Mr Olaoluwa Lawson

Precious Smile (Watford)

Inspection Report

3 Goodrich Close
Watford
Hertfordshire
WD25 0BZ
Tel:01923 679703
Website:www.mobile-dentist.co.uk

Date of inspection visit: 25 January 2017
Date of publication: 21/04/2017

Overall summary

We carried out an announced comprehensive inspection on 25 January 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

Precious Smiles (Watford) is a mobile dental service providing dental care to patients who are unable to attend a dental practice. There is one dentist and one trainee dental nurse who visit patients in their own home or care facility.

The service is operated from a residential property in Watford, but these premises are administrative only and patients are not seen here as there is no treatment room on site. There is an office and a decontamination room.

Both the dentist and the trainee dental nurse work part time and provide care most commonly on a Saturday, but occasionally in the evenings if the urgency of the situation demands it. On average the service was treating approximately three patients per week at the time of the inspection.

The service offers a range of dental treatment; most commonly the provision of dentures, also simple extractions and fillings. Recently they started providing X-rays if required by means of a hand held X-ray unit.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. 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.

Summary of findings

We received feedback from patients by way of comment cards that we sent to the service two weeks prior to our inspection, and from interviewing staff at care homes where services are provided by Precious Smiles (Watford). We received feedback from six people in this way.

Our key findings were:

- Staff were committed to providing good dental care to vulnerable people who were unable to access dental services in other ways.
- Staff had been trained in medical emergencies and took the medical emergencies kit with them to all visits.
- Patients and care homes commented that the service provided was of high quality, and could be accessed in a timely manner.
- The dentist used nationally recognised guidance in the care and treatment of patients.
- The practice did not meet national guidance in some of the aspects of infection control; however changes were made immediately following the inspection.
- The practice had appropriate systems in place to ensure they employed fit and proper persons.
- Patients received clear explanations about their proposed treatment and were involved in making decisions about it.
- Staff had a good understanding of most of the aspects of the Mental Capacity Act and it's relevance in obtaining consent to treat.
- The medical emergencies kit was missing a medicine to treat low blood sugar, as well as three sizes of oro-pharyngeal airway that are recommended in national guidance.
- The practice had recently introduced a new system of governance. Comprehensive policies and protocols were available, but had not always been fully implemented at the time of the inspection.
- The practice was not carrying out clinical audit in infection control.

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

- Ensure effective systems are in place in order that the regulated activities at Precious Smile (Watford) are compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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:

- 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.
- Review its responsibilities as regards to the Control of Substance Hazardous to Health (COSHH) Regulations 2002 and, ensure all documentation is up to date and staff understand how to minimise risks associated with the use of and handling of these substances.
- Establish whether the practice is in compliance with its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000.
- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as, Public Health England (PHE).

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 carried out appropriate pre-employment checks on prospective members of staff to ensure they employed fit and proper persons.

Staff understood their responsibilities in chaperoning and raising concerns regarding vulnerable adults.

We found areas where improvements should be made relating to the safe provision of treatment. This was because the provider did not have all necessary equipment to deal with medical emergencies in the event of an emergency occurring. We also noted failures within the decontamination process although these were immediately amended.

Are services effective?

No action

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

Staff were appropriately registered in their roles, and had access to ongoing training and support.

Staff demonstrated a clear understanding of the process of consent, although staff did not seem entirely confident in the understanding of who can consent on behalf of a patient that lacks the capacity to consent for themselves.

Staff had undertaken training in the Mental Capacity Act; understood and implemented the principles of this legislation.

Are services caring?

No action

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

Care homes commented that staff were professional and considerate of the needs of their patients.

Confidential patient information was kept securely, and transported to visits appropriately.

Are services responsive to people's needs?

No action

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

The practice provided flexible care to patients who could not access dental care any other way.

Summary of findings

A range of treatment could be provided to patients on their own home or residential care setting.

Complaints policies were given to all new patients with relevant contact details to raise a complaint outside the service.

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 a whistleblowing policy in place and staff were confident to raise concerns if necessary.

