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J Tan Dental Surgery

Inspection Report

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Overall summary

The inspection took place on 3 February 2015 as part of our national programme of comprehensive inspections.

J Tan Dental Surgery provides private, general dental services to patients of all ages. The practice team consists of the principal dentist, who is the provider of this service, a part time dentist, a part time dental hygienist and a part time dental therapist. The clinical team are supported by three dental nurses who also share the role of practice receptionist.

The practice is located in a converted residential property and is spread across two floors. There are two treatment rooms, one on the ground floor and one on the first floor. The reception and waiting area are on the ground floor along with a dedicated decontamination room and patient toilet. The practice is accessible to patients who have mobility issues as treatment can be carried out in the ground floor treatment room.

During our inspection we spoke with three patients and reviewed 31 comments cards, which patients had completed in the week before our visit. All patients commented positively about the care and treatment they had received and the friendly, polite and professional staff. A number of patients commented on the discussions they had with the dentist about their care and treatment and how they felt listened to and made to feel relaxed.

Our key findings were:

- The practice provided a clean well equipped environment
- All staff were kind and caring in the way they dealt with patients
- There was clear leadership of the practice and staff told us they felt well supported and comfortable to raise concerns or make suggestions.
- The practice responded promptly to suggestions and comments made by patients.

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

- Ensure all medicines and equipment recommended by the British National Formulary (BNF) and the Resuscitation Council (UK) are available and in date for use, in order to deal with any medical emergencies that may arise.
- Ensure there are systems in place to effectively monitor the expiry dates of medicines, equipment and filling materials and dispose of them when they reach expiry date.
- Ensure all policies, procedures and risk assessments are dated, reviewed and updated to reflect current practice.
- Ensure there are systems in place to monitor the quality of the service and clinical practice.

Summary of findings

- Ensure appropriate guidance is followed in the assessment and monitoring of patients' gingival (gum) health.

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

- Ensure a risk assessment in relation to Legionella is carried out by an appropriately informed and trained person and that a written scheme is produced for controlling any identified risks.
- Provide relevant staff with training and guidance in relation to the Mental Capacity Act 2005
- The provider should ensure the equipment needed for testing the autoclave is always available and the required test monitored to ensure it is carried out.
- Ensure the Health and Safety Executive are notified of the practice's use of ionising radiation to conform with the Ionising Radiation Regulations 1999(IRR99)
- Complete a risk assessment in relation to dental care professionals working without dental nurse support.

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?

The infection prevention and control practices at the practice followed current essential quality requirements. All equipment at the practice was regularly maintained, tested and monitored for safety and effectiveness.

Staff were trained to deal with medical emergencies, however the practice did not have all the recommended medicines and equipment available to deal with a medical emergency should it occur.

Patients' medical histories were obtained before any treatment took place. The dentist was aware of any health or medication issues which could affect the planning of treatment.

Are services effective?

The practice ensured that patients were given sufficient information about their proposed treatment to enable them to give informed consent.

The dentist had recorded their examination of soft tissues and teeth. However we did not see a record of the checks of patients gum health. Without a recorded assessment it would be difficult to monitor patients' gum health or plan their treatment.

Health education for patients was provided by the dentist, dental hygienist and dental therapist. They provided patients with advice to improve and maintain good oral health. We received feedback from patients who told us that they found treatment successful and effective. Staff confirmed there were few if any treatments that had to be repeated because the restoration had failed.

Are services caring?

Patients were complimentary about the practice and how the staff were caring and sensitive to their needs. Patients commented positively on the caring compassionate staff, describing them as friendly, understanding and professional.

Patients felt listened to by all staff and were given appropriate information and support regarding their care or treatment. They felt their dentist explained the treatment they needed in a way they could understand. They told us they understood the risks and benefits of each option.

Are services responsive to people's needs?

Staff told us all patients who requested an urgent appointment would be seen within 24 hours. They would see any patient in pain, extending their working day if necessary.

Appointment times varied in length according to the proposed treatment and to ensure patients and staff were not rushed.

The treatment rooms at the practice were on the ground floor and first floor. The waiting room and toilet were on the ground floor and were accessible to patients who had mobility difficulties. We received feedback from a patient with mobility issues who told us the practice did all they could to meet their needs and arranged for their treatment to be carried out in the ground floor surgery.

