Astek Dental Laboratory Limited

Astek Dental Centre

Inspection Report

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Date of inspection visit: 6 February 2017
Date of publication: 10/03/2017

Overall summary

We carried out an announced comprehensive inspection on 6 February 2017 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

Astek Dental operates from a converted commercial property and provides private dentistry for adults. The practice did not see children. The practice is situated in the town of Leatherhead Surrey. There are two dental treatment rooms and a separate room for the cleaning and reprocessing of dental instruments. The practice has an in-house dental laboratory that manufactures dental appliances such as dentures, crowns and bridges that form part of the patient's dental treatment.

The practice employs three dentists, a clinical dental technician who can carries out the clinical stages of denture construction, one dental nurse and a practice manager who undertakes reception duties.

The practice opens Monday to Friday between 9.00am and 5pm.

There are arrangements in place to ensure patients receive urgent dental assistance when the practice is closed. This is provided by an out-of-hours service. If patients called the practice when it was closed, an answerphone message leaves a telephone number for patients to ring depending on their symptoms.

The practice owner 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.

The inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

Before the inspection we sent Care Quality Commission (CQC) comments cards to the practice for patients to complete to tell us about their experience of the practice. We collected 14 completed cards. All the comments from patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

Our key findings were:

- We found that the practice ethos was to provide patient centred dental care in a relaxed and friendly environment.
- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were systems in place to reduce and minimise the risk and spread of infection.
- The practice had safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- There was a system in place for reporting incidents.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- The practice maintained a system of policies and procedures, however there were shortfalls within the system. This included files containing policies and procedures from several different compliance systems which led to confusion with respect to operating practice policies, procedures and protocols.

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

- Ensure the practice's infection control procedures and protocols are suitable giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- Ensure the practice undertakes a Legionella risk assessment and implements the required actions giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'
- Ensure that the practice is in compliance with its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000.
- Ensure that a policy is in place for dealing with vulnerable adults.

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

- Consider providing an annual statement in relation to infection prevention control required under The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance is prepared.
- Review the storage of products identified under Control of Substances Hazardous to Health (COSHH) 2002 Regulations to ensure they are stored securely.

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?

No action

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

The practice had arrangements in place for infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). However, we did find shortfalls with respect to the decontamination room. We found that all the equipment used in the dental practice was properly maintained. Staff received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

Are services effective?

No action

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

The dental care provided was evidence based and focused on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals. The staff received professional training and development appropriate to their roles and learning needs. Staff where appropriate were registered with the General Dental Council (GDC).

Are services caring?

No action

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

Staff were focussed on a 'patient centred' approach to treating patients. They were aware of the importance of protecting patients' privacy and dignity. We observed staff were welcoming and helpful when patients arrived for their appointment or made enquiries over the phone. The comments cards we received all made positive remarks about the staff's caring and helpful attitude.

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. The patient feedback we received via comments cards confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

Are services responsive to people's needs?

No action

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

Summary of findings

Patients were able to access treatment within a reasonable time frame and had adequate time scheduled with the dentist to assess their needs and receive treatment. The practice treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions.

The practice had a complaints procedure that explained to patients the process to follow. The practice followed the correct processes to resolve any complaints.

Are services well-led?

We found that this practice was not providing well-led care in accordance with the relevant regulations.

Although the clinical care provided by the dentists and the clinical dental technician led to good patient outcomes, there were shortfalls in the clinical governance systems and processes underpinning the clinical care.

Areas of concern were the organisation of policies and procedures from different compliance systems which led to confusion with respect to operating practice policies, procedures and protocols. This led to shortfalls in the maintenance of a policy in relation to recruitment, vulnerable adults and a lack of a risk assessment in relation to Legionella. Policies such as health and safety and RIDDOR were not applicable.

Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the management team. They were confident in their abilities to address any issues as they arose.

Requirements notice ✖

Astek Dental Centre

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 6 February 2017. The inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

During our inspection visit, we reviewed policy documents and staff training and recruitment records. We spoke to four members of staff, conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the systems that supported the patient dental care records.

We reviewed 14 Care Quality Commission (CQC) comment cards that had been completed by patients in the two weeks prior to our inspection. All the comments were positive.

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 an incident reporting system in place along with forms for staff to complete when something went wrong, this system also included the reporting of minor injuries to patients and staff. We did note that although the practice had in place a policy document in place for RIDDOR (The reporting of injuries diseases and dangerous occurrences regulations) this had not been personalised to the practice. It had simply been downloaded from the Health and Safety Executive.