A newly implemented system of governance had comprehensive polices and protocols, but these were not always being followed by the practice.

The practice was not completing infection control audits and consequently did not recognise failings in that process which were apparent during the inspection.

The practice had not effectively assessed the risk in not moving to a system of safer sharps.

Requirements notice 

Precious Smile (Watford)

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 carried out an announced, comprehensive inspection on 25 January 2017. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Before the inspection we asked the provider for information to be sent this included the complaints the practice had received in the last 12 months; their latest statement of purpose; the details of the staff members, their qualifications and proof of registration with their professional bodies. We spoke with two members of staff during the 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 a newly implemented system in place to investigate, respond to and learn from significant events. They had not had an incident and so we were unable to see the procedure in action. The practice had a policy in place dated 30 August 2016 which detailed the process and a template in place to facilitate reporting.

We discussed with the principal dentist how incidents would be handled, it was evident that the dentist understood the principles pertaining to candour when investigating concerns. Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

The practice were aware of their responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). RIDDOR is managed by the Health and Safety Executive (HSE). Information on when and how to make a report was available in the practice risk policy dated 6 October 2016.

The practice was not receiving communication from the Medicines and Healthcare products Regulatory Agency (MHRA). These would alert the practitioner to concerns over equipment and medicines. The principal dentist was aware of recent relevant alerts through his work in another practice, and following the inspection made arrangements to receive the alerts to the practice.

Reliable safety systems and processes (including safeguarding)

The practice had policies in place regarding safeguarding vulnerable adults and child protection. These were dated 17 November 2015 and indicated how and when to raise a concern, although they did not contain contact numbers to facilitate this.

We spoke with the trainee dental nurse who, at the time of the inspection had not completed training in safeguarding. They demonstrated good knowledge of the situations when she would raise a concern and was confident to do so.

Following the inspection the trainee dental nurse completed safeguarding training appropriate to her role.

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

A protocol was in place detailing the actions required in the event of a sharps injury. This directed staff to seek advice based on a risk assessment of the circumstances. The dentist took sole responsibility for disposing of sharps within portable sharps bins taken to each visit.

We discussed chaperoning with the trainee dental nurse. The dentist only visited patients with a second person. The trainee dental nurse was aware of their responsibilities in chaperoning consultations. They indicated that care staff would be called upon to remain with the patient in the event that the dentist or dental nurse had to leave the room for any reason.

Medical emergencies

The dental practice had medicines and equipment in place to manage medical emergencies. These were stored together as a kit and taken to all visits. We were told that the emergency kit was not always brought out of the car, meaning that in the event of a medical emergency the dental nurse would have to return to the car to retrieve it. Immediately following the inspection the principal dentist confirmed that the medical emergencies kit would be brought to the treating room for every patient so that it was immediately on hand.

Emergency medicines were in date, stored appropriately, and in line with those recommended by the British National Formulary with the exception of a medicine to treat low blood sugar which was not available. Following the inspection this was purchased.

Medicines were checked weekly, but no log was kept of these checks.

Equipment for use in medical emergency was available in line with the recommendations of the Resuscitation Council UK with the exception of a full range of oro-pharyngeal airways which can be used to support the airways of a semi-conscious or unconscious patient.

The practice had an automated external defibrillator (AED). An AED is a portable electronic device that automatically

diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. We were told the AED and emergency oxygen were checked daily, but these checks were not logged. Following the inspection the checks were logged.

The dentist and trainee dental nurse had received training in basic life support within the year preceding our inspection. The trainee dental nurse had received this as part of her dental nurse training course at college, but had not received a certificate of this training.

Staff recruitment

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all recruitment files. This includes: proof of identity; checking the prospective staff members' skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed). DBS checks identify whether a person had a criminal record or was 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 reviewed the staff recruitment files for both members of staff. An application for a DBS check was in place for the trainee dental nurse, but the practice did not have a formal risk assessment in place in the interim. This was implemented following the inspection.

Proof of identification and references were in place to ensure the practice were employing fit and proper persons.