Summary of findings

Are services well-led?

Staff felt supported and empowered to make suggestions for the improvement of the practice. There was a culture of openness and transparency. Staff at the practice were supported to complete training for the benefit of patient care and for their continuous professional development.

Some improvements were required to the way in which quality was monitored within the practice.

J Tan Dental Surgery

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 and to pilot a new inspection process being introduced by the CQC.

- This inspection was carried out on 3 February 2015 by an inspector from the Care Quality Commission (CQC).
- Prior to the inspection we reviewed information we held about the provider. We also viewed information that we asked the provider to send us in advance of the inspection.
- During the inspection we spoke with the principal dentist who is also the registered manager, the dental hygienist, a dental nurse and the practice receptionist who was also a qualified dental nurse.
- We observed staff interaction with patients and looked around the premises and the treatment rooms.
- We spoke with three patients and reviewed 31 comment cards to obtain their views about the staff and the services provided.
- We reviewed a range of policies and procedures and other documents, including dental care records.

We informed the local Healthwatch that we were inspecting the practice; we did not receive any information of note from them.

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

Learning and improvement from incidents

There was a system for recording incidents and accidents. The incident recording books showed that no incidents or accidents had occurred since the practice was registered with CQC in 2011. staff told us as they were such a small team; they often informally discussed ways in which their service could be improved. The team could not identify any specific learning from incidents.

Staff told us they were confident about reporting incidents and accidents and all were aware of how to record any event. The provider and their staff understood their responsibilities in Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR) and had the appropriate recording forms available.

Reliable safety systems and processes (including safeguarding)

The principal dentist who was the provider of this service was the lead for safeguarding, staff told us they would go directly to them if they had any concerns. Staff told us they had completed training in safeguarding children and vulnerable adults appropriate to their role. This was confirmed by their continuing professional development files. Staff were clear about their responsibilities to report any concerns relating to children or vulnerable adults. The practice had a child protection policy and guidance for staff along with a safeguarding vulnerable adults policy. These provided staff with the contact details of local authority safeguarding teams should they need further information or advice or to raise any concerns.

Care and treatment of patients was planned and delivered in a way that ensured their safety and welfare. Patients told us and we saw dental care records which confirmed that new patients were asked to complete a medical history and yearly thereafter, these were reviewed at each appointment. The dentist was aware of any health or medication issues which could affect the planning of a patient's treatment. For example an allergy, the patient reaction to local anaesthetic or their smoking status. All health alerts were recorded on the front of the patient's dental care record.

The dentist at the practice ensured that clinical practices reflected current guidance in relation to safety. For example the dentist routinely used a rubber dam for certain procedures to ensure their patients safety and to increase the effectiveness of treatment. (Rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth).

Infection control

In November 2009, and updated in March 2013, the Department of Health published a document called 'Health Technical Memorandum 01-05 Decontamination in primary care dental practices' (HTM 01-05). This document describes in detail the processes and practices essential to prevent the transmission of infections and to promote clean safe care. It is used by dental practices to guide them to deliver an expected standard of decontamination.

We saw there were effective systems in place to reduce the risk and spread of infection. During our visit we spoke with the dental nurse, who had responsibility for infection prevention and control. They were able to demonstrate they were aware of the safe practices required to meet the essential standards of HTM 01-05. They were aware of the need for personal protective equipment (PPE). We observed PPE being used appropriately.

The dental nurse explained accurately the processes and procedures in place to decontaminate instruments. They also described the checks they carried out to ensure the decontamination equipment was functioning properly. However one of the recommended tests, for steam penetration, used to check the efficiency of the autoclave was not part of their testing routine. (An autoclave is the equipment used for sterilising instruments). This was brought to the attention of the provider and we were informed shortly after our inspection that the testing strips had been purchased and were being used.

The practice followed the guidelines in HTM 01-05 for the manual cleaning of instruments which met essential quality requirements. Staff had a thermometer to check the water used for manual cleaning was at the optimum temperature. Visual checks were made of instruments following manual cleaning using an illuminated magnifier.

The dental nurse was able to describe the decontamination procedures in operation within the surgery. They ensured clinical areas were appropriately cleaned between patients and explained the clean and dirty areas in the surgery to ensure the prevention of cross contamination. The practice used single use equipment wherever possible.

