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Wigmore Dental Clinic

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 17 November 2015 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

Wigmore Dental Clinic is a private dental practice situated in the Wigmore area of Luton.

The practice is open from 9.00 am to 6.15 pm Monday, Tuesday, Thursday and Friday. The practice is closed on Wednesday.

There is currently one dentist working at Wigmore Dental Clinic, and the practice offers a wide range of dental procedures including short term orthodontics (a term used to describe quick orthodontic treatments that usually only affect the front teeth. These types of systems can use transparent trays instead of conventional braces to effect simple tooth movements) and “smile design” where teeth are cosmetically altered using a variety of restorative means to improve the overall appearance of the smile. These are in addition to a full range of general dental treatments (for example, fillings, root fillings, crowns, bridges and dentures) and oral surgery.

The practice offers ‘occasional’ conscious sedation (this is a technique in which the use of a medicine or medicines 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) but most patients requesting this treatment were referred to a specialist centre.

A visiting dentist attends the practice occasionally to fit dental implants as and when requested by the principal

Summary of findings

dentist. A dental implant is a metal post that is placed surgically below the gum line with a ceramic tooth, bridge or denture on top. It is used to replace a single missing tooth or multiple missing teeth.

The Principal Dentist is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) 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.

We received feedback on the service by 21 patients, either by way of them filling in a CQC comment card or in person. They were overwhelmingly positive about the service offered, and made particular reference to the friendliness of the whole team, and how clean and hygienic the premises seemed to them.

Our key findings were:

- There was appropriate equipment for staff to undertake their duties, and most equipment was well maintained.
- The practice was carrying out effective infection control procedures, as described in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' Published by the Department of Health.
- The practice had systems, processes and policies in place to monitor and manage risks to patients, staff and visitors to the practice.
- Feedback from patients described the service as friendly, kind and caring. Particular reference was made to the staffs' ability to reassure nervous patients and put them at ease.
- Patient dental care records provided an accurate, thorough and contemporaneous record of patient care.
- The practice had a comprehensive schedule of clinical audit demonstrating their commitment to continuous improvement.
- The practice had failed to recognise that X-ray units were working outside of expected parameters.

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

- Ensure robust systems are in place to monitor and recognise concerns raised following routine testing of X-ray equipment.
- Ensure the practice pays due regard to guidelines published by The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015'. This should include a review of practice's protocols for conscious sedation as well as a system to ensure that dentists carrying out conscious sedation and dental nursing staff who are assisting in conscious sedation have the appropriate training and skills to carry out that role.

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 systems to ensure that the practice is in compliance with its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000.
- Review systems to ensure the practice's recruitment policy and procedures are suitable and the recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.
- Review availability of equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society
- 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.

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 was carrying out effective infection control procedures, as described in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' Published by the Department of Health.

The practice was not compliant with the Ionising Radiation Regulations 1999. Critical examination packs that had been carried out to test the X-ray equipment in April 2014 had shown that the two intra-oral X-ray units had failed on equipment performance and patient dose. In addition there was no Radiation Protection Advisor appointed to the practice. This person is usually a medical physicist and is required to advise on matters pertaining to ionising radiation. Following inspection these concerns have been addressed and rectified.

Emergency medicines were checked and stored appropriately, but some pieces of emergency equipment were missing including an automated external defibrillator (AED). An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. Following our visit we have received evidence that this has been acquired.

Staff we spoke with had a good understanding of the signs of abuse and neglect and were confident to raise a concern should the situation arise.

Are services effective?

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

The dentist kept accurate, contemporaneous records of patient care.

Oral assessment tools were routinely used to discover dental disease which may not be obvious initially.

Dental care records indicated that an assessment of patients' oral hygiene was made and oral hygiene instruction given to patients when indicated.

Are services caring?

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

We observed staff were friendly, kind and considerate, with efforts made to accommodate the individual needs of the patients.

Feedback we received from patients commented on how they were put at ease by the team, and how they felt involved in their care.

Are services responsive to people's needs?

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

The practice demonstrated an appointments system that met the needs of the patients. Emergency patients were generally fitted in on the same day.

The practice invited comments from patients and visitors and had responded to feedback from patients to alter the opening hours.

Summary of findings

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 demonstrated a robust commitment to continuing improvement by way of clinical audit.

The practice failed to recognise that X-ray equipment was working outside of recognised parameters, despite this being highlighted following routine testing in April 2014.

The practice had failed to keep up to date with training regarding conscious sedation.