Monitoring health & safety and responding to risks

The practice had systems in place to monitor and manage risks to patients and staff. A health and safety folder contained a policy that was available to staff to reference. This included topics such as first aid, moving and handling and waste disposal as well as a brief risk assessment pertaining to the disposal of sharps.

A protocol was in place to attend patients in their own homes or a residential care environment. This included to risk assess the environment in which they would provide treatment. This was being carried out informally at the time of the inspection with the dentist and dental nurse confirming that they appraise the environment first, and establish 'clean' and 'dirty' zones before they bring equipment in. The practice had implemented formal assessment templates for this, but had not started using them at the time of the inspection.

The practice did not have a formal sharps risk assessment, however, the needle stick injury policy pointed to the use of 'safe sharps'. These are medical sharps that have an in built safety mechanism to reduce the risk of injury. The practice were not using such sharps and had given no consideration to moving over to this type of system; however the dentist took sole responsibility for handling and disposing of sharps. Following the inspection the practice addressed this.

Sharps bins were transported in the boot of the car, and sealed within a bag. In the event of an accident and the box breaking the sharps would be contained.

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 the hazardous substances used in the practice and actions described to minimise their risk to patients, staff and visitors. Data sheets were available, but not all the risk assessments had been completed.

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 had an infection control policy which was reviewed on 3 October 2016. This included topics on the essential quality requirements and taking instruments to and from other locations.

The practice had a dedicated decontamination facility in a building adjacent to the office. The principal dentist took sole responsibility for decontamination of used instruments.

The dirty instruments were returned to the decontamination room in a solid, lockable transport box and were kept wet until processed; however processing the

instruments took place several days after use. We raised this with the principal dentist during the inspection and the protocol was immediately altered to ensure instruments were processed on the day of use.

We observed the principal dentist cleaning instruments under running water, which can create an aerosol of contaminated material. The practice used a foaming detergent to clean the instruments and did not have a separate rinsing bowl. This was against the guidance in HTM 01-05, and the principal dentist re-visited this guidance and implemented a new protocol for cleaning instruments following the inspection.

Instruments were inspected and sterilised in an autoclave prior to being pouched and dated with a use by date.

The practice had recently signed a contract to have an external contractor take over the process of decontamination of all instruments but this had not commenced at the time of the inspection.

Tests carried out on the process were in line with the recommendations of HTM 01-05, but evidence was not retained. Following the inspection we were sent evidence that an autoclave log had been commenced.

Impressions taken to make dental moulds were disinfected prior to being sent to the laboratory, but work received from the laboratory was not disinfected prior to being given to patients. The principal was under the impression that this was carried out by the laboratory before the work was sent to him, but confirmed they would check this and implement disinfecting returned devices himself if the laboratory were not doing this.

All clinical staff had documented vaccinations 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. The trainee dental nurse had not yet completed the course of vaccinations at the time of the inspection. The practice had informally risk assessed the situation and the dental nurse did not handle sharps of perform decontamination of dental instruments. Following the inspection a formal risk assessment was implemented.

The practice had a protocol in place for the portable drill unit regarding disinfection of the water lines. The unit was only used on one patient before being disinfected as per the manufacturer's guidance.

The practice had contracts in place for the disposal of contaminated waste and waste consignment notes were seen to confirm this.

Equipment and medicines

The practice had a full range of equipment to carry out the services they offered and in adequate number to meet the needs of the practice.

Portable appliance testing had been carried out in January 2017. Servicing and testing of the autoclave was completed in January 2017. The portable drill unit had not been serviced at the time of the inspection. Following the inspection we received evidence that a service had been completed and that it was exempt from pressure vessel testing.

The machine that develops X-rays was also serviced in September 2016.

The principal dentist told us he rarely wrote prescriptions, but we were shown a stock of individually numbered private prescription forms for use if required.

We checked the practice's vehicle and found it had appropriate business insurance. However, a TREM card (traffic emergency card) was not available. This must be carried in the cab of any vehicle that is transporting dangerous goods by road. It contains instructions and information that the driver can refer to in the event of an incident involving the hazardous load. This was obtained following the inspection.