Are services safe?

The practice had carried out a Legionella risk assessment and had concluded there was an insignificant risk. (Legionella is a bacterium that can grow in contaminated water). The practice did not have all the information available in accordance with the Health and Safety Commission's (2000) Approved Code of Practice L8. We were told that microbiological testing of the water system had taken place, however the risk assessment was not dated to indicate when this had happened. The practice had a protocol for the management of Legionella. This included the flushing of dental unit water lines at the beginning and end of the day and between patients and testing the temperature at one of the water outlets. Dental unit water lines contained a solution to provide continuous decontamination of the water used in the dental units.

The practice had an infection control policy and had carried out an audit on 27 January 2015 of their decontamination process and procedures to identify any shortfalls or areas they could improve and work towards best practice. We saw that four actions had been identified and these had been completed at the time of our inspection. For example the introduction of pedal bins and the removal of all sink plugs. The practice infection control policy covered all aspects of infection prevention and control such as; instrument decontamination and storage of instruments. We found that sections of the policy were not complete, such as where cleaning equipment was stored and who to report any sharps injuries to. Although we found that information for staff about sharps injuries was available in each room. We observed correct infection control practices however parts of the policy did not reflect current guidance on safe and effective procedures, for example it directed staff to rinse instruments under running water.

Equipment and medicines

We found that all equipment was regularly maintained and serviced. This included equipment such as autoclaves (equipment used in the sterilising of instruments), the compressor and X-ray units. Portable appliance testing (PAT) was booked to be carried out on 16 February 2015. Records showed servicing; maintenance and validation of equipment had taken place in accordance with manufacturer's instructions.

The practice kept a supply of emergency medicines which were found to be in date and monitored regularly by staff to ensure they remained safe to use. However we found two boxes of antibiotics and one cartridge of local anaesthetic which had exceeded their expiry date. This was raised with the provider who immediately removed the expired medicines and arranged for the oxygen cylinder to be tested, refilled and validated. We were notified shortly after the inspection that this had been done

The patient records we reviewed showed the prescribing of medicines was recorded. Records showed that quantities, batch numbers and expiry dates of local anaesthetics or any medicines dispensed to patients were recorded. Medicines kept at the practice were stored securely.

Monitoring health & safety and responding to risks

The practice had carried out a practice risk assessment in November 2010 which included fire safety. This risk assessment had not been repeated. There was guidance in the waiting room for patients about fire safety and the actions to take.

Staff were aware of their responsibilities in relation to the control of substances hazardous to health (COSHH), there had been a COSHH risk assessment done for certain materials used at the practice to ensure staff knew how to manage these substances safely.

The practice had minimised risks in relation to used sharps (needles and other sharp objects which may be contaminated) by ensuring sharps bins, although not secured to the wall, were stored appropriately in the treatment room. Staff and patients were protected from these items being accidentally knocked over.

Medical emergencies

There were arrangements in place to deal with foreseeable emergencies. We saw that the practice had emergency medicines and oxygen available which may be needed to deal with any medical emergencies should they arise. However we brought to the attention of the provider that the oxygen was labelled as expired on 23 August 2014. The equipment available for dealing with medical emergencies did not meet the recommendations of the Resuscitation Council (UK). Equipment included an automatic external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. However there were no airways available. Checks were

Are services safe?

made of the emergency medicines and oxygen to ensure they were in date and ready for use should they be needed. These checks had not been effective as the expiry date of oxygen had not been identified.

Six of the seven staff had taken part in annual basic life support training provided by an external company in July 2014. They had trained as a team and the training had included medical emergency scenarios which they may encounter. Annual cardiopulmonary resuscitation (CPR) is a requirement of all staff registered with the General Dental Council (GDC) as part of their continuing professional development.

Staff recruitment

The provider kept staff files which contained evidence of the checks they had carried out to ensure that staff working at the practice were suitable for their role. The majority of staff had worked for or known to the provider for a number of years.

The provider ensured they had satisfactory documentary evidence of the suitability of all the staff. Staff files contained evidence of continuous employment with an explanation of any gaps. Criminal record checks by the disclosure and barring service (DBS) had been carried out for all staff. All staff at this practice were qualified and registered with the General Dental Council GDC. There were copies of current registration certificates and personal indemnity insurance. (Insurance they have in place to cover their working practice).