Reliable safety systems and processes (including safeguarding)

We spoke to a dental nurse about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current EU directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne diseases. The practice used a system whereby needles were not manually resheathed using the hands following administration of a local anaesthetic to a patient. The practice used a special safety syringe for the administration of dental local anaesthetics to prevent needle stick injuries from occurring. Dentists were responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur. The systems and processes we observed were in line with the current EU directive on the use of safer sharps.

We asked staff how they treated the use of instruments used during root canal treatment. They explained that these instruments were single patient use only. They also explained that root canal treatment was carried out where practically possible using a rubber dam. (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). Patients can be assured that the practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam.

The practice had a policy and procedures in place for child protection, however we did note that there was no written policy in place for safeguarding vulnerable adults. We did see contact details for the local authority safeguarding team, social services and other agencies, such as the Care Quality Commission. The provider acted as the lead for safeguarding and all the staff we spoke with were aware of this. The dentist we spoke with demonstrated they had a good understanding of what they needed to do if they suspected potential abuse.

We saw evidence that staff had completed safeguarding training to the appropriate levels and staff we spoke with were able to describe what might be signs of abuse or neglect and how they would raise concerns with the safeguarding lead. There had been no safeguarding issues reported by the practice to the local safeguarding team.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Staff had received training in how to use this equipment. The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had access to oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines and oxygen we saw were all in date and stored in a central location known to all staff. The practice held training sessions each year for the whole team so that they could maintain their competence in dealing with medical emergencies.

Staff recruitment

The practice employs three dentists, a clinical dental technician who can carries out the clinical stages of denture construction, one dental nurse and a practice manager who undertakes reception duties.

There was no recruitment policy in place and when we reviewed all the available recruitment files for staff members, we noted there was no file for one of the dentists that had been working in the practice for over five years. The practice manager told us they had contacted the dentist during our inspection to request all the necessary documents.

Are services safe?

For the files that were available, we saw that relevant checks to ensure that the person being recruited was safe and competent for the role had been carried out. This included DBS checks for all members of staff, a check of registration with the General Dental Council (GDC) where appropriate, references, ID checks and employment profiles. All staff were up to date with their Hepatitis B immunisations and records were kept on file. (The DBS checks 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).

Monitoring health & safety and responding to risks

The practice had some arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice maintained a system policies and risk assessments for fire safety, general health and safety. The practice had in place a Control of Substances Hazardous to Health (COSHH) file. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients.

We did find that there was no process in place to receive national patient safety alerts such as those from the Medicines and Healthcare Regulatory Agency (MHRA).

Infection control

There were systems in place to reduce the risk and spread of infection within the practice. However, there were shortfalls in the infrastructure supporting infection control, these were associated with the decontamination rooms used to process contaminated instruments.

The practice used one room for pre-sterilisation cleaning and another one for sterilisation of the pre-cleaned instruments. We found that the pre-sterilisation cleaning room was cluttered and untidy with cleaning materials and chemical cleaning agents not securely stored in accordance with COSHH regulations. We noted on the day of our inspection that a staff member had eaten food and drink within this area.

The room used for packaging of pre-cleaned instruments prior to sterilisation contained the steriliser, stored processed instruments used for the placement of dental implants and sand blasting equipment. This resulted in the area having a layer of fine sand on working surfaces and in the cupboards used to store processed instruments. There was also an air extraction hood over the steriliser which was visibly dusty. We also noted that the flooring was in poor condition which prevented effective cleaning along with disused cardboard boxes stored on the floor.

Although the practice had carried out an audit of infection prevention control, the issues we found were not highlighted and addressed by the completed audit tool.

We saw that the dental treatment room in use, waiting area, reception and toilet were visibly clean and tidy. Clear zoning demarking clean from dirty areas was apparent in the treatment room. Hand washing facilities were available including liquid soap and paper towel dispensers were available. Hand washing protocols were also displayed appropriately in various areas and bare below the elbow working was observed.

The drawers of a treatment room were inspected and these were clean, ordered and free from clutter. Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

The dental nurse we spoke with described to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. They demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

We found that a Legionella (Legionella is a term for particular bacteria which can contaminate water systems in buildings) risk assessment had not been carried out at the practice by a competent person. However, we did note that the dental water lines were maintained to prevent the growth and spread of Legionella bacteria and staff described the method they used which was in line with current HTM 01 05 guidelines.