We discussed the transportation of medical oxygen to the domiciliary visits. Although the emergency kit was transported in the boot of the car the oxygen cylinder was not secured during transport. This meant that in the event of an accident it was free to move and could become a dangerous projectile. Following the inspection we were shown evidence of how the oxygen cylinder was now secured in the boot of the car.

Equipment needed for domiciliary visits had been divided into sub kits (such as those for fillings, extraction, impressions and dirty instruments) and stored in boxes for transport to patient's houses of residential care setting.

Are services safe?

Radiography (X-rays)

The practice had recently acquired a hand held X-ray machine for use on domiciliary visits.

The Health and Safety Executive was informed of the use of ionising radiation in December 2016 and the practice contracted the services of a radiation protection advisor (RPA) as per the regulations.

The equipment had undergone a full performance check in November 2016 and all the recommendations had been carried out by the principal dentist. Following the inspection they commenced regular visual checks on the X-ray machine which were logged.

The RPA had provided a radiation protection file, which had not been fully filled in at the time of the inspection. In addition the practice did not have local rules in place pertaining to the use of the X-ray machine.

The practice had templates available to audit the quality of X-rays taken, but had not yet started to use them as they had only just begun offering dental X-rays.

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 patient care records to illustrate our discussions.

A comprehensive medical history form was completed by patients prior to all new course of treatment. If the patient was unable to fill out the form themselves the dentist involved carers and family members to ensure that they were kept informed of any medical conditions that may affect treatment.

The dentist offered a range of treatment to patients in their own homes including; provision of dentures, simple tooth extractions, scaling and adhesive fillings (with white filling material not mercury amalgam).

Despite being asked to attend patients for specific problems they tried to carry out a full examination of the patient where compliance allowed for this. We were shown evidence of good oral screening from patient dental care records.

The dentist was aware of nationally recognised guidance in the care and treatment of patients, for example; the National Institute of Health and Care Excellence guidance, and guidance provided by the Faculty of General Dental Practice.

In the future the practice was hoping to expand to have the facility to provide ongoing care and treatment, rather than simply responding to a patient with an immediate concern.

Health promotion & prevention

Dental care records we were shown indicated that an assessment of oral health was made for the patients and advice given on oral hygiene. Particular reference was given to oral hygiene aids that facilitate oral hygiene in patients who may find tooth brushing difficult. For example: the use of electric tooth brushes as they are easier to manipulate.

Medical history forms that patients were asked to fill in included information on nicotine use and alcohol consumption; this was used by dentists to introduce a discussion on oral health and prevention of disease.

The dentist provided oral hygiene talks to carers in residential and nursing care settings to facilitate then assisting with this aspect of care. In addition family and carers were encouraged to assist with oral hygiene where the patient may be having difficulty in effective oral care.

Staffing

The practice was staffed by a dentist and a trainee dental nurse, both of whom worked with the service part time.

Prior to our inspection we checked that all appropriate clinical staff were registered with the General Dental Council and did not have any conditions on their registration.

The trainee dental nurse was registered and undergoing dental nurse training at college, and confirmed that she also received in-house training regularly from the principal dentist.

Care homes we spoke with that receive services from the practice confirmed that the dentist was always accompanied by a dental nurse, although the dentist himself stated that he would consider attending a care home in an emergency if a member of the care staff from the home could be present as chaperone.

Routinely they encouraged care staff and/ or family members to be present during treatment, if that fitted with the patient's wishes.

The dentist was up to date with their recommended continuous profession development training as detailed by the GDC including medical emergencies, infection control and safeguarding training.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the treatment themselves. Because of the access concerns felt by the majority of the patients to the practice, referrals would often be made to hospital if treatment could not be carried out in a domiciliary setting.

The dentist explained the situations where referrals would be made including the in the situation where a necessary extraction may be deemed too difficult to attempt in a domiciliary setting, or where a straightforward extraction was complicated by the patient's medical history.

Are services effective?

(for example, treatment is effective)

Referral for suspected serious pathology would be made by registered post, and followed up with a telephone call to ensure that it had been received.

