

Primary Medical Services Oral Health

Pre-assessment information request



Please return this information to the inspector directly,
as soon as possible prior to on-site visit.

Location Name:	
Location ID:	
Name of Provider	
Name of Registered or Practice Manager	
Inspection ID number:	

Contact name and details: <i>(Please insert the name of the person completing this form or who we can contact if we need further information)</i>	Name:	
	Telephone:	
	Email:	

Opening hours: <i><days / hours></i>	Monday	
	Tuesday	
	Wednesday	
	Thursday	
	Friday	
	Saturday	
	Sunday	

Please note: The square boxes will show a cross if you click inside them

Staffing and Services provided:

About the practice: Service Type:	Number of dental chairs/surgeries in practice:	
	Corporate/Group practice?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If yes, please specify which group (name)?	
	If known, please specify number of practices in group:	
	NHS <input type="checkbox"/> Private <input type="checkbox"/> Mixed <input type="checkbox"/>	
	Total UDA allocation if providing NHS:	
	CCTV (in or outside) the practice?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Do you have Gas central heating?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Do you use locum staff (nurses/dentists)?	Yes <input type="checkbox"/> No <input type="checkbox"/>

	Do you use a governance toolkit (iComply) If yes which one do you use?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Referral (into) Practice	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Please list specialisms referred into practice:		
Registration Type:	Individual	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Partnership	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Organisation	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Number of CQC registrations at this address:		
	Has there been a recent change in registration?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	If yes – please specify:		
Staffing Numbers:	Please specify staffing numbers:		
	Specialists: (please list)		
	Dentists:		
	Foundation Dentists:		
	Foundation Hygienists/Therapists:		
	Hygienists:		
	Therapist:		
	Qualified Dental Nurses:		
	Trainee Dental Nurses:		
	Reception staff:		
	Treatment coordinators:		
	Administrators:		
	Practice management:		
	Support staff:		
	Visiting staff:		
Other (please list):			
Specialism/ services offered at practice:	Foundation Training	<input type="checkbox"/>	
	In-house sedationist	<input type="checkbox"/>	
	Visiting sedationist	<input type="checkbox"/>	
	Orthodontics	<input type="checkbox"/>	
	Domiciliary	<input type="checkbox"/>	

	Dental Implants	<input type="checkbox"/>	
	Endodontics	<input type="checkbox"/>	
	Oral surgery	<input type="checkbox"/>	
	Clinical Technician	<input type="checkbox"/>	
	Other e.g., shared premises with other healthcare professionals (please list):		
Extended duties:	Radiography	<input type="checkbox"/>	
	Fluoride application	<input type="checkbox"/>	
	Impression taking	<input type="checkbox"/>	
	Oral Health Educator	<input type="checkbox"/>	
	Sedation	<input type="checkbox"/>	
	Intra-oral scanning	<input type="checkbox"/>	
	Other (please list):		
Lead roles:	Role	Name	
	Safeguarding lead:		
	Legionella lead:		
	Fire Safety lead:		
	Infection control lead:		
	Complaints lead:		
	Other (please list):		
Equipment at practice:	Equipment type	Quantity:	
	Intra oral X-ray units		
	Handheld X-ray units		
	Cone Beam Computed Tomography (CBCT)		
	Orthopantomogram (OPG)		
	Laser		
	Ultrasonic baths:		
	Steam Autoclaves:		
	Vacuum Autoclaves:		
	Washer Disinfectors:		
	Statim:		
	DAC:		

	Do you manually clean instruments?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Medicines	Do you dispense medicines? If yes, please specify which medicines:	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Do you offer sedation?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	If yes, who carries out sedation (name)?		
	Please specify which sedation medicine you use:		

Supporting information	Response	Attachment
A copy of your Statement of Purpose (SoP)	N/A	<i>Please attach</i>
How do you ensure your recruitment policy is followed in line with Schedule 3 of the HSC Act 2014		<i>If you have a spreadsheet or equivalent, please attach this, otherwise complete attached doc</i>
How do you have oversight of all staff Continuous Professional Development (CPD)?		<i>If you have a spreadsheet or equivalent, please attach this, otherwise complete attached doc</i>
Continuous improvement	Audit type (name): Infection prevention and control	
	Date last completed:	
	Learning points	Yes <input type="checkbox"/> No <input type="checkbox"/>
	How frequently do you carry out these audits?	
	If yes, how these are shared with colleagues:	
	Audit type (name): Clinical dental care records	
	Date last completed:	
	Learning points	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If yes, how these are shared with colleagues:	
	Audit type (name): Radiographic	
	Date last completed:	
	Learning points	Yes <input type="checkbox"/> No <input type="checkbox"/>
	How frequently do you carry out these audits?	

	Audit type (name): Antimicrobial	
	Date last completed:	
	Learning points	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If yes, how these are shared with colleagues:	
	Audit type (name): Disability Access	
	Date last completed:	
	Learning points	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If yes, how these are shared with colleagues:	
	Audit type (name): Implant failure (where applicable)	
	Date last completed:	
	Learning points	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If yes, how these are shared with colleagues:	
	Audit type (name): Conscious sedation (where applicable)	
	Date last completed:	
	Learning points	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, how these are shared with colleagues:		
Add more audits if necessary		
How do you ensure all of you equipment is maintained and serviced effectively?		
COSHH	Is there a COSHH risk assessment for each COSHH identified product?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Fire Safety	Is there a Fire risk assessment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Who carried out the assessment?	
	Date last completed/reviewed:	
	Any risks highlighted	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Action taken:	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Please detail:	

Legionella	Is there a Legionella risk assessment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Who carried out the assessment?	
	Date last completed/reviewed:	
	Any risks highlighted	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Action taken:	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Please detail:	
Sharps	Is there a Sharps risk assessment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Date last completed/reviewed:	
	Any risks highlighted	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Action taken:	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Please detail:	
Summary of Significant events / accidents last 12 months:		
Summary of complaints last 12 months:		
Summary of how patient feedback is gathered, and practice responds:		
Tell us about what you do well and what you are doing to improve the areas that are presenting you with certain challenges?		
How do you support disabled patients to attend appointments (dedicated parking, ramp, wheelchair accessible WC, hearing loop, vision aids, etc)?		
Summary of barriers for patients to receive treatment, if applicable (access to dental services).		
Are you accepting new patients/emergency new patients?		

Is there parking for 2 cars available at the practice (if not where can we park - postcode)?
Do you have an office or spare surgery we can work in?
How do we find the practice (next to garage, above the chemist, etc)?
How many floors is the practice and what facilities are situated on each floor (i.e. two treatment rooms and decon room on first floor, one surgery and disabled persons WC on ground floor, etc?