Miss Shikha Mittal

# Royston Dental Suite

## Inspection Report

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## Overall summary

We carried out an announced comprehensive inspection on 21 October 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 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**

We carried out a comprehensive inspection of Royston Dental Suite on 21 October 2015. Royston Dental Suite is a single handed practice and provides both NHS and private dental treatment to patients of all ages. The lead dentist employs a dental nurse and a regular locum dental nurse, provided by an agency is used.

The practice is located on the first floor, above shops in the High Street and access is by a staircase. It has one treatment room, a staff kitchen area, reception, waiting room and one decontamination room for cleaning, sterilising, and packing dental instruments. The practice is open Monday to Friday 9am to 5.30pm. For private patients, the practice has extended opening hours on Monday and Thursday evenings to 7.30pm. The contract held for NHS patients does not include extended hours.

We spoke with three patients during our inspection and received six comments cards that had been completed by patients prior to our inspection. We received positive comments about the cleanliness of the premises, the empathy, and responsiveness of staff and the quality of treatment provided.

Three people told us that staff explained treatment plans to them well. Patients reported that the practice had seen them on the same day for emergency treatment. Patients commented that the service they received was good, and that they were always clear about the costs involved in their treatment.

**Our key findings were:**

# Summary of findings

- The practice had sufficient policies in place, however, the management systems needed to give oversight to ensure that they were being followed needed to be strengthened.
- There were sufficient numbers of staff to meet patients' needs.
- The practice actively sought feedback from patients through questionnaires and used it to improve the service provided.
- The practice offered extended hours and out of hours emergency care for patients.
- We found that systems, risk assessments, and regular audits were not in place to give oversight and ensure compliance with regulations, safety including management of materials and medicines, and performance to identify risks, mitigate, and drive improvements.
- We found that dental care records were not well maintained and did not contain the relevant information needed to reflect patients' consent, and decisions in relation to their treatment.

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

- Ensure the practice policy for staff recruitment is followed and temporary staff receive induction and explaniation to practice's processes.
- Ensure that dental care records are written, maintained and contain the relevant information needed to reflect patients' consent, and decisions in relation to their treatment.
- Ensure that systems, risk assessments, and regular audits are in place to ensure compliance with regulations, safety including management of materials and medicines, and performance to identify risks, mitigate and drive improvements.

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

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

- Have regard to NHS England's publication for Delivering Better Oral Health- an evidence based toolkit to support dental practices in improving their patients' oral and general health, National institute of Clinical Excellence (NICE) guidelines, and Faculty of General Dental Practice record keeping/selection criteria for X-rays.
- Record verbal feedback to identify areas where improvements could be made.
- Obtain evidence that locum staff, provided through an agency hold up to date training records.

# 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 care which was safe in accordance with the relevant regulations.

The practice had some systems and processes in place to ensure all care and treatment was carried out safely.

Staff had received training in safeguarding vulnerable adults and children, and they could describe the signs of abuse and were aware of the external reporting process. Staff were suitably trained and skilled to meet patient's needs and there were sufficient numbers of staff available at all times.

Infection control procedures were in place and staff had received training. Radiation equipment was suitably sited and used by trained staff only. Emergency medicines in use at the practice were stored safely and checked to ensure they did not go beyond their expiry dates. Sufficient quantities of equipment were in use at the practice, serviced, and maintained at regular intervals.

**Are services effective?**

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

Patients received an assessment of their dental care needs including taking a medical history. Explanations were given to patients in a way they understood and risks, benefits and options available to them. Staff were supported through training, appraisals, and opportunities for development. Patients were referred to other services in a timely manner.

**Are services caring?**

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

Patients were treated with dignity and respect and their privacy maintained. Patient information and data was handled confidentially. We saw that treatment was clearly explained and patients were provided with treatment plans. Patients with urgent dental needs or pain were responded to in a timely manner, usually on the same day, including those that required treatment when the practice was closed.

**Are services responsive to people's needs?**

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

The practice offered a range of services to meet patients' needs, and provided emergency out of hours treatment for those that needed it.

Appointments were easy to book and the practice offered extended opening hours two evenings a week to meet the needs of those who could not attend during normal opening hours. The practice offered slots each day enabling responsive and efficient treatment of patients with urgent dental needs.

There was a clear complaints procedure and information about how to make a complaint was displayed in the waiting area.

**Are services well-led?**

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

Staff understood their roles and responsibilities, however, the leadership needed to be strengthened.

# Summary of findings

The practice had a number of policies and procedures to govern activity and held regular staff meetings. It proactively sought feedback from staff and patients, which it acted on. However, we found that the provider did not have systems to give oversight to ensure good governance of the practice.

