Dhody's Ltd

Dhody's

Inspection Report

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Overall summary

We carried out an unannounced comprehensive inspection on 19 January 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Dhody's Ltd is a relatively new dental practice which has provided private treatment for around two years mainly for adults. Children are seen free of charge if the parent is a patient of the practice. The practice is situated in a converted commercial property. The practice has one dental treatment room and a separate decontamination area adjacent to the treatment room for cleaning, sterilising and packing dental instruments. Dental care was provided on the ground floor which also has a reception and waiting area.

The practice is open 9.00am to 8:00pm Monday to Friday. The practice had one dentist who was supported by a trainee dental nurse/practice manager a part time dental hygienist and a receptionist.

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'. 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 registered manager was supported in their role by a practice manager who is also training to be a dental nurse

Our key findings were:

Summary of findings

- The practice had a safeguarding policy in place with processes for escalating safeguarding issues for children and adults should the need arise.
- The practice had a system in place for recording incidents with the practice meeting used as the vehicle for shared learning. No incidents were recorded in 2015.
- A Infection control policy was in place and procedures followed mainly reflected published guidance. We highlighted areas for improvement during the inspection and these were dealt with promptly by the practice manager.
- The dentist received annual update training to handle emergencies in the dental chair.
- Emergency equipment for dealing with medical emergencies in the dental chair mainly reflected published guidelines. We found a number of shortfalls and these were dealt with promptly by the practice manager whilst we were on site and shortly after we left.
- We saw that when a recent member of staff was recruited important pre-employment checks were undertaken in accordance with current regulations.
- The dentist provided dental care in accordance with current professional and National Institute for Care Excellence (NICE) guidelines.
- We sought the view of patients on the day of our visit and they reported that the standard of care was good.
- The service was aware of the needs of the local population and considered these in how the practice was run.
- Patients could access treatment and urgent and emergency care when required.
- The dentist had received regular continued professional development (CPD) in accordance with maintaining their professional registration.
- The practice captured patient feedback using an on line format, we noted that the practice responded to each of the comments posted on line.
- The small size of the dental team meant that there was a possibility of professional isolation occurring in the practice. It was also apparent that these factors posed difficulties in terms of keeping abreast with contemporary systems of dental practice management.

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

- Ensure availability of medicines and equipment to manage medical emergencies giving due regard to guidelines issued by the British National Formulary, the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Ensure the practice's infection control procedures and protocols giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance
- Ensure an effective system is established to assess, monitor and mitigate the various risks arising from undertaking of the regulated activities.
- Ensure systems in place to assess, monitor and improve the quality of the service are effective and where appropriate audits have documented learning points and the resulting improvements can be demonstrated.

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

- Consider accessing professional assistance to help with the management of the practice and obtaining peer support such as that available through the various professional associations available for dentists and practice managers.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

We found areas that required improvements relating to the safe provision of treatment. This was because the provider did not have all recommended equipment to deal with medical emergencies in the event of an emergency occurring. We observed that some elements of the infection control processes required improvement; this included the standard of general environmental cleaning in the practice and the control of clutter in various areas of the practice.

We found that the equipment used in the dental practice for infection control and radiography was maintained according to the manufacturer's instructions. The practice were aware of the importance of identifying, investigating and learning from patient safety incidents. The dentist had received safeguarding training and was aware of their responsibilities regarding safeguarding children and vulnerable adults.

Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. The dentist received professional training and development appropriate to their role and learning need. Staff where appropriate, were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

Are services caring?

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

We obtained the views of nine patients on the day of our visit. These patients provided a positive view of the service the practice provided. Patients commented that the quality of care was very good. Patients commented on friendliness and helpfulness of the staff and dentist was good at explaining the treatment that was proposed and put them at their ease. The views of patients posted on line also reflected this view.

Are services responsive to people's needs?

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

The service was aware of the needs of the local population and considered these in how the practice was run. Patients could access treatment and urgent and emergency care when required. Patients had access to telephone interpreter services when required and the practice manager spoke several languages of the Indian sub-continent to help patients from these areas whose first language was not English. The practice had a ground floor treatment room and level access into the building for patients with mobility difficulties and families with prams and pushchairs.