The practice used a system of manual scrubbing using the two-sink arrangement (one sink for scrubbing and one sink for rinsing) for the initial cleaning process, following inspection; the instruments were placed in an autoclave (a device for sterilising dental and medical instruments). The

Are services safe?

practice used a vacuum steriliser so manually cleaned instruments were pouched before they were sterilised. All pouches were dated with an expiry date in accordance with current guidelines.

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

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. This was stored in a separate locked room adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection.

We saw that general environmental cleaning was carried out according to a cleaning plan developed by the practice.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclave had been serviced and calibrated in March 2016 and was due to be tested and calibrated again in march 2017. The practices' X-ray machine had been serviced and calibrated as specified under current national regulations in May 2014 and was due to be tested again in May 2017. Portable appliance testing (PAT) had been carried out in February 2015 and the practice compressor had been serviced in June 2016.

Radiography (X-rays)

We were shown documentation in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). Included in this documentation were 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 and a copy of the local rules. However, we did note that the local rules were out of date because they did not reflect changes in personnel.

We saw that the practice carried out a quality assurance system for dental X-rays. Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentist we spoke with carried out consultations, assessments and treatment in line with recognised general professional guidelines. The dentist described to us how they carried out their assessment of patients for routine care. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. 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. Following the clinical assessment, the diagnosis was then discussed with the patient and treatment options explained in detail.

Where relevant, preventative dental information was given to improve the outcome for the patient. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Dental care records that were shown demonstrated that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums). These were carried out where appropriate during a dental health assessment.

Health promotion & prevention

The practice was very focussed on the prevention of dental disease and the maintenance of good oral health. The dentist we spoke with explained that patients at high risk of tooth decay were identified and were offered fluoride varnish applications or the prescription of high concentrated fluoride tooth paste to keep their teeth in a healthy condition. Other preventative advice included tooth brushing techniques explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area.

Staffing

Staff we spoke with told us staffing levels were suitable for the size of the service and they received appropriate professional development and training. We checked some of the staff recruitment files and saw that this was the case. The training covered all of the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, safeguarding, infection control and X-ray training.

There was a written induction programme for new staff to follow and evidence in the staff recruitment files that this had been followed at the time of their employment.

Working with other services

Dentists could refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as oral surgery.

Consent to care and treatment

The dentist explained how they implemented the principles of informed consent; the dentist had a very clear understanding of consent issues. They explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they understood their treatment options.

The dentist went onto explain how they would obtain consent from a patient who suffered with any mental impairment that may mean that they might be unable to fully understand the implications of their treatment. They went on to say they would involve relatives and carers if appropriate to ensure that 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

Treatment rooms were situated away from the main waiting areas and we saw that doors were closed always when patients were with the dentist. Conversations between patients and dentists could not be heard from outside the treatment rooms which protected patient's privacy. Patients' clinical records were stored in paper form. Paper records were stored in locked metal filing cabinets to prevent unauthorised access by the public. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality.

The Care Quality Commission comments cards we received all made positive remarks about the staff's caring and helpful attitude. They all described a very positive view of the service the practice provided. Patients indicated that they felt comfortable and relaxed with their dentist/clinical dental technician and that they were made to feel at ease during consultations and treatments. Patients who were nervous about dental treatment indicated that their dentist was calm, listened to their concerns, and gave them reassurance throughout the processes of the dental treatments. We also observed staff were welcoming and helpful when patients arrived for their appointment or made enquiries over the phone.

Patients commented that the whole team were welcoming, professional, caring, respectful and friendly. They were very happy with the quality of treatment provided. During the inspection we observed the general atmosphere in the practice was calm, welcoming and friendly.

All the staff we spoke with were focussed on a 'patient centred' approach to treating patients. They were aware of the importance of protecting patients' privacy and dignity. We observed that staff always kept the treatment room doors closed when patients were in the room.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. Leaflets were available that detailed the costs of private treatment. The dentist we spoke with paid attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them.

The patient feedback we received via comments cards confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We looked at examples of information available to people. We saw that the practice waiting area displayed a wide variety of information including leaflets about the services the practice offered, how to make a complaint and information about maintaining good oral health. The practice website also contained useful information to patients such as details about each dentist and the services provided.