Consent to care and treatment

The clinician described the process of gaining full, educated and valid consent to treat. This was underpinned by policies addressing patients with communication difficulties and the mental capacity act (MCA).

Consent was described as a multi-stage process, where explanations were given to the patients as well as written treatment plans, and involving carers and family members if the patient lacked the capacity to consent for themselves.

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Staff demonstrated an understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment. Although there was generally a good understanding of the principles highlighted in the mental capacity act the principal dentist did not seem confident in who was able to legally give consent on behalf of a patient that lacked capacity to consent for themselves.

Templates were available and guided staff in assessing capacity, as well as exploring the legalities of who could consent on behalf of the patient. These had been recently introduced, and had not yet been used.

Following the inspection we received evidence that the trainee dental nurse had completed training in the MCA.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Comments we received from patients of the service and from care home managers that we contacted to enquire about the service indicated that they were pleased with the service they received. Comments indicated that the dentist and dental nurse were patient and kind, and attended in a timely manner when contacted.

Treatment was carried out in care home treatment rooms or in the patient's own room to protect their privacy. Care home managers we spoke with indicated that the dentist was always chaperoned, and that care staff would also be asked to be present (if that met with the wishes of the patient).

Patient care records were kept in a locked file at the office and transported in an opaque folder to the premises for treatment. These files were never left in the vehicle, but kept with the dentist at all times whilst out of the office.

These measures were underpinned by a policy on confidentiality dated 24 October 2016.

Involvement in decisions about care and treatment

The practice had an involvement policy dated 8 April 2016, this prompted staff to invite comment on patient's expectations. In addition a policy for patients with communication difficulties suggested support of interpreters or speech therapists.

There was good evidence in the dental records we reviewed which demonstrated the inclusion of the patients, family and care home staff where appropriate in decision making processes. Where appropriate treatment plans we sent to patients and their families. A patient commented that their concerns and history were listened to by the dentist.

Costs were outlined in the treatment plans and given to patients or their families prior to commencing treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The service was specifically designed around the needs of people whose circumstances made it difficult to receive care in a traditional dental setting. The dentist carried suitable portable dental, medical and emergency equipment to enable him to provide a range of dental treatments to people in their own home.

The service usually arranged to see patients at evenings or weekends and would try to attend a patient on the same day if the patient was in pain.

Discussions we had with the dentist indicated that treatment could be arranged flexibly to accommodate patient's individual needs for example; certain groups for patients may find it easier to co-operate with treatment in the mornings. The dentist would endeavour to accommodate these needs.

The dentist described situations where a multi-stage treatment process was carried out in several different care facilities and hospitals as the patient's needs changed.

Tackling inequity and promoting equality

Staff we spoke with expressed that they welcomed patients from all backgrounds and cultures, and all patients were treated according to their individual needs.

The service was designed to treat those patients that were unable to attend dental practice; therefore the patients treated by the service often had restricted mobility or were bed bound. The dentist and trainee dental nurse described how that would utilise the patient's bed in care homes to adjust to a position where the patient was comfortable to have treatment. Often the dentist and dental nurse would stand to accommodate the comfort of patients.

The dentist described how building trust with patients who had failing mental capacity was important to complete treatment, and they would arrange multiple visits with certain patients in order to build confidence, and keep treatment times down.

Several patients were hard of hearing and the dentist described how adjustments would be made to ensure that the patients understood, and were comfortable with treatment.

These measures were underpinned by the practice's policies in dignity, respect and fair access and equality and diversity, both of which were dated April 2016.

Access to the service

Patients accessed the service via the telephone to the office where a message could be left if the dentist was not available.

Care home managers we spoke with indicated that arrangements to attend the premises were usually made within a day or two of them initially contacting the service.

The contact number for the service would be answered out of hours by the dentist, and so advice could be given, or arrangements made to attend the premises as required.

Concerns & complaints

The practice had a complaints policy in place which was given to all the patients of the service so that they were aware of how to raise a complaint should they have one.

As part of this policy the contact details for an independent external agency that handles complaints was listed.

