M Verma & S Verma Abacus Dental Care

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Inspection Report

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Overall summary

We carried out an unannounced comprehensive inspection on 21 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

M Verma & S Verma Abacus Dental Care is a husband and wife dental team that have taken over the site in the Crownhill area of Milton Keynes one year ago. The practice provides NHS and private general dentistry to adults and children.

In addition to a full range of general dentistry, a visiting dentist to the practice offers dental implants (a metal post placed surgically into the jaw bone that can be used to support a single tooth, a bridge or denture). This treatment can be carried out under conscious sedation (techniques in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation).

The premises are over two floors and consist of a waiting area, treatment room and office on the ground floor, and

Summary of findings

further waiting room, two treatment rooms and decontamination room on the first floor, although one of the treatment rooms was not in use at the time of our visit.

The practice is open from 8.30am to 5.00pm Monday, Wednesday, Thursday and Friday. From 6.00pm to 8.00pm on a Tuesday evening and alternate Saturday mornings from 9.00am to 1.00pm.

The principal dentist 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.

During our inspection we spoke with six patients who attended the practice that day. The feedback we received was entirely positive, with all patients commenting that options are always thoroughly explained to them, and they are given ample opportunity to ask questions.

Our key findings were:

- The practice had equipment and medicines for treating medical emergencies in line with the recommendations of the British National Formulary and the Resuscitation Council UK guidance.
- The practice met the essential requirements of the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices, with the exception of six monthly infection control audits, although we have received evidence that an audit has been completed following the inspection.
- Patients to the practice commented that they were always treated with dignity and kindness and treatment options were always explained to them in detail.
- Dental care records were found to lack detail, and evidence that routine screening was undertaken. In addition they were not always written at the time of the appointment.
- Practice policies, although available, were arranged haphazardly. For example, there were multiple policies on the same subject in several folders and some no longer relevant making it difficult for staff to reference information that may be required in the running of the practice and safeguarding of visitors to the practice.
- Action plans from a fire risk assessment and following an inspection of the X-ray machines had not been implemented. Although following the inspection we received information that the fire risk action plans have now been completed.
- A written justification for taking X-rays and a written report of the findings of the X-rays were not always noted in the dental care records. As specified in the Ionising Radiation (Medical Exposure) Regulations 2000.

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

- Ensure effective systems to assess monitor and improve the quality and safety of the service are in place. With specific reference to clinical audits being carried out as a tool to identify areas of concern, and ensuring dental care records are completed giving due regard to guidance provided by the Faculty of General Dental Practice regarding record keeping.

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

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

- Continue the programme of improvement of updating the practice policies and arranging them in such a way that staff can find all relevant information easily.
- Review the practice's protocols and procedures for promoting the maintenance of good oral health giving due regard to guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'
- Review 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.

Summary of findings

- Review the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking the X-ray and quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.
- Review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.
- Establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by patients.
- Implement a training log with specific reference to the continuing professional development requirements of the general dental council for all dental professionals in the practice.
- Review arrangements to meet the Control of Substances Hazardous to Health guidance.

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.

The practice had all equipment and medicines detailed in the British National Formulary and Resuscitation Council UK guidance to treat medical emergencies in the dental practice.

Staff demonstrated a good understanding of the situations in which they might have to raise a safeguarding concern against a vulnerable adult or child.

X-ray equipment was tested and maintained in accordance with the Ionising Radiation Regulations 1999.

Are services effective?

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

Comprehensive patient medical history forms were completed at every check-up appointment, and were checked verbally by staff at each visit.

The practice was not consistently recording results of screening for oral disease including basic periodontal examination to screen for gum disease, and soft tissue examination to screen for oral cancer, although the dentist explained that they were being completed, just not always recorded. Following the inspection the practice has undertaken a record keeping audit, which has highlighted areas for improvement and an action plan has been drawn up to implement change.

