable emergencies. There were a number of risk assessments that had been

Are services safe?

completed. For example, Control of Substances Hazardous to Health (COSHH) fire safety, radiation, general health and safety issues affecting a dental practice. However, the practice procedures were operated inconsistently. Monitoring of the premises had not identified some materials used for dental fillings were left in a plastic cup lodged in a radiator.

We found clinical staff were immunised against the blood borne virus Hepatitis B that could be transmitted from patients because of a contaminated sharps injury.

The practice did not have a business continuity or disaster recovery plan in place. The practice manager and principal dentist provided staff with emergency contact details during any planned holidays or absence. However, if an emergency situation arose when the principal dentist or practice manager were unexpectedly unable to attend the practice staff would not have access to information enabling them to maintain the service. When we discussed what might happen during unplanned absence the manager and dentist told us they would formalise a recovery plan that would be available at all times.

Infection control

The practice was mostly clean and tidy but some improvement could be made. Dental surgery rooms were clutter free and the system for disposal of clinical waste from these rooms, including sharps bins, was appropriate. However, cupboard and drawer fronts in one of the treatment rooms were stained giving the appearance of being dirty. The drawers contained dental instruments.

The computer keyboards in treatment rooms were not of wipe down construction and were not covered to avoid contamination from airborne contaminants. Guidance states that keyboards should either be covered or able to be wiped clean to reduce the risk of cross infection.

We also found that clinical waste was held awaiting collection for long periods of time. For example, collection records showed that a 10 month period had elapsed between May 2015 and March 2016 during which time clinical waste had been held, securely, awaiting collection. The practice did not have a contract for disposal of sanitary waste and this was combined with clinical waste awaiting collection. When we discussed this with the dentist and manager they took action to ensure sanitary waste was separated from clinical waste.

We observed the decontamination process and noted suitable containers were used to transport dirty and clean colour coded instruments between the treatment rooms and decontamination room. The practice used a system of manual scrubbing for the initial cleaning process, following inspection with an illuminated magnifier the instruments were then placed into an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilised, they were pouched and stored until required. All pouches were dated in accordance with current guidelines. The decontamination room did not contain any signage or marking out to identify the clean and dirty areas. Identifiable separation of the decontamination room helps to ensure dirty instruments are kept away from clean and sterile instruments and reduces the risk of cross contamination.

We were shown the systems in place to ensure the autoclave used in the decontamination process was working effectively. It was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were always complete and up to date.

Cleaning of the general areas of the practice was undertaken by both the trainee dental nurses and the reception staff. The practice did not have a cleaning schedule in place. We were told that soft furnishings in waiting areas and carpets were subject to an annual deep clean. Guidance for cleaning of soft furnishings requires this to be carried out on a six monthly basis. The cleaning equipment used to clean hard floors had not been put away in accordance with guidance. Some of this equipment was discoloured and appeared dirty.

Our checks of the dental treatment rooms showed that disposable aprons were not available to staff in the treatment rooms. However there were disposable gloves and eye protection available for staff and patient use. The treatment rooms had designated hand wash basins for hand hygiene and liquid soaps and paper towels. There was a hand hygiene poster displayed above all hand wash basins.

The required audits of the processes and procedures to reduce the risk of cross infection had been undertaken. However, these had not identified the lack of demarcation of the decontamination room, uncovered computer keyboards, absence of disposable aprons in treatment rooms and absence of cleaning schedules.

Are services safe?

The practice had a legionella risk assessment in place. **(**Legionella is a term for particular bacteria which can contaminate water systems in buildings). We found that actions required from the risk assessment had been not been completed. For example the control measure of testing hot and cold water temperatures was not undertaken.

Equipment and medicines

We saw that the practice was well equipped to deal with a wide range of dental treatments. However, two of the dental chairs had splits in the fabric and these were covered by adhesive tape. The practice did not demonstrate at the time of inspection that they had a plan to complete a permanent repair of these chairs. The maintenance records we reviewed showed that servicing of other medical equipment, in use, was undertaken in accordance with manufacturers' recommendations.

The practice held stocks of local anaesthetic required for dental procedures. This was held securely and stock recorded. When local anaesthetic was administered the batch number was recorded in the patient's dental record.

If a patient required a medicine this was prescribed by the dentist and the prescription was taken by the patient to a pharmacy of their choice. There were appropriate arrangements in place for the security of prescription pads.

We found a cup of materials used for dental fillings lodged in a radiator in one of the dental treatment rooms. It was not clear whether these were ready for use or awaiting disposal.

We checked the maintenance records for the building and found that the electrical safety certificate was issued in 2004. It is a requirement upon owners of public buildings to complete wiring safety checks every 5 years. Therefore, the practice could not demonstrate that the wiring in the building was safe.

Radiography (X-rays)

The practice had arrangements in place that were in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). The practice had records that contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment.

The principal dentist was the Radiation Protection Supervisor. We saw the critical

examination packs for each X-ray set along with the three yearly maintenance logs and a copy of the local rules. The maintenance logs were within the current recommended interval of three years.