We found there was a lack of systems of review in place to help monitor performance and drive improvement.

# Royston Dental Suite

**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 21 October 2015 and was conducted by a CQC inspector, a dental specialist advisor, and a dental nurse advisor.

Royston Dental Suite is a single handed dental practice and employed one dental nurse and a cleaner. A dental nurse provided by an agency also worked at the practice two to three days per week. During the inspection we spoke with the dentist and two dental nurses. We also spoke with three patients. We reviewed six comment cards about the quality of the service that patients had completed prior to our inspection. 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**

The practice received national and local alerts relating to patient safety and safety of medicines. The dentist who received the alerts by email recorded if any action was needed. For example, a medical device alert was received 10 April 2015. The dentist had signed and annotated that no action was required on that same day.

Staff understood the process for accident and incident reporting including the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). There had been no incidents logged. Staff we spoke with told us that if an event occurred they would discuss with the dentist and would take any action needed but they did not have a system to record these events or the learning that would be gained from them.

**Reliable safety systems and processes (including safeguarding)**

The practice had satisfactory child protection and vulnerable adult policies and procedures in place. These provided staff with information about identifying, reporting, and dealing with suspected abuse. The dentist and permanent member of staff had completed the required training in child protection however; evidence of training undertaken by the agency staff was not available. All staff, including the agency staff member, knew who the safeguarding lead was and how to recognise signs of abuse in vulnerable adults and children and had access to the policies for contact details of both child protection and adult safeguarding teams.

The British Endodontic Society uses quality guidance from the European Society of Endodontology recommending the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work. The practice showed us that they had rubber dam kits available for use when carrying out endodontic (root canal) treatment.

We noted that there was good signage throughout the premises clearly indicating fire exits, the location of first aid kits, medical emergency equipment, and X-ray warning signs to ensure that patients and staff were protected.

**Medical emergencies**

The employed staff had received training in cardiopulmonary resuscitation and first aid and those we spoke with knew the location of all the emergency equipment in the practice. There was no evidence of training relating to the agency staff member, however, she was able to demonstrate that she had the knowledge to deal with an emergency.

We checked the emergency medical treatment kit available and found that this had been monitored regularly to ensure that it was fit for purpose. There was adequate equipment in place to deal with all medical emergencies as recommended by the Resuscitation Council (UK). For example there was an automated external defibrillator, blood glucose measurement device**,** and self-inflating bags. The staff we spoke with could describe the actions that would be needed in an emergency.

Emergency medicines, in line with guidelines issued by the British National Formulary were available to deal with a range of emergencies including angina, asthma, chest pain, and epilepsy, and all drugs were within date for safe use. We noted that emergency medicines were stored in a refrigerator that contained food. There is a risk of contamination to both food and medicine and they should not be stored together.

The location of first aid boxes and emergency equipment was clearly signposted.

**Staff recruitment**

We checked records for two employed staff which contained evidence (if appropriate to role) of their GDC registration, employment contract, job description, indemnity insurance, and a disclosure and barring check (DBS). The Disclosure and Barring Service carries out checks to identify 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. Employment references for the staff that had been recruited within the past two years had not been obtained. The file for the agency staff member contained evidence of qualification, registration, and DBS check; however, there was no evidence of training.

# Are services safe?

New staff underwent an induction to their job this was detailed in their file. However, despite working regularly at the practice the agency staff had not undertaken an induction and explanation of practice processes.

**Monitoring health & safety and responding to risks**

The practice had comprehensive health and safety policies in place, which covered a range of issues including moving and handling, equipment, medicines and radiation. We found evidence that the practice conducted regular health and safety checks to ensure the environment was safe for both staff and patients.

We spoke with staff who understood their role and responsibilities and had an awareness of fire safety. They told us that they had recently had fire safety training but this had not been recorded. They had a clear plan of how to evacuate the building keeping patients safe in the event of a fire. The practice had only one entrance and exit and was well signed posted and fire extinguishers had been checked.

A business continuity plan was in place to deal with a range of emergencies that might impact on the daily operation of the practice. Risks identified included loss of utilities, fire, and flooding.

The document contained relevant contact details for staff to refer to. For example, contact details of equipment and IT suppliers and tradesmen. This plan was available off site in case the premises could not be accessed in an emergency.

**Infection control**

Patients who completed our comment cards reported that they always found the practice clean and had no concerns about cleanliness or infection control. We found that the dental treatment areas, decontamination room and the general environment was visually clean, tidy and clutter free.