Clinicians were able to describe how they would ensure that they had valid and educated consent for a procedure. Giving the patient time to consider their options before deciding on a course of treatment.

Patients we spoke with commented on how well their treatment options were explained to them; however there was limited detail of these conversations recorded in the dental care record.

Are services caring?

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

Patients we spoke with commented on how friendly the staff were, how they always took the time to talk to them, and how the practice had a calm and inviting ambiance. We observed staff greeting patients in a polite and friendly manner.

Patients told us that the dentist always took the time to explain their treatment options in detail, and how involved they felt in the decisions about their care.

Staff explained to us how patient information was kept confidential. A patient we spoke with commented that the practice had taken the time to explain to her how her confidential information was stored, for her peace of mind.

Are services responsive to people's needs?

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

The practice varied its opening hours to include one late evening and alternate Saturday mornings. In this way they were able to cater for patients who might have other commitments during normal working hours.

Summary of findings

The practice kept and emergency out of hours' mobile phone ensuring that patients could speak directly with a dentist in the event of an emergency when the practice was closed.

The practice kept aside emergency slots during the day for patients who needed to be seen urgently. Patients we spoke with verified that they had been seen promptly if they phoned up in pain.

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).

The practice had started a programme of updating and reorganising the practice policies to improve their effectiveness.

The practice had undertaken patient satisfaction surveys for each clinician to highlight areas that patients felt they could improve.

Clinical audits were not in place to ensure continuous improvement of the service, although an infection control audit was completed shortly following the inspection.

The practice did not have a staff training log in place to ensure that staff were up to date with the training requirements of the general dental council.

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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.

The inspection was carried out on 21st January 2016 by a CQC inspector and a dental specialist advisor.

We informed the NHS England area team that we were inspecting the practice; however we did not receive any information of concern from them.

During the inspection we toured the premises, spoke with the principal dentist (who was the registered manager), a dentist and two trainee dental nurses. We reviewed a range of practice policies and protocols and other records relating to the management of the service. We spoke with patients who were visiting the practice during our inspection.

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 recently implemented a new system of recording incidents; however this was not yet well established. We were shown a record of a recent significant incident. Although staff told us that significant incidents were discussed at team meetings, there were no documented learning points pertaining to this incident.

The practice had a 'being open' policy that detailed the expectation that staff would be open and honest in the investigation and management of significant incidents and complaints.

The practice received alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). These were e-mailed to the principal dentist who printed them to show all relevant alerts to staff, and then they were filed for reference.

The practice had a policy detailing their responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). An accident book was available, which had no recent entries.

Reliable safety systems and processes (including safeguarding)

The practice had policies in place regarding child protection and safeguarding vulnerable adults, although the policy folders were haphazardly arranged and it was not easy to find the appropriate information quickly. In addition there was information pertaining to safeguarding in several folders, which were not always labelled appropriately.

There was however a flow chart on display in the kitchen which detailed the steps to take should a member of staff need to raise a safeguarding concern. In addition a document with useful contact numbers was on display in the treatment room, for example the contact number for children's social care, the safeguarding named nurse at the local hospital, and the named general practitioner lead within the clinical commissioning group.

Staff we spoke with were able to describe the situations in which they would raise a safeguarding concern and how they would undertake that.

Some staff had undertaken safeguarding training appropriate to their role, and the practice had made arrangements for those that had not had specific training to undertake online training within a week of the inspection. This training has now been completed.

The practice had an up to date Employers' liability insurance certificate due to expire in January 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

Medical emergencies

The practice had medicines and equipment in place to manage medical emergencies. These were located in the file room behind the reception desk.

Emergency medicines were present in accordance with the British National Formulary. They were checked weekly to ensure they were in date for safe use. In addition the practice had emergency oxygen, this was checked daily to ensure the tank was full, but the expiry date of the oxygen had not been checked and documented. We bought this to the attention of the principal dentist who assured us that this would be rectified.