Dental care records we saw showed when dental X-rays were taken they were justified and, reported upon. A quality assurance process was in place to document the quality of each X-ray taken by the dentists. The practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Patients completed a full medical history and were asked if there were any changes to medical conditions or medicines taken before any course of treatment was undertaken. The dental care records we reviewed showed medical history had been checked and the three patients we spoke with confirmed this.

The practice used current guidelines when making decisions on treatment and clinical risk. For example the requirement to take X-rays and the frequency of recall was based upon a full oral examination. Each time the patient received a dental check their records were updated and decisions about their future treatment and check-up regime were noted.

Health promotion & prevention

The dental care records we reviewed and comments we received on CQC comment cards showed us that oral health and preventative measures were discussed with patients. The dentists provided oral health advice and undertook hygiene checks and cleaning of patient's teeth. There were health promotion leaflets available in the practice to support patients to look after their oral health. These included information about good oral hygiene.

The dentists working in the practice carried out consultations, assessments and treatment in line with recognised general professional guidelines. We spoke with two dentists on the day of our visit. They described to us how they carried out their assessments. The assessments began with the patient updating a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment.

Staffing

There were enough support staff to support the dentists during patient treatment. However, these staff were in training and were supervised by the dentists at all times.

We spoke with two of the trainee dental nurses. Both confirmed that they received supervision from the dentists and were enrolled on training courses to become qualified dental nurses.

Staff received mandatory training. For example, in cardio pulmonary resuscitation (CPR), infection control, child protection and adult safeguarding. Training certificates we saw also evidenced that the dentists attended off site training when this was appropriate. This demonstrated that the provider was supporting the staff to deliver care and treatment safely and to an appropriate standard.

We spoke with a member of staff who had been in post for over a year they had their learning needs identified through both informal discussions and their annual appraisal. An appraisal system was in place for all staff who had been employed for over a year and we saw that trainees received appropriate mentoring and support from the principal and associate dentists.

We saw evidence of medical indemnity cover for the dentists who were registered with the General Dental Council.

Working with other services

We discussed with the dentist how they referred patients to other services. Referral letters and responses were held in the patients' dental care records. These ensured patients were seen by appropriate specialists. Dentists were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice.

When the patient had received their treatment they would be discharged back to the practice for further follow-up and monitoring. There was a system in place to ensure the information received from other services was entered in the dental care records to ensure the dentist saw this when they next treated the patient.

Consent to care and treatment

The three patients we asked said the dentists involved them in decisions about their care and treatment. Over 50% of the 43 patients who completed CQC comment cards also offered comment about the dentists involving them in decisions about their care. The dentists we spoke with had a clear understanding of consent issues. They stressed the importance of ensuring care and treatment was fully explained to patients to enable the patient to give consent. The two dentists we spoke with explained how they would

Are services effective?

(for example, treatment is effective)

take consent from a patient who suffered with any mental impairment, which may mean they might be unable to fully understand the implications of their treatment. The dentists explained if there was any doubt about the patient's ability to understand or consent to the treatment, then treatment would be postponed. They explained they would involve relatives and carers to ensure the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We saw that staff made significant effort to maintain the confidentiality of patient information. For example the receptionist avoided repeating patient names, or asked the patient for their date of birth, when taking telephone calls. This reduced the risk of other patients in the waiting room overhearing personal details.

The dentists or trainee nurses came to greet patients from the waiting room and take them to the dental treatment rooms for their treatment. The treatment rooms were situated so that conversations between patients and dentists could not be overheard by others waiting. The computers in the practice were password protected and those at reception were positioned so that patients could not see the information on the screens.

The 43 patients who completed comment cards and the three patients we spoke with were all positive about the dentists treating them with care and concern. Parents were encouraged to accompany children during their treatment, as were carers who visited with patients who required extra support.

Involvement in decisions about care and treatment

Information to enable patients to make decisions about their treatment was available in written formats. However, we were told by the dentists, and patients confirmed, that the emphasis was on verbally advising patients of the treatment proposed or options available. We saw that NHS treatment plans were used to confirm the treatments proposed and that these were signed by patients. Dental care records we reviewed showed us that options were documented.

The three patients we spoke with and comments contained on CQC comment cards told us that patients felt they had sufficient time with the dentists and that the dentists took time to ensure treatment was fully explained along with oral health advice to help avoid future dental problems.

We noted that two patients had posted reviews for the practice on the NHS choices website in 2015 and both were positive. Both emphasised the caring nature of the dentist and the involvement in decisions about future dental care.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Information on the range of treatments available from the practice was displayed in the waiting room along with the opening times of the practice. The information included the costs for both NHS and private treatment.

The practice provided continuity of care to their patients by enabling them to see the same dentist each time they attended. When this was not possible they were able to see one of the other dentists.

Patients new to the practice were required to complete a patient questionnaire so that the practice could conduct an initial assessment and respond to their needs. This included a medical history form. The dentists undertook a full examination when patients attended for their first appointment and this was documented in the patient dental care record.