The practice had a range of relevant written policies in place for the management of infection control including those for exposure to blood borne viruses, hand hygiene, and legionella management. A legionella risk assessment had been completed and staff carried out regular checks of water temperatures in the building as a precaution against the development of legionella. Regular flushing of dental water lines was carried out in accordance with current guidelines.

The agency staff member had not received induction and explanation of practice processes for infection control and was not following the practice policy. We highlighted this to the practice who rectified the situation immediately.

Training files we viewed showed that staff employed at the practice had received appropriate training in infection prevention. Evidence of training for the agency staff member was not produced.

Some audits of infection control was undertaken to ensure the practice's procedures were effectively implemented. There was no audit to ensure substances hazardous to health were updated in the Control Of Substances Hazardous to Health (COSHH) file. The practice had a record of staff immunisation status in respect of Hepatitis B, and there were clear instructions for staff about what they should do if they injured themselves with a needle or other sharp dental instrument. However, the practice had not undertaken a risk assessment of sharps injuries and did not display posters in the treatment or de-contamination room.

The 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05) published by the Department of Health sets out in detail the essential processes and practices to prevent the transmission of infections. Decontamination of dental instruments took place in a dedicated room in the practice. We observed the practice's processes for the cleaning, sterilising and storage of dental instruments and reviewed their policies and procedures.

We found that in general the practice was meeting the HTM01- 05 essential requirements for decontamination in dental practices.

The nurse showed us how the practice checked that the autoclave (equipment used to sterilise dental instruments), was working effectively. The autoclave had a memory chip which transferred information regarding essential validation checks of sterilisation cycles to the practice's computer. A daily visual observation check of the autoclave was undertaken at the start of the day to check they were operating effectively.

We observed the practice's processes for cleaning the premises. Regular inspections had taken place with checklists completed, for example cleaning of floors and surfaces daily.

# Are services safe?

We inspected the drawers in the treatment room which were clean and tidy. All of the instruments were in dated packs and it was clear which items were single use. We noted that the matrix bands which are used for a filling were not pouched. We found out of date needles and gel; the system for checking and maintaining the stock in the treatment room needed to be strengthened. Staff uniforms were clean; however the dentist was wearing jewellery, and therefore there could be a risk of cross infection. We saw that personal protective equipment, such as glasses and gloves, was available. Staff and patients told us that they wore appropriate personal protective equipment and the patient was given eye protection to wear during their treatment.

The practice used an appropriate contractor to remove dental waste from the practice and we saw the necessary waste consignment notices. Sharps boxes were sited safely, and assembled and labelled correctly.

**Equipment and medicines**

The equipment used for sterilising instruments was checked, maintained, and serviced in line with the manufacturer's instructions. Records showed that the equipment was in good working order and being effectively maintained. The test for portable electrical equipment to ensure its safety was overdue; however, we saw that a contractor had confirmed attendance at the practice for 2 November 2015. The dentist confirmed that any adverse drug reaction would be reported via British National Formulary yellow card scheme. This scheme collects information on suspected problems or incidents involving medicines.

The batch numbers and expiry dates for local anaesthetics were not always recorded in the dental records.

Processes were in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates.

Prescription pads were stored securely with a system in place to monitor their issue to prevent incidents of prescription fraud.

**Radiography (X-rays)**

The practice had not registered with the health and safety executive as required under Ionising Radiations Regulations 1999 (IRR99) Reg. 6(2) Notification of Work with Ionising Radiations. We highlighted this to the practice and they took immediate action to rectify this.

There was Radiation Protection Adviser and Supervisor as required by the Ionising Regulations for Medical Exposure Regulations (IRMER) and a well maintained radiation protection file.

This contained the required information including the local rules and inventory of equipment, critical examination packs for the X-ray machine and maintenance logs.

The practice monitored the quality of the X-rays images on a regular basis. This ensured that they were of the required standard and reduced the risk of patients being subjected to further unnecessary X-rays. However, the practice did not undertake a detailed audit of these results.

We looked at a sample of dental care records where X-rays had been taken. These did not show that the dentist recorded the reasons they had taken X-rays, and the results.

# Are services effective?

(for example, treatment is effective)

## Our findings

**Monitoring and improving outcomes for patients**

Dental care records that the dentist showed us did not show that NICE guidance, the better oral healthcare toolkit or that FGDP record keeping was followed. For example, in some records where X- rays had been taken the justification had not been recorded nor had the patients consent. The dental records were in a damaged state with inserts/X-rays or forms falling out and there was a risk that patients information could be lost, resulting in poor or delayed care.

The practice had not conducted any audits to ensure compliance or good practice and to drive improvements.