The practice had equipment available to treat patients in the event of a medical emergency. The included an automated external defibrillator (portable electronic devices that automatically diagnose life threatening irregularities of the heart and deliver an electrical shock to attempt to restore a normal heart rhythm). Other medical equipment was also available in accordance with the Resuscitation Council UK guidelines.

Staff we spoke with had a good understanding of how to respond in various medical emergency scenarios.

The practice had not undertaken basic life support training within the previous year, but this had been arranged for a date two weeks following the inspection.

Staff recruitment

We looked at the recruitment files for three staff members to check that the correct recruitment procedures had been followed. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all staff recruitment files. This includes: proof of identity; checking the prospective staff members' skills and qualifications; that they are registered with professional bodies where relevant, and

Are services safe?

where necessary a Disclosure and Barring Service (DBS) check was in place. 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.

We found that although the practice had DBS checks in place for the trainee dental nurses, these were for a previous place of employment and dated more than six months ago.

We found all other records regarding staff recruitment were in order.

The practice had a system of staff induction over a three month period introducing new members of staff to the policies and procedures of working in the practice. This included a monthly one to one meeting where training needs and concerns were discussed.

Monitoring health & safety and responding to risks

The practice had some systems in place to monitor and manage risks to patients, staff and visitors to the practice. Although these were not as robust as they could be.

A health and safety policy was in place at the practice, this was dated 12/1/2016, and contained an up to date health and safety risk assessment. In addition there was a second health and safety policy in a different folder which had been reviewed on 5/1/2016, this contained contact names of the previous owners of the practice. This could have led to confusion for any staff that were looking for guidance from the practice policy.

An external fire risk assessment had been carried out on 23/2/2015; this included servicing of all of the fire equipment. However it also highlighted 29 action points for the premises, none of which had been carried out by the practice. Following the inspection we received information that these have now been actioned.

Staff we spoke with had a good understanding of the actions to take in the event of a fire, and could locate the muster point external to the building.

A generic practice risk assessment had been carried out on 29/4/2015, but no action plan had been implemented from this assessment.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a file of information pertaining to some of the hazardous substances used in the practice and actions described to minimise their risk to patients, staff and visitors. However this was not comprehensive, and did not cover all hazardous materials in use at the practice.

Infection control

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

The practice was in the process of updating its infection control policy when we visited. We saw the new policy that was being implemented which covered areas such as manual cleaning of instruments, hand hygiene and sharps injuries.

The practice was visibly clean and tidy, treatment rooms were uncluttered and an inspection of the sterilised instruments found that they were all clean, were dated with the date that the sterilisation would become ineffective and were stored appropriately.

We did find several single use burs replaced into the bur stand after use and sterilisation (a bur is the drill attachment used in a dental handpiece). We asked the practice principal who assured us that they were sterilised and replaced in error, and would not have been re-used. These burs were disposed of, and we saw the practice had an ample supply of new burs for use.

The practice had a separate decontamination room in which equipment was cleaned and sterilised. We observed a dental nurse carrying out the decontamination process. Cleaning was carried out manually in lukewarm water, although we observed the dental nurse scrubbing the instruments out of the water, rather than under it. This could cause an aerosol of contaminated material. We bought this up with the trainee dental nurse, who immediately altered her practice.

Inspection of the instruments was carried out under an illuminated magnifier. The instruments were then sterilised in an autoclave before being sealed in pouches and dated ready for use again.

Are services safe?

We were shown records of checks that were carried out to ensure that the decontamination process was effective, and these were robust, and in accordance with the guidance.

We noted that there were several cracks in the work surface in the decontamination room, which staff were taping up each decontamination cycle; we were informed that a plan was in place to have the work surface replaced.

In addition we noted that the clinical waste bag in the decontamination room was very full, however staff assured us that they would change this before placing anything else in there.