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).

We found that improvements could be made to improve the way in which the practice was run. Although the practice had in place a governance structure that included a suite of policies, we were not fully assured that all of the policies were being successfully implemented or fully understood by the practice team.

Summary of findings

For example, we found that the practice did not have all of the recommended equipment for dealing with medical emergencies and environmental cleaning in relation to preventing clutter was lax. Although audit was being carried out improvements could be made to the audit process showing learning points and resulting improvements. To assist in the improvement of the overall management and running of the practice, the registered manager and practice manager could access additional professional support to help with the management of the practice.

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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.

We had received concerning information that related to concerns about infection prevention control at this practice and aspects of the conduct to the provider.

The inspection took place on 19 January 2016 and was the inspection was led by a CQC inspector and supported by a dental specialist advisor.

During the inspection, we spoke with the registered manager, practice manager/trainee dental nurse and receptionist and reviewed policies, procedures and other documents. We also obtained the views of nine patients on the day of our visit.

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 in place a system for recording incidents occurring in the practice. We observed a protocol and incident reporting forms and saw that there had been no incidents during 2015. We saw examples of staff meeting minutes that showed that provision was made to share learning with staff members should incidents occur. The practice governance system showed a system was in place to identify how materials under the Control of Substances Hazardous to Health (COSHH) should be used during the provision of dental treatment. We saw a set of COSHH data sheets detailing how the materials should be used along with the risks to users and patients and how problems associated with these materials would be managed. The practice also had a system in place to receive national alerts such as those issued by the medicines and healthcare products regulation authority (MHRA).

Reliable safety systems and processes (including safeguarding)

We spoke to the registered manager and trainee dental nurse about the prevention of needle stick injuries. Generally, the systems and processes we observed were in line with the current EU Directive on the use of safer sharps. However, we did find that the sharps bin appeared rather full and was in need of replacement. The practice used a system whereby needles were not resheathed using the hands following administration of a local anaesthetic to a patient. The dentist was responsible for ensuring safe recapping using dental tweezers, which they demonstrated, to us. The provider trialled a single use local anaesthetic delivery system; however, they found they preferred their current method. A protocol was displayed in the decontamination area describing how a sharps injury should be managed. The practice explained to us the occupational health arrangements that were in place should such an injury occur.

We saw that a rubber dam kit was available for use when the dentist carried out 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). Patients can be assured that the practice followed appropriate guidance by the British Endodontic Society in relation to the use of the rubber dam. We also saw that the practice held ample stocks of single use root canal instruments.

We saw that a policy was in place for staff to refer to in relation to children and adults who may be the victim of abuse or neglect. Training records showed that the registered manager had received appropriate safeguarding training for both vulnerable adults and children in 2013. Information was displayed in the reception that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations.

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. The practice had in place emergency medicines for dealing with common medical emergencies in a dental practice. There was one shortfall. The practice used diazepam instead of midazolam the medicine of choice as set out in the British National Formulary for dealing with a patient suffering from an epileptic seizure. We also noted that the diazepam was out of date. We pointed this out to the practice manager who assured us that the correct medicine would be replaced as soon as possible. We also found that although the oxygen cylinder was full, the tank had exceeded its expiry date and we noted that some of the manual breathing aids and portable suction recommended by the Resuscitation Council UK was not available. Again, the practice manager assured us that a new tank and the required breathing aids and portable suction would be purchased as soon as possible. We received documentary evidence within two days of the inspection that a new contract with a supplier had been put into place and this included the provision of the full range of breathing aids recommended by the Resuscitation Council UK and midazolam had been ordered. Minutes from practice meetings showed that common medical emergency scenarios were discussed regularly within the team and was led by the registered manager, who also received

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annual update training. We saw that the expiry dates of medicines and equipment were monitored using a weekly check sheet, however this was not effective due to the fact that we saw two out of date items.