**Health promotion & prevention**

There was a good selection of information leaflets including smoking cessation available for patients in the waiting areas. Staff we spoke with were aware of the importance of health promotion. Patients we spoke with told us that the dentist advised them on health promotion. For example one patient who was having treatment explained that the dentist had advised her on which foods not to eat and had suggested smoking cessation referral.

Dental care records we viewed did not detail important information about the patients' risk of gum disease, dental decay, and soft tissue status was not recorded. Not all the dental care records reviewed contained a written medical history.

**Staffing**

The provider was the full time dentist and had responsibility for the management of the practice. One full time dental nurse supported them; a dental nurse provided by an agency was regularly used. Records showed that the dentist and nurse were up to date with their continuing professional development; however, there was no evidence that the agency nurse was. (All people registered with the General Dental Council (GDC) have to carry out a specified number of hours of continuing professional development (CPD) to maintain their registration).

The staff told us that there was enough staff and that a locum dentist or agency staff were used if needed. The dental nurse had had an appraisal in June 2015. Minutes from the staff meeting July 2015 showed that planning for annual leave was discussed and cover agreed to ensure that adequate staffing levels were maintained.

**Working with other services**

Patients requiring specialised treatment such as complex restorative work, oral surgery, or pathology were referred to other dental specialists. We reviewed one record that showed a referral letter which was comprehensive and contained detailed information about patients' needs. However, the practice did not keep a log of referrals to keep track and did not undertake audits to ensure appropriate use of pathways.

**Consent to care and treatment**

Dental care record we viewed did not demonstrate that patients' consent to their treatment had been obtained and that this was recorded. The dentist and dental nurses spoke knowledgeably about the importance of gaining patients' consent to their treatment, and told us that patients were always asked to sign relevant consent. Patients told us that their consent was obtained and that they were informed of treatment plans and costs.

# Are services caring?

## Our findings

**Respect, dignity, compassion & empathy**

Before the inspection we sent comment cards to the practice for patients to use to tell us about their experience of the practice. We collected six completed cards in total. These provided a positive view of the service the practice provided. We reviewed 22 survey reports that the practice had collected between August and October 2015, including four Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on the services provided.

Patients commented that staff were respectful, efficient, and empathetic to their needs. Some patients commented that staff were particularly good at treating their children and dealing with their need for emergency treatment. Several wrote that they were seen on time and were pleased with their dental treatment.

We spent time in the patient's waiting area and found the general atmosphere was welcoming and friendly. Staff were polite and helpful towards patients, both in person and on the phone.

Patient confidentiality was taken seriously; we noted that staff did not use more information that necessary when discussing next appointments or charges. If patients wanted to talk to reception staff in confidence they could be taken to another room.

**Involvement in decisions about care and treatment**

Patients we spoke with, and comments cards we received, indicated that patients felt they were involved in decisions about their dental care, and that the dentist explained treatments in a way that they could understand. They reported that the dentist spoke to them throughout their treatment ensuring that they were comfortable. The dentist also gave out information leaflets to patients to help them better understand their treatment and oral health care. However, this was not evident in the dental care records we viewed.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting patients' needs**

The practice provided a range of services to meet patients' needs. It offered both NHS and private treatment to children and adults.

There was good information for patients about the practice, available both in the waiting area and in the practice leaflet. This included details about the dental team, the services on offer, how to raise a complaint, and information for contacting the dentist in an emergency. Emergency and out of hours cover was provided by the dentist. There was clear information about NHS and private costs on display in the waiting room. We noted a few suitable toys in the waiting room for children to enjoy whilst they waited.

**Tackling inequity and promoting equality**

The practice was based on the first floor, with steps to its front door, making it difficult to access for those in wheelchairs or with push chairs. As a result it was not able to meet the needs of wheelchair users. However, this was made explicit in the practice's information leaflet and reception staff signpost patients to other practices if needed. Steps inside the practice had been made more visible by the use of brightly coloured tape.

The practice did not have access to any translation services but staff spoke several languages including Hindi, German, and Persian. The practice had a low population of patients whose first language was not English and they did not have any homeless or travellers registered.

There was no hearing loop to help those with hearing impairments. The staff were able to obtain information, usually without delay, in other formats or languages if required.

**Access to the service**

The practice was open Monday to Friday 9am – 5.30pm and offered extended hours for private patients two evenings a week until 7.30pm to meet the needs of private patients unable to attend during the working day. The contract held by the practice for NHS patients did not include extended hours.

Appointments could be booked by phone or in person. Staff told us patients were seen as soon as possible for emergency care and this was normally on the same day. Patients we spoke with and comment cards said that the practice had responded quickly when they had a need for urgent treatment.