The practice had systems in place to reduce the risk of Legionella. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The practice were checking the mains water temperatures, and also flushing and disinfecting the water lines. An assessment of risk had been carried out by an external assessor in June 2012 and the practice policy was in line with the recommendations of this assessment. A new assessment had been booked with an external assessor the month following our visit.

All clinical staff had documented immunity against Hepatitis B. Staff who are likely to come into contact with blood products, or are at increased risk of needle stick injuries should receive these vaccinations to minimise the risk of contracting blood borne infections.

Clinical waste was stored and disposed of appropriately. We saw waste consignment notices relating to the regular collection of clinical waste, amalgam and extracted teeth. However the doors to the storage bin area behind the practice were secured with bolts but not locked, which would be required to prevent unwanted access to the bin and its possible removal.

Environmental cleaning of the communal areas was carried out by an external contractor, and the dental nurses were responsible for cleaning the treatment rooms. We saw separate cleaning schedules for the treatment rooms and communal areas.

Documented minutes of a recent staff meeting (January 2016) indicated that infection control was discussed and revised.

Equipment and medicines

We saw evidence that regular servicing of the compressor and autoclave was being undertaken, as well as the X-ray equipment, in line with manufacturer's recommendations.

Glucagon is an emergency drug that is used to treat diabetics with low blood sugar. It needs to be stored between two and eight degrees celsius in order to be effective until the expiry date. We found that, although this medication was being stored in a medicines fridge, the temperature of the fridge was not being checked. Therefore the practice could not be sure that this medicine would be effective in the case of a medical emergency. We raised the concern with the principal dentist, who took immediate steps to ensure it was stored appropriately, and modified the expiry date to account for the fact that the temperature of cold storage could not be assured.

The practice carried out conscious sedation (these are techniques in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation). This was carried out by a visiting dentist who was trained in sedation and who brought a trained dental nurse with them. We saw dental care records where sedation had been carried out and found that all the appropriate checks and monitoring of the patients had been carried out. The medicine used to for the sedation, as well as the reversal medicine were stored securely on the premises, and were in date.

We saw examples of the information leaflets and consent form given to patients prior to them undergoing conscious sedation. These detailed the medication used, techniques involved and patient requirements before and after treatment.

Radiography (X-rays)

The practice had 'local rules' on display in each surgery. These detailed specifics of each X-ray machine in the treatment room, in addition to which the responsible individuals were named, and schematic diagrams of each treatment room indicating the area of X-ray scatter (the small amount of radiation that escapes the X-ray beam).

The practice used exclusively digital X-rays, which could be viewed almost instantaneously, as well as delivering a lower effective dose of radiation to the patient.

Are services safe?

The practice had a radiation protection file which contained information pertaining to the X-ray machines. This included servicing and testing of the machines to ensure they were working within normal parameters.

All relevant staff were up to date with the required training set out in Ionising Radiation (Medical Exposure) Regulations 2000.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

During the course of our inspection patient care was discussed with the dentists and we saw dental care records to illustrate our discussions.

Comprehensive patient medical history forms were filled in at every check-up appointment, and were checked verbally at each visit.

Records showed that assessment of the periodontal tissues (the gums and soft tissues of the mouth) was not always undertaken at examination appointments. Where these were in place they had been recorded using the basic periodontal examination (BPE) screening tool. BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to patients' gums. Higher figures would trigger further investigation, referral to a dental hygienist, or to an external specialist.

Although it was explained by the dentists that recall intervals for patients were decided on an individual basis and based on clinical need, this was not carried out with specific reference to the National Institute of Health and Care Excellence guidelines.

We found that dental care records were not always written contemporaneously, and were not in suitable detail. Discussions with the principal dentist principal dentist indicated that although he was carrying out the screening checks they were not always being recorded.

A written justification for taking X-rays and a written report of the findings of the X-rays were not always noted in the dental care record.