Radiography (X-rays)

The practice radiation protection file contained information required to meet the requirements of the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R 2000) and the Ionising Radiation Regulations 1999 (IRR99). This file contained details of the radiation protection advisor, the radiation protection supervisor, evidence of the maintenance and critical testing of the X-ray set, staff training and local rules. Local rules were displayed to provide staff with guidance on the safe use of radiography within the practice. The radiation protection file did not contain a copy of the provider's notification to the Health and Safety Executive (HSE) of their use of ionising radiation; the HSE should be informed to meet IRR 99 regulations.

The dentist continually assessed the quality of X-ray images. The dentist graded the radiographs (X-rays) they took to monitor their quality to ensure they did not have to be repeated, which could pose a risk to patients. The practice used aiming devices (these are devices used to ensure the X-ray film and X-ray set are correctly placed) which improved the quality of images which meant the number that had to be retaken was minimal. Following a decline in quality the provider had arranged for the X-ray sets to be checked and serviced this resulted in the fault identified in the processing. Changes were made to the dark room which resolved the issue and improved quality.

We looked at a sample of dental care records which documented when X-rays had been taken. When X-rays were taken the records showed the grading the dentist had given the image but did not always record the justification for or the findings of the X-ray. Patients told us that the dentist always explained treatment options to them which included why X-rays were required and what they showed.

Are services effective?

(for example, treatment is effective)

Our findings

Consent to care and treatment

The practice ensured patients were given sufficient information about their proposed treatment to enable them to give informed consent. Staff told us how they explained treatment options with their patients including the risks and benefits of each option. Patients told us the dentist was exceptionally good at explaining their treatment; however we did not see these discussions recorded in patient dental care records. Patients were provided with a written treatment plan for complex or multiple treatments which ensured they were aware of the financial and time commitment of their treatment. Patients were asked to sign a copy of the treatment plan to confirm their understanding and to consent to the proposed treatment. Each patient was given a copy of the practice consent policy and were asked to confirm they had read it. This policy documented what the practice would do if they had doubts about a patient's ability to consent to treatment. However this did not make reference to the Mental Capacity Act 2005. Staff had not had formal training in mental capacity. They were clear about how they would deal with a situation, should it arise, but were not sure of the requirements under the Act.

Patients told us they always felt fully informed about their treatment and they were given time to consider their options before giving their consent to treatment.

Monitoring and improving outcomes for patients

All patients had a current medical history recorded when they attended for examination, and these were updated at each visit. Patients told us the dentist always asked if there had been any changes to medical conditions or any medicines they were taking. This information was recorded in the dental care record with any relevant medical condition highlighted on the front of the record. The dentist was aware of any medical issues which could affect the planning of a patient's treatment.

We looked at a sample of dental care records; these enabled us to see the information recorded for each examination. The dentist had recorded their examination of soft tissues and teeth. There was no record of the checks of patients' gingival (gum) health. The British Society of Periodontology guidelines are that each patient should be assessed for gum health and a Basic Periodontal Examination (BPE) carried out which should be followed up with more in depth assessments for those who would require specialist treatment. Without a BPE or a similar assessment it would be difficult to monitor patients gum health or plan their treatment. Diagnostic tests, such as radiographs (x-rays), were carried out if they were clinically necessary. The results were discussed with the patient. Patients told us they were aware of the dentist carrying out an examination of their whole mouth. They said the dentist explained what they were doing and why.

Patients told us they found the treatment they had received successful and effective. Staff confirmed that there were few if any treatments that had to be repeated because the restoration had failed.

Working with other services

The practice referred patients for secondary (hospital) care when necessary. For example for assessment or treatment by oral surgeons. Referral letters contained detailed information regarding the patient's medical and dental history.

The dentist explained the system and route they would follow for urgent referrals if they detected any problems during the examination of a patient's soft tissues. The hygienist explained how advanced periodontal cases were referred for specialist treatment. (Periodontics is the specialty of dentistry concerned with gum health and the supporting structures of teeth, as well as diseases and conditions that affect them)

Health promotion & prevention

A dental hygienist and a dental therapist worked at the practice, each on a part time basis. They and the dentist provided patients with advice to improve and maintain good oral health. Patients told us that they were well informed about the use of fluoride paste and the effects of smoking on oral health.