The practice's answer phone message detailed how to access out of hours emergency care if needed. However there was no information outside the building informing patients of out of hours emergency services, should they come to the practice when it was closed.

All the patients we spoke with were satisfied with the appointments system and said it was easy to use.

**Concerns & complaints**

There was information available for patients giving them details of how to complain however, the practice did not have any complaints recorded. Staff told us that they had not received any written complaints, if a patient had a query or question the staff dealt with it at the time. These were not recorded for future learning and to show how improvements were made.

Patients we spoke with told us they felt confident that staff would respond appropriately to any concerns they had. The staff were aware of how to deal with a complaint should they need to. For example, a NHS patient wanted to understand why they were not able to have an evening appointment. The dentist spoke with the patient and explained that the NHS contract they held only covered the hours of 9am to 5pm.

# Are services well-led?

## Our findings

**Governance arrangements**

The practice lacked systems that gave oversight to the management of the practice.

- The practice did not have completed audits to ensure compliance or good practice and to drive improvements for example, an audit on the use of X-rays.
- The practice had not registered with the health and safety executive (HSE) as required by the ionising regulations for Medical Exposure Regulations (IRMER).
- Agency staff had not received an induction to the practice to ensure that they were able to carry out their role safely.
- The practice did not always assess risks to ensure safety, for example they had not completed a sharps injuries risk assessment.
- Recruitment references had not been obtained for staff employed in the last 2 years.
- There was no oversight to assurance that staff had been trained appropriate to their roles and that this training was up to date.
- Staff told us that significant events or verbal feedback was not collated to identify trends and to drive improvements.
- There was no system in place to routinely check that materials in the treatment room had not expired and were safe to use.

There was a full range of policies and procedures in use at the practice. These included health and safety, infection prevention control, needle stick injury and safeguarding people.

There was a system in place to show that staff had read, understood and agreed to abide by them, however, this did not include agency staff. The policy folders were accessible to everyone and the agency staff we spoke with knew where to find them.

The staff met each morning and planned the day; this included discussing patients and their needs. For example if a patient with low mobility was booked, the staff were able to be prepared to assist them to climb the stairs.

There were monthly meetings where the staff discussed a range of practice issues such as administrative protocols, appointment systems, and targets. Minutes of the meetings were taken. Staff received a yearly appraisal of their performance, in which they were set specific objectives which were then reviewed. Staff reported that their appraisal was useful, and helped them identify any further training needs.

**Leadership, openness and transparency**

Staff told us they felt able to raise concerns at any time and did not wait for the monthly meeting. Staff felt involved with the management of the practice. Although they had not needed to use it, staff we spoke with were aware of the whistle blowing policy and understood when it was appropriate to use. However, we were not assured that the leadership was robust for example the need to have oversight and improve undertaking risk assessments.

**Learning and improvement**

Staff working at the practice were supported to maintain their continuous professional development as required by the General Dental Council; however, we noted that agency staff records were not checked. We found there was a lack of information recorded in dental care records, including justification for X- ray, health promotion, consent and the recording of involvement of patients in their care and treatment. There was no specific significant events or complaints log and no annual analysis of events or incidents that would detected any common themes. There was no evidence of shared learning that lead to improved service.

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

Patients were given the opportunity to give feedback and influence how the service was run at each appointment. The practice offered comment cards for the NHS family and friends test as well as their own questionnaire. Patient involvement and feedback was discussed at staff meetings, at the meeting held June 2015 it was identified that the number of responses was lower and that staff needed to encourage patients to give feedback.

Although there was no specific survey for staff, staff told us that the dentist was approachable and they felt they could

# Are services well-led?

give their views about how things were done at the practice. Staff confirmed that they had regular meetings where they could suggest improvements to how the practice ran.

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<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**Regulation: 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**<br>Good Governance<br>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<br>the carrying on of the regulated activity;<br>• We found that systems, risk assessments, and regular audits were not in place to give oversight and ensure compliance with regulations, safety including management of materials and medicines, and performance to identify risks, mitigate, and drive improvements.<br>17 (1)(2)(C) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and<br>treatment provided to the service user and of decisions taken in relation to the care and treatment provided;<br>We found that dental care records were not well maintained and did not contain the relevant information needed to reflect patients' consent, and decisions in relation to their treatment. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br>**Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** |

This section is primarily information for the provider

# Requirement notices

19 (1) (b) have the qualifications, competence, skills and experience which are necessary for the work to be performed by them.

We found that the practice policy for staff recruitment was not followed and temporary staff had not received induction and explanation to practice's processes.