Health promotion & prevention

The medical history form that patients were required to complete at every new check-up appointment asked specific questions regarding smoking, drinking alcohol and use of tobacco based products. Patients we spoke with told us that they were given oral health advice during their appointments, although this was not corroborated by entries in the dental care records.

Leaflets were available in the waiting areas regarding oral health promotions, with specific leaflets on the effect of diabetes on oral health and how to effectively brush and floss your teeth.

We found a limited application of guidance issued in the DH publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Staffing

The practice had two dentists, a newly appointed qualified hygienist and two trainee dental nurses. The trainee dental nurses would cover reception on some days and carry out dental nurse duties on other days. They told us that they felt supported in their learning, and encouraged to achieve their qualifications.

In addition a dentist visited the practice to undertake placement of implants, which would sometimes be under conscious sedation.

Trainee dental nurses did not have support from a trained dental nurse colleague. In addition we noted that when decontamination was taking place the trainee nurse on reception would cover in the treatment room meaning that reception was left unstaffed. We discussed these concerns with the principal dentist, who explained that they were currently advertising to employ someone to address the staffing levels.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves.

The practice used a series of referral templates to ensure that each referral made was suitable for the service receiving it.

Urgent referrals for suspected serious conditions were made on a specific template which was faxed to the hospital to ensure it was received quickly. In addition patients were given a specific timeframe by which point they should have heard from the hospital, and were told to contact the practice if they had not. In this way the timeliness of urgent referrals was assured.

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

It was clear through discussions with the dentist and the patients attending the practice that time was afforded to discuss all the treatment options available to the patients. Patients also commented that they were encouraged to ask questions, and their wishes were taken into account.

The principal dentist explained how he always gave the patient (urgency permitting) the opportunity to go away and consider their treatment options, and when they returned he asked them what they had chosen, why they had chosen this option, and why they had discounted the other options. In this way he could be assured that the patients understood what was explained to them, and full valid and educated consent had been given.

Dental nurses we spoke with had a limited understanding of how consent could be sought for patients who lacked the capacity to make decisions for themselves. The Mental Capacity Act 2005 – provides a legal framework for acting and making decisions on behalf of adults in this situation. Staff had a good understanding that patients should be aided if possible to make the decision for themselves, but were less clear on the processes involved in making a 'best interests' decision.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Staff we spoke with informed us how patients' confidentiality was maintained. At the reception desk, the computer screen was below the level of the counter which prevented anyone at the desk from overlooking. Any paper dental care records for the day were kept out of sight in the file room behind the reception desk, and paper records not in use that day were locked away in file cabinets.

The practice was partially paperless, and computer systems were password protected.

Patients who provided feedback about the service were highly complimentary. Comments were made about the calm and friendly atmosphere, how nervous patients were put at ease, and how staff remembered them, and treated them as individuals.

Involvement in decisions about care and treatment

Patients that we spoke with all expressed that they felt very involved in the decisions about their care. All options and costs were explained to them in advance and they were given as much time as they needed to make a decision.

Private and NHS price lists were on display in the waiting rooms.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We examined appointments scheduling, and found that adequate time was given for each appointment to allow for assessment and discussion of patients' needs.

Patients we spoke with commented on the convenient opening hours, particularly the late evening on a Tuesday and Saturday morning opening which meant that patients with commitments in regular working hours were catered for. Patients also told us they appreciated receiving a text message in advance of their appointment.

The practice had a page on a social media site. This meant they were able to inform patients of any changes to the practice and engage with certain population groups in a format that appealed to them.

The practice detailed their out of hours' arrangements. The practice had a mobile phone number listed on its website, and on the practice answerphone, this was held by one of the practice's dentists at all times.

Tackling inequity and promoting equality

Staff told us they welcomed patients from diverse backgrounds and cultures, and their individual needs were catered for.

The practice had an equality and diversity policy which had been reviewed 8 June 2015. This detailed that the practice had leaflets available in other languages, and translation services were available, however when we spoke to staff they were unaware of either of these being available.