The practice had a system in place to schedule enough time to assess and meet patients' needs. The dentist could decide on the length of time needed for their patient's consultation and treatment. The staff we spoke with told us they scheduled additional time for patients depending on their knowledge of the patient's needs, including scheduling additional time for patients who were known to be anxious or nervous.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. Staff told us that they could provide written information for people who were hard of hearing and use large print documents for patients with some visual impairment.

We asked staff how they would support patients that had difficulty with hearing or vision. They explained how they would face the patient and speak slowly and clearly especially for someone who had hearing difficulties to allow the patient to lip read. Staff told us they would assist a blind patient or any patient who had difficulty with mobility by physically guiding and holding their arm if needed.

The practice had made reasonable provision for patients using wheelchairs although we noted the toilet facilities were not fully accessible. The practice had a wide entrance door and when entering the practice there was a level floor leading to the reception area, waiting area and ground floor treatment room.

Access to the service

The practice opens Monday to Friday between 9.00am and 5pm.

The practice displayed its opening hours on their premises, on the practice website and in the practice information leaflet available in the waiting area.

We asked the staff about access to the service in an emergency or outside of normal opening hours. They told us the answer phone message gave details about how to access out-of-hours emergency treatment.

Concerns & complaints

There was a complaints policy which described how the practice handled formal and informal complaints from patients. Information about how to make a complaint was available in the reception area and in the practice information leaflet. The staff explained if patients were not happy they could discuss the issues with the practice manager so the problem could be resolved quickly and amicably. The practice told us they had not received any complaints within last year that needed investigating or a formal response.

Are services well-led?

Our findings

Governance arrangements

Although the clinical care provided by the dentists and the clinical dental technician led to good patient outcomes, there were shortfalls in the clinical governance systems and processes underpinning the clinical care.

Areas of concern were the organisation of policies and procedures from several different compliance systems which led to confusion with respect to operating practice policies, procedures and protocols. This led to shortfalls in the maintenance of a policy in relation to vulnerable adults and a lack of a risk assessment in relation to Legionella. Policies such as health and safety and RIDDOR were not personalised to the practice and had been downloaded from the Health and Safety Executive website. We also found that there was no process in place to receive national patient safety alerts such as those from the Medicines and Healthcare Regulatory Agency (MHRA). We also found that the local rules had not been kept up to date with respect to changes in personnel.

Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the management team. They were confident in their abilities to address any issues as they arose.

Leadership, openness and transparency

The practice ethos focussed on providing patient centred dental care in a relaxed and friendly environment. The comment cards we saw reflected this approach. The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. There was a no blame culture within the practice. They felt they were listened to and responded to when they did raise a concern. We found staff to be caring and committed to the work they did. Staff appeared motivated and enjoyed working at the practice and were proud of the service they provided to patients.

Learning and improvement

The practice carried out clinical audits, these included infection control and X-ray quality. However the infection control audit had not identified the issues we found in the rooms dedicated for cleaning instruments. Although the staff had received training in infection control this was not demonstrated when reviewing the environment for cleaning and storing the instruments. We saw no evidence of systems to identify staff learning needs which were underpinned by an appraisal system.

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

The practice gathered feedback from patients on an ongoing basis through patient questionnaires kept at the reception desk. They reviewed responses and comments as they came in. The practice shared the comments that had been received in 2016. Patients commented; they would recommend the practice to friends and family, the practice was clean, dental team were very friendly and professional and the dentists were good at putting patients at ease when they arrive anxious and nervous.

Staff told us that the management team were open to feedback regarding the quality of the care.

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 (1)(2) (b),(d)** **Good governance** The registered person did not have effective systems in place to ensure that the regulated activities at the Astek Dental Centre were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: • The infection control audit had not identified the shortfalls in the rooms dedicated for cleaning instruments. These shortfalls included using sand blasting equipment in the decontamination room which resulted in the area being visibly dusty and the flooring not being fully sealed. • Legionella risk assessment had not been carried out at the practice by a competent person • There were no systems to identify staff learning needs which were underpinned by an appraisal system. • The provider had no recruitment policy in place and had not kept any of the recruitment checks for one of the dentists working in the practice. • Policies such as health and safety and RIDDOR were not personalised to the practice. • There was no policy in place for dealing with vulnerable adults. • There was no process in place to receive or review national patient safety alerts such as those from the Medicines and Healthcare Regulatory Agency (MHRA). • The local rules for radiology equipment had not been kept up to date with respect to changes in personnel.