Staff recruitment

The practice had a recruitment policy that detailed the checks required to be undertaken before a person started work.For example, proof of identity, a full employment history, evidence of relevant qualifications, immunisation status and references. We looked at an example of the recruitment process for a new member of staff who was about to join the practice, a dental nurse. Records we saw confirmed that the individual had been recruited in accordance with the practice's recruitment policy. The systems and processes we saw were in line with the information required by Regulation 18, Schedule 3 of Health & Social Care Act 2008 (Regulated Activities) Regulations 2015. We saw that all staff working in the practice on the day of our visit had received a criminal records checkthrough the Disclosure and Baring Service (DBS).

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice carried out a number of risk assessments including a well-maintained Control of Substances Hazardous to Health (COSHH) file, radiation, fire safety, health and safety. However we were not assured that the practice understood the impact that the clutter we found, including multiple carboard boxes stored on the floor in the decontamination room and the room where the clinical waste was stored prior to collection had on fire safety and the ability to clean these areas effectively.

Infection control

Although the cleaning process for instruments described to us showed that the practice was meeting essential quality requirements of HTM 01 05 (national guidance for infection prevention control in dental practices') we did find areas that could be improved. It was noted for example that although the waiting area and toilets were clean, tidy and clutter free; the treatment room, decontamination area and a storage room were rather cluttered and untidy, the floors also showed signs of debris. However, this was dealt with by the end of our visit by the cleaner who carried out a thorough clean of the practice. Although a cleaning plan was in place, it appeared the practice cleaner came in only once per week.

Hand washing facilities were available including liquid soap and paper towel dispensers in each of the treatment room and toilet. Hand washing protocols were also displayed appropriately in various areas of the practice.

The drawers of the treatment room were inspected; we found appropriate single use items including suction and three in one tips. However some of the drawers were cluttered and there were some loose local anaesthetic syringes in one drawer, although we were assured that these would be either used by the end of the clinical session or reprocessed. We noted that the appropriate routine personal protective equipment available for staff use and was being worn during treatment, this included protective gloves and visors. However, we did note that the trainee dental nurse was wearing everyday clothes when supporting the dentist rather than an appropriate uniform and shoes and their hair was not tied back. We did point this out and we were told the uniform was in the wash.

The practice manager and registered manager 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.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings) they described the method used which was in line with current HTM 01 05 guidelines. A Legionella risk assessment had been carried out by the property owner of the building but the practice did not have the assessment at hand. However, the practice manager informed the practice intended to obtain their own assessment. The practice manager assured us this would carried out as soon as possible. Within two days of our inspection, we had received documentary evidence that a new Legionella risk assessment had been booked to take place in early February 2016.

Are services safe?

The practice had a separate decontamination area adjacent to the treatment room for instrument processing. This room was appropriately zoned into dirty and clean areas; however, we found the floor was cluttered with extraneous boxes and equipment. We also noted that the stainless sink used to scrub and rinse instruments prior to sterilisation was stained with lime scale that gave the appearance of not being clean. We also noted that the rinsing sink contained unprocessed instruments from the previous day's late clinical session. The practice explained that they did not have time to process them at the time. We pointed out that in accordance with HTM 01-05 guidance if there are delays to the reprocessing of instruments due to late finishing, these should be kept moist in a suitable container with a secure lid.

The practice manager demonstrated the process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a defined system of zoning from dirty through to clean.

The practice used a system of manual scrubbing for the initial cleaning process, following inspection with an illuminated magnifier, they were placed in an autoclave (a machine used to sterilise instruments). When instruments had been sterilized, they were pouched or if stored unpouched they were appropriately stored until required. 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 was working effectively. It was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were always complete and up to date.

The practice used an appropriate contractor to remove dental waste from the practice and this waste was stored in a separate room prior to collection, however the floor of this room was cluttered with a number of cardboard boxes not related to clinical waste and could constitute a fire or trip hazard. Waste consignment notices were available for inspection.