We examined complaints made to the service and found that they had been dealt with in accordance with the practice policy.

Are services well-led?

Our findings

Governance arrangements

The principal dentist took responsibility for the day to day running of the practice, including direct responsibility for all governance procedures, infection control, equipment and medicines.

There was a full range of policies and procedures for use at the practice. These included health and safety, infection prevention control, patient confidentiality and recruitment. Staff were aware of the policies and they were readily available for them to access.

The practice had recently implemented a new system for governance, and although these policies and risk assessments were specific and relevant we found that they had not been fully embedded at the time of the inspection. For example; an environmental risk assessment document was available for visits, but not yet in use, similarly an assessment for mental capacity was available, but not yet in use.

Systems and processes were not operated effectively resulting in shortfalls not being identified by the service, although they were rectified immediately following the inspection for example; servicing of the portable dental unit and training in safeguarding for the trainee dental nurse.

The practice were not following national standard in infection control for decontamination of dental instruments. Infection control audits which would have highlighted the failures in this regard had not been carried out. Following the inspection a revised protocol was provided for immediate implementation which met national guidance.

Risk had not been assessed in the use of sharps, or of the lack of assurance of the trainee dental nurse's immunity to Hepatitis B as they had not finished the course of vaccinations. Additionally the risk had not been assessed regarding the trainee dental nurse attending vulnerable patients before the results of a disclosure and barring service checks were received. (The latter two risk assessments were put into place following the inspection).

The practice had informed the vehicle insurance company of the business use of the vehicle, but had not advised them of the transportation of oxygen and emergency drugs. In addition the dentist did not have a TREM card.

The practice did not have a reliable system in place to receive and action local and national alerts which could impact on the safety of patients. We received confirmation that this was implemented following the inspection.

We saw from the dental care records that inadequacies in the record keeping were being addressed and the dentist was educating the trainee dental nurse in writing dental care records, recent examples of this were detailed and clear.

The practice had not risk assessed the absence of a medicine to treat low blood sugar and three sizes of oro-pharyngeal airway from the medical emergencies kit, despite the recommendation by the British National Formulary and the Resuscitation Council UK guidance that these be available at all times. Although staff informed us that equipment checks were carried out, There was no evidence of these checks as they were not logged.

Leadership, openness and transparency

Staff we spoke with reported an open and honest culture across the practice and they felt fully supported to raise concerns with the principal dentist.

A whistleblowing policy was available which guided staff in how to raise concerns about a colleague's actions or behaviours this was dated 14 December 2016.

We spoke with the trainee dental nurse regarding raising concerns; they felt empowered to do so should they need to. The principles of duty of candour were clearly demonstrable through her answer and they were able to identify where they would find the information to raise a concern to an outside agency as this was a recent topic for discussion through the college course they attended.

Learning and improvement

The practice were keen to support training and improve in this regard. The dentist was up to date with all required training as set out by the General Dental Council including recent training in the mental capacity act. The trainee dental nurse was receiving training through a formal college course in dental nursing, as well as in house

Are services well-led?

training with the principal dentist. They confirmed that they received regular training from the principal dentist and felt supported in approaching him with any questions or concerns.

The practice policy on audit stated the need to complete infection control and radiology audits. We were not shown any infection control audits, which are recommended six monthly by the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' published by the Department of Health. Infection control audits would have recognised the failings in this area that were apparent during the inspection.

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

The practice sought feedback from patients and care homes visited. In December 2015 questionnaires were sent to the care homes that the practice visited and the results of these were analysed.

The trainee dental nurse felt empowered and supported to raise any ideas or concerns with the dentist and both commented that they worked well together.

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: The registered person did not have effective systems in place to ensure that the regulated activities at Precious Smile (Watford) were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This included: · Risks to the health, safety and welfare of patients were not assessed and actions taken to mitigate these. For example infection control audits were not completed and the practice was therefore unable to highlight failings in the decontamination process. · There was no assessment of risk or other measures to identify and mitigate the risks associated with the absence of emergency equipment and the use of medical sharps. **Regulation 17 (1)**