The dental hygienist and dental therapist focused on treating gum disease and giving advice about the prevention of decay and gum disease including advice on tooth brushing techniques and oral hygiene products. Information leaflets on oral health were given out by staff.

Staffing

The practice had systems in place to support staff to be suitably skilled to meet patients' needs. Staff kept a record of all training they had attended; this showed staff had the right skills to carry out their work. The provider was aware of the training their staff had completed even if this had

Are services effective?

(for example, treatment is effective)

been done in their own time. Most staff had carried out annual medical emergencies and basic life support training. They trained together at the practice to ensure they knew their roles and responsibilities should an emergency arise.

Records showed staff were up to date with their continuing professional development (CPD). (All people registered with the General Dental Council (GDC) have to carry out a specified number of hours of CPD to maintain their registration.) Staff records showed professional registration was up to date for all staff and they were all covered by personal indemnity insurance.

Dental nurses worked part time and were flexible in their ability to cover their colleagues at times of sickness. We were told there had been no instances of the dentist working without appropriate support from a dental nurse. However the hygienist and therapist who worked at the practice always worked unaccompanied; there was no risk assessment in place for their lone working.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

During and our visit we spoke with three patients about their care and treatment, we also reviewed 31 comment cards. All patients commented positively about the caring compassionate staff, describing them as friendly, understanding and professional. A large number of patients commented on the happy staff who addressed them politely and cheerfully and the welcoming relaxed atmosphere.

Patients told us they felt listened to by all staff. We observed reception staff interacting with patients before and after their treatment and speaking with patients on the telephone. Although we were able to hear appointment arrangements being made we did not hear any personal information discussed during our observations in the waiting room. Reception staff were polite and friendly in all situations.

On the day of our visit one dentist was working at the practice. All treatment was carried out with the treatment room doors closed. People's privacy and confidentiality was maintained.

Involvement in decisions about care and treatment

Patients who used the service were given appropriate information and support regarding their care or treatment. Everybody told us the dentist they saw discussed the treatment options available to them. They felt their dentist explained the treatment they needed in a way they could understand. They told us they understood the risks and benefits of each option. Patients were given written treatment plans for complex treatment which clearly documented the proposed treatment and related costs. Patients told us that although they did not always get a written treatment plan for single items of treatment they had sufficient information about the treatment they would be receiving and the associated costs.

Patients told us they felt involved at every stage with the planning of their treatment and also during treatment. They all felt confident in the treatment, care and advice they were given. We looked at the dental care records for 11 patients. Records showed that, when necessary, patients had been given relevant information including the risks and benefits of complex treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patient's needs

The practice was responsive to the needs of their patients. They provided general dentistry to an established group of patients. Patients were informed of the treatments available at their initial consultation at the practice. Appointment times varied in length according to the proposed treatment and to ensure patients and staff were not rushed. The dentists were supported by a dental hygienist and a dental therapist who met the needs of those patients who needed treatment and support to maintain good oral health.

Staff told us the majority of patients who requested an urgent appointment would be seen within 24 hours. Patients we spoke with confirmed this.

Tackling inequity and promoting equality

The treatment rooms at the practice were on the ground floor and first floor. The waiting room and toilet were on the ground floor and were accessible to patients who had mobility difficulties. We received feedback from a patient with mobility issues who told us the practice ensured all their treatment was carried out in the ground floor surgery.

The reception desk was at a low level that suited all patients. A chair by the desk was positioned to help those patients who had to sit to complete paperwork or payments. There was a low level reception desk for the benefit of patients in wheelchairs.

Access to the service

Opening hours varied each day 9:00a.m – 5:00p.m Monday, Tuesday and Thursday and 9:00a.m to 4:00p.m Wednesday and Friday. The practice also offered Saturday morning appointments 9a.m – 1p.m one Saturday each month. Outside these hours the practice answer phone directed patients to call the dentist's personal telephone number if they had a dental emergency.

Staff told us all patients who requested an urgent appointment would be seen within 24 hours. They would see any patient in pain, extending their working day if necessary. Staff gave us examples of the dentist coming into the practice out of hours to see a patient in an emergency. The dental nurses were also able to come into the practice at short notice to support the dentist.