Tackling inequity and promoting equality

The practice was accessible to patients in wheelchairs and those with walking difficulties via an entrance adjacent to the car park. Patients in wheelchairs, or those with pushchairs and prams alerted reception to their arrival and the receptionist assisted them to enter the practice via a level entry hall. The reception desk was at wheelchair height. The main waiting room had sufficient space for a wheelchair or for pushchairs and prams. Two of the treatment rooms were on the ground floor.

The practice had a hearing loop to assist patients who used hearing aids. We were told there were very few patients registered whose first language was not English. Those who required a translator brought a relative or friend to support them. We saw that appointments were available outside of school hours.

Access to the service

The practice was open between 9am and 5pm Monday to Friday. Appointments were from 9am to 12.50pm and 2pm to 4.50pm daily. Patients in urgent need of dental care were always seen on the day they called or given advice by the dentist. If an urgent appointment was not available the patient was offered the opportunity to sit and wait to be seen.

None of the patient comment cards or the patients we spoke with expressed any concerns about difficulty accessing appointments. There was a message on the practice telephone system which advised patients of the number to call for dental emergencies when the practice was closed.

Concerns & complaints

The practice had a complaints procedure. The practice manager was responsible for investigating and responding to any complaints the practice received. The complaints procedure was displayed in the waiting room. Staff we spoke with were clear in their understanding of the practice procedure and how they would support a patient who wished to lodge a complaint.

The practice had not received any complaints in the last year. We saw that four formal compliments had been recorded in the last year.

Are services well-led?

Our findings

Governance arrangements

The practice manger and principal dentist were responsible for the day-to-day management of both the clinical and administrative functions of the practice.

There were a range of policies and procedures in place to govern the practice. For example, control of infection, health and safety and training and development. However, application of the policies and procedures was not always consistent. Staff were aware of where policies and procedures were held.

The practice did not have a business continuity plan that staff could refer to, at any time, if they needed to deal with an emergency situation to maintain delivery of services. The practice had not completed a formal risk assessment to determine whether trainee dental nurses were required to undertake a DBS check. Audit of control of infection had not identified a number of issues that would have reduced the risk of cross infection. Premises checks had not identified that some items of dental equipment were left in plastic cups.

Leadership, openness and transparency

The practice had a statement of purpose. There was a strong ethos of providing effective and caring personal treatment and we saw that staff were committed to the ethos. Communication in the team was supported by meetings. Minutes of meetings we reviewed showed that three had taken place in the last eight months and that all staff had been present. Informal communication channels were mostly employed because there was a small team of staff that facilitated regular discussion between the principal dentist and the rest of the team. Staff we spoke with told us they were encouraged to put forward ideas and they told us they were generally well supported to carry out their roles and responsibilities. Staff had job descriptions and were clear on the duties that were expected of them.

Staff we spoke with told us the practice had an open culture and that they would have no hesitation in bringing any errors or issues of concern to the attention of the principal dentist or the practice manager when they were on duty. We noted that the dentist had a very busy appointment schedule. None of the staff we spoke with recalled any instances of poor practice that they had needed to report.

Learning and improvement

The principal dentist was approved as a trainer for foundation dentists. The practice had a foundation dentist in post but they were not on duty at the time of inspection. Foundation dentists are qualified dentists in their first year of practice. The trainee dental nurses were enrolled on approved courses of study to become qualified dental nurses and they received supervision from the dentists. Mandatory training in CPR and safeguarding was undertaken by all staff.

Dentists maintained their continuing professional development (CPD) through use of various media for learning. (CPD is the means by which people maintain their knowledge and skills related to their professional lives. It is continuing education as applied to professional development. It is a requirement for dental professionals to maintain a specific level of CPD on a cycle of learning). We saw the training files for the dentists which confirmed they were up to date with their CPD.

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

The dentists regularly undertook patient satisfaction surveys based on random samples of 10 patients each. The practice sent us three samples of the results and we saw these were very positive describing treatment as very good or excellent. Feedback was also encouraged by the use of a suggestion box and the national friends and family recommendation test. We noted that 16 responses had been received from patients completing the test and all 16 would recommend the practice. The practice also had a strong rating on NHS choices and we saw that four formal compliments had been recorded in the last year. Due to the positive feedback about the delivery of services there had not been a need to adjust services in response to patient feedback.

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 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good Governance (1) & (2), (a), (b) & (f) **Good governance** **17.**—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (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; (f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e). • Checks of the premises had not identified some dental materials being stored inappropriately. • A fixed wiring test had not been completed in accordance with regulations. • The infection control audit had not identified issues of risk of cross infection. For example, computer keyboards in treatment rooms that were not covered or of wipe clean construction, lack of demarcation of the decontamination room, inappropriate segregation of clinical and sanitary waste, lack of cleaning schedule,

This section is primarily information for the provider

Requirement notices

inconsistent monitoring of cleaning standards, cleaning equipment not kept in accordance with best practice and clinical waste being stored for long periods before collection by an accredited carrier.

- At the time of inspection the practice was not following the control measures identified in their legionella risk assessment.