The practice employed a cleaner on a weekly basis to carry out the environmental cleaning of the practice and we saw cleaning plans that the cleaner followed. We noted that the practice followed the National Patient Safety Agency colour coding system, however we did note that the storage of cleaning implements were stored haphazardly and not in accordance with suggested guidelines.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclave was brand new had been calibrated in December 2015. We were assured that the practices' X-ray machine had been serviced and calibrated. However, at the time of our visit we were awaiting documentary evidence from the provider, likewise with the portable appliance electrical testing certificate (PAT). Within two days of our inspection, we received documentary evidence of the critical examination pack for the practice X-ray set and the PAT certificate. The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. However, we did find that local anaesthetic cartridges were stored loose in the drawers rather than the more appropriate blister packs. The practice provided over the counter medicines to patients that were stored in an appropriately locked cupboard and container. We observed that the practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid and mercury spillage.

Radiography (X-rays)

The practice used a system of digital radiography utilising a hand held X-ray set. We were shown documentation that mainly demonstrated that dental radiography was being provided in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). We saw documentation that included the names of the Radiation Protection Advisor and the Radiation Protection Supervisor, Health and Safety Executive notification from October 2013 and the local rules. On the day of our visit, we were not able to observe the critical examination pack, however within two days of our inspection we received documentary evidence of the critical examination pack and the associated test dated March 2014. We observed that the registered manager carried out an audit of dental X-rays, however the format of the audit could be improved by using a methodology suggested by for example the British Dental Association in

Are services safe?

their advice sheet on dental radiography. 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 carried out consultations, assessments and treatment in line with recognised general professional guidelines. They 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 carried out at the start of treatment and subsequently. 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 in order to improve the outcome for the patient. This included dietary advice and general dental hygiene procedures such as 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 either given to each patient or sent by email 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 we reviewed showed 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 is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need).These were carried out where appropriate during a dental health assessment.

Health promotion & prevention

The practice sold a range of dental hygiene products to maintain healthy teeth and gums. These were available in the reception area. In addition to the dentist, the practice used a dental hygienist on each Wednesday to deliver preventive dental care. Adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. Tooth brushing techniques were explained to them 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'. Dental care records we observed demonstrated that dentist had given oral health advice to patients.

Staffing

On the day of our visit, the staffing structure consisted of the dentist, a practice manager who was also a trainee dental nurse and a receptionist. The practice also employed a dental hygienist on a Wednesday. The practice had suffered from staffing difficulties in recent times in that they had difficulty in recruiting and retaining staff.

Working with other services

The dentist was able to 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 or special care dentistry. This ensured that patients were seen by the right person at the right time. We saw records of five referrals that confirmed that patients were referred to other services appropriately. We also saw that when referrals were made by email the patient was copied into this email ensuring the patient was kept informed during the progress of the referral.

Consent to care and treatment

We spoke to the dentist about how they implemented the principles of informed consent. They explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. The dentist explained that following the consultation, the patient would be contacted by email or letter explaining the treatment and the costs to ensure that they had sufficient information to enable them to consent for treatment. The dentist showed us an example of such an email that confirmed that this occurred in practise.

The dentist had received update training in the principles of safeguarding for adults and children

Are services effective?

(for example, treatment is effective)