Concerns & complaints

The practice had a complaints handling policy which provided staff with clear guidance about how to handle a complaint. Staff told us how they would raise any comments or concerns immediately with the dentist, who was also the provider of this service, to ensure a timely response was given.

We discussed the practice procedure for acknowledging, recording; investigating and responding to complaints, concerns and suggestions should they be made by patients. However there had been no comments or complaints made by patients in recent years.

Information for patients about how to raise a concern or make a complaint was posted on the wall in the reception area. Patients told us they were aware they could make a complaint. They would feel comfortable discussing concerns with any member of staff but had not had any reason to complain about the service.

Are services well-led?

Our findings

Leadership, openness and transparency

There was clear leadership in the practice. The principal dentist who was also the provider of this service provided clinical leadership to all staff. They were also responsible for human resources, policies, procedures and risk assessments. We found that policies, procedures and risk assessments were in place to support the running of the service; however some of these were not dated or had not been reviewed so it was not clear if they reflected current practice. For example, the risk assessment for Legionella was not dated so it was not possible to assess if this was a true reflection of current risks. Staff were following current guidance in infection control, however the infection control policy had not been reviewed. We found the policy did not reflect current guidance or the layout of the practice building. The lack of review meant that this had not been identified and amended. The provider delegated lead roles, for example, infection control and complaints management to suitably qualified and experienced members of staff.

Staff told us there was an open culture at the practice and they felt valued and well supported. They told us the provider was very approachable. There were informal arrangements for sharing information across the practice including general discussions amongst the small staff team at lunchtime or other break times. Staff told us that the close working relationship enjoyed by all staff within the practice helped them to make suggestions, share ideas and to provide feedback to the provider.

Governance arrangements

The principal dentist was the provider of the service and was responsible for the day to day running of the service. They led on the individual aspects of governance such as risk management and audits within the practice. There were some systems in place to monitor the quality of the service. For example the infection control procedures had been audited and changes made to improve practice. There was on going monitoring of X-rays to ensure consistent quality. However there was no audit plan and no monitoring of clinical practice or record keeping, which could be used to make improvements to the service.

There were systems in place for the monitoring of emergency medicines and equipment however these had not been effective in identifying shortfalls in the equipment recommended for use in an emergency. We found filling materials and equipment in the treatment rooms which had passed their expiry date. There was no system of stock control to prevent this happening. When raised with the provider these items were immediately removed.

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

Patients who used the service had been asked for their views about their care and treatment. The practice sought continuous patient feedback and conducted annual patient satisfaction surveys. The most recent survey conducted in January 2015 showed that patients were satisfied with the service and the treatment they had received. All comments were positive with two respondents making suggestions. These suggestions were that they would like more information left on the practice answerphone and another that the décor in the waiting room could be improved. The provider had acted on the suggestions. They had organised for redecoration to be started in late February 2015 and the answerphone message had been updated with the opening hours and the dentist's contact telephone number for emergency treatment.

Staff told us they were always involved in discussions about changes to the practice and were able to make suggestions for improvements at any time. Staff were given the opportunity to make suggestions for improvements to the practice and this was actively encouraged.

Management lead through learning and improvement

Staff told us they had good access to training and the practice monitored staff training to ensure essential training was completed each year. Staff working at the practice were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC). It is a requirement of the GDC that all people registered with them complete a specified number of hours of CPD, including training in medical emergencies, to maintain their registration. Personal training records showed all but one member of staff had taken part in basic life support. This training was organised on a regular basis by the practice and included role play and practise of simulated medical emergencies.

Are services well-led?

Practice staff did not take part in a system of appraisal. They all commented that they openly discussed their training needs and could always request a meeting if they had any concerns or problems. Staff told us that they shared learning with each other after attending, or completing online, training.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The provider had not taken proper steps to protect patients by means of carrying out an assessment of their needs and planning and delivering their care and treatment in such a way as to reflect published research evidence and guidance as to good practice in relation to care and treatment. The provider did not have procedures in place for dealing with emergencies which are reasonably expected to arise. Regulation 9 (1) (a) (b) (iii) (2) How the regulation was not being met: The practice did not have the equipment recommended for the safe management of medical emergencies. The provider did not follow professional guidance in relation to the monitoring of periodontal health. The justification for the taking of X-rays was not routinely recorded.