The practice had in place a whistleblowing policy which had been reviewed on 25 August 2015 and again on 5 January 2016 that directed staff on how to take action against a co-worker whose actions or behaviours were of concern. This highlighted the General Dental Council Standards for the Dental Team document which states it is the duty of dental professionals to report concerns.

Access to the service

Emergency appointments were put aside each day, and patients in pain were prioritised and seen as soon as practicable. We spoke with patients who had called in an emergency and had been seen promptly.

The practice was suitably equipped to allow for wheelchair access.

Concerns & complaints

The practice had recently updated its complaints policy, which detailed for patients how they could make a complaint, and who to escalate the complaint to should it not be dealt with effectively by the practice. This was displayed in the waiting room for patients to reference.

The practice had a system of templates to handle complaints which detailed the investigation, and actions to be taken as well as documented timeframes for contact with the complainant. There were not any complaints logged in the last year, and when we asked the principal dentist he said that straightforward issues were dealt by him, and not necessarily logged in the complaints' file.

Staff we spoke with confirmed that any negative patient feedback was discussed at practice meetings.

Are services well-led?

Our findings

Governance arrangements

The principal dentist (who was the registered manager) was responsible for the day to day running of the practice, and the governance arrangements.

The practice held regular staff meetings, although there was only one recorded minutes of a staff meeting within the last year.

During the inspection we found that critical actions derived from a fire risk assessment had not been carried out. Following the inspection we received information that this has now been completed.

Critical appraisal of the X-ray arrangements by an external specialist had also yielded some suggestions which had not been implemented.

The practice had policies and procedures in place to support the management of the service, however these were disorganised and in many cases outdated. The practice were aware of the shortcomings in this area and had started a programme to review and replace the policies, and we saw evidence that this had been commenced.

The practice did not have a system in place to ensure that all the dentists were up to date with the requirements from the General Dental Council pertaining to continuous professional development.

Leadership, openness and transparency

Staff we spoke with expressed the openness with which they could approach anyone in the practice, and this was underpinned by a policy detailing the practice's expectations of candour.

The practice had a whistleblowing policy detailing how a staff member could raise concerns about the actions and behaviours of a colleague, although it was difficult to find.

Learning and improvement

The practice understood its responsibility to continuously assess and improve with the use of clinical audit. However limited clinical audit had been carried out in the year preceding our visit.

An audit of the quality of X-rays being taken had been completed in January 2016, which assessed the quality of 50 X-rays per clinician and scored them on their clinical effectiveness. However, no action plan had been implemented detailing how to improve the results next time.

The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' published by the Department of Health details that infection control audits should be carried out every six months. In the year preceding the inspection we found three partially complete audits, none of which had an action plan or other details on where the practice could improve in this regard. Following our inspection we have received evidence of a completed infection control audit, with action plans and a timeframe for improvements to be made.

Staff were supported in achieving the General Dental Council's requirements in continuing professional development (CPD). The practice did not keep copies of the CPD undertaken on the premises, and did not keep training log to ensure that requirements were met; however, following the inspection we were sent evidence that staff were up to date with required training.

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

The practice had systems in place to involve, seek and act upon feedback from patients using the service. There was a comments box in the reception area, and the practice also invited comments through the NHS friends and family test.

The practice had undertaken a clinician specific patient satisfaction audit in the last year. This indicated levels of satisfaction. But no specific action points had been documented to improve the service.

Practice staff we spoke with felt that their opinions were valued and felt comfortable approaching the principal dentist with any concerns or ideas they had to improve the service.

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 **How the regulation was not being met:** We found that the registered person did not have systems or processes in place to maintain the polices required for the smooth running of the service. We found the registered person was not undertaking regular clinical audit to assess monitor and improve the quality and safety of the service. We found the registered person was not maintaining a complete, accurate, up to date and contemporaneous record for each patient. This was in breach of Regulation 17 (1) (2) (a), (b), (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.