Including how to 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. This followed the guidelines of the Mental Capacity Act 2005. The training also dealt with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence principles help clinicians to identify children aged under 16 who have the legal capacity to consent to examination and treatment. However, it should be pointed out that the practice treated very few children.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The treatment room was situated away from the main waiting area and we saw that door was closed at all times when patients were with the dentist during our visit. We found that conversations between patient and dentist could not be heard from outside the room ensuring the protection of the patient's privacy. Patients' dental care records were stored mainly as electronic versions with medical histories stored in paper form. The practice computer was password protected and paper records were stored in a lockable cupboard. The computer screen in the treatment room was not overlooked which ensured patients' confidential information could not be viewed by others. On the day of our visit we witnessed patients being treated with dignity and respect by the receptionist when making appointments or dealing with other administrative enquiries. We observed that they were polite and helpful towards patients and that the general atmosphere was welcoming and friendly. We obtained the views of nine patients on the day of our visit. These provided a positive view of the service the practice provided. Patients commented that the quality of care was very good; they also commented that the dentist was caring and put them at ease. We noted that 30 patients had made comments about the caring nature on line. For example one patient commented on the fact that the provider had opened up the practice very late into the evening because the patient was in great pain and was very gentle. Another patient had commented on the professionalism of the provider the the gentleness of the care.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. A poster and patient information leaflets detailing the private treatment costs were displayed in the waiting area. We saw evidence in the records we looked at that the dentist recorded the information they had provided to patients about their treatment and the options open to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We saw that the practice waiting area displayed a variety of information including the practice patient information leaflet. This explained opening hours, emergency 'out of hours' contact details and arrangements and basic treatment costs. We looked at the appointment schedules for patients and found that patients were given adequate time slots for appointments of varying complexity of treatment. Patients were also invited to come and sit and wait should they be in pain. The dentist decided how long a patient's appointments needed to be and took into account any special circumstances such as whether a patient was very nervous, had a disability and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to prevent inequity for disadvantaged groups in society. The practice used a translation service via mobile phone if it was clear that a patient had difficulty in understanding information about their treatment. The practice manager explained that they spoke several languages and would be able to help patients on an individual basis if patients were from the Indian sub-continent and unable to speak English. There was level access into the building and one ground floor treatment room for patients unable to go upstairs.

Access to the service

The practice is open 9.00am until 8:00pm Monday to Friday. The practice provided a 24 hour on call system to give advice in case of a dental emergency when the practice was closed. A telephone number was available and publicised in the practice information leaflet and on the internet when the practice was closed.

Concerns & complaints

The practice had a complaints policy in place. The practice received 3 complaints in 2015 and these were dealt with effectively. On the day of our visit only two of the nine patients we sought the views of definitely knew how to complain if it was found necessary. This may have been because the complaints procedure was not clearly displayed in the patient waiting area.

Are services well-led?

Our findings

Leadership, openness and transparency

Overall leadership of the practice was provided by the dentist who also was the registered manager. Supporting them in this role was the practice manager/trainee dental nurse. We found the dentist to be hard working, caring towards the patients and committed to the work they did. The practice manager was willing to learn and wanted to do the right thing at all times.

Governance arrangements

On the day of our visit, we were shown by the registered manager a system of policies and procedures including infection prevention, complaints handling, radiation, safeguarding, health and safety, staffing and general maintenance of the practice. This system was maintained as an electronic system on their lap top computer. The policies were personalised as far as we could tell to the practice. The registered manager was responsible for the review of these policies. Because the practice was relatively new, the policies did not require immediate review. We saw that the practice maintained other files that showed that they undertook various risk assessments including a fire safety risk, radiation and health and safety. Although the practice had in place this structure, we were not fully assured that all of the policies were embedded in the practice culture. This was illustrated by shortfalls in relation to some infection control procedures including environmental cleaning and the equipment and medicines used to deal with medical emergencies in the dental chair.

Learning and improvement

Although some clinical audit was undertaken in the practice, it was unclear if or how the practice used this information to help improve their practice. For example, X-ray audits did not collate and analyse the percentage of scores for the quality of a sample of radiographs taken by the dentist. The infection control audit indicated that the overall appearance of the practice environment was tidy and uncluttered but we found that this was not the case with respect to the decontamination area the treatment room floor.

We did see that previous staff had undergone a form of appraisal of their performance. For example, we saw that four members of staff had received a type of appraisal using a 'one-to-one' recording sheet that indicated the areas where improvement could be made. We saw that these forms had been completed by the registered manager and practice manager.

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

We noted that there had been staff meetings held during 2015 where there was an opportunity for staff to provide feedback to the registered manager. The practice appeared to use on line feedback using a well-known search engine to assess the quality of care provided. We noted that 30 reviews by patients had been posted on line, all of the responses we looked at were positive about the service provided by the practice. Each review was accompanied by a response by the practice.

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 17.-(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; * Systems in place for the monitoring of infection prevention control procedures as set out in HTM 01 05 were ineffective. * Systems to ensure that equipment and medicines used to deal with medical emergencies in the dental chair did not meet the current requirements set out in the British National Formulary and Resuscitation UK guidelines.