There was evidence of good communication and leaning through the regular staff meeting undertaken by this small team.

Wigmore Dental Clinic

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 17 November 2015. The inspection was led by a CQC inspector and a dental specialist advisor.

We informed Healthwatch that we were inspecting the practice; we did not receive any information of concern from them.

During our inspection we interviewed members of staff regarding their practise, policies and procedures. We spoke with people using the service and their relatives, observed the workings of the practice and reviewed their documentation.

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 demonstrated a robust system of reporting and learning from significant incidents. A form was filled out that showed the details, investigation and outcomes of such an incident, as well as any learning that came from it. These forms demonstrated that apologies were issued to patients appropriately, and learning fed back through the staff meetings to reduce the risk of reoccurrence. Agendas and minutes of staff meetings confirmed this.

Staff were aware of their responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). The practice manager informed us how they would make such a report, and there was a policy in place. There had not been any such incidents in the past 12 months.

The practice received alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) these were e-mailed to the principal dentist who disseminated relevant alerts to the staff during regular practice meetings.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding vulnerable adults. These included an action flow chart demonstrating how to escalate a concern and lists of relevant contact details should a concern need to be raised.

Staff we spoke with had a good understanding of the signs of abuse and neglect and were confident to raise a concern should the situation arise. Staff had undergone in house training in safeguarding and child protection, and the safeguarding lead had undertaken training with an external provider at an appropriate level.

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

The practice was using a re-sheathing device to aid in the safe disposal of sharps. This was in accordance with Health and Safety (Sharp Instruments in Healthcare) 2013 guidance.

The dentist reported that he did not use rubber dams during root canal treatment. A rubber dam is a thin, rectangular sheet, usually of latex rubber. It is used in dentistry to isolate a tooth from the rest of the mouth during root canal treatment; it prevents the patient from inhaling or swallowing debris or small instruments. The British Endodontic Society recommends the use of rubber dam for root canal treatment. They mitigated the risks of root canal instruments being inhaled or swallowed by using root canal instruments in a special dental hand piece when carrying out root canal treatment.

Medical emergencies

The practice carried emergency equipment and medicines to deal with any medical emergencies that may arise. The emergency medicines were checked and found to be present in accordance with the British National Formulary (BNF) guidelines. They were found to be stored appropriately and temperature sensitive medicines were kept in a designated medicines fridge for which the temperature was checked daily and logged.

The practice kept some emergency equipment as defined by the Resuscitation Council UK guidance, with the exception of an automated external defibrillator.

They were also missing portable suction and a yankaur suction tip from their emergency equipment. These would be used in a medical emergency to clear the airway of vomit or secretions which could hinder breathing, or be inhaled to the lungs.

Following our visit we have received evidence from the practice that the missing emergency equipment has been ordered, and a risk assessment provided that describes how, in the interim they will have the use of an AED from the medical centre in the same road, should the necessity arise.

Oxygen was available and was checked weekly to ensure that it was full and in date.

The practice staff had all undertaken basic life support training within the last year, and staff we spoke with were clear on how to react in a number of medical emergencies.

Staff recruitment

We looked at the staff recruitment files for three staff members to check that the recruitment procedures had been followed. The Health and Social Care Act 2008

Are services safe?

(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 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 all appropriate members of staff had a DBS check, with the exception of a visiting dentist and his dental nurse who worked occasionally in the practice. In their case we were provided with DBS checks that had been carried out through their regular place of work, evidence of their registration with the GDC, and current indemnity.

Monitoring health & safety and responding to risks

The practice had some systems, processes and policies in place to monitor and manage risks to patients, staff and visitors to the practice.

A health and safety policy was in place, and a health and safety at work poster was on display in the reception area. Health and safety audits had been carried out yearly, most recently in February 2015, and an action plan was noted following this audit.

An external fire risk assessment was not necessary for this practice as there were only three members of staff, but fire safety planning was nonetheless robust. Fire drills were carried out six monthly and a risk management process was in place. It was noted that there was a lockable grille over the second fire exit to the rear of the building. It was explained to us that this was always unlocked at the start of the day and locked again as the practice was shut down for the night. This was noted on the day to be unlocked allowing for the escape route to be maintained.

There were adequate 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.

The provider informed us that conscious sedation was carried out at the practice 'occasionally'; the majority of the patients requesting this treatment were referred to a local specialist centre. Nonetheless in the couple of procedures that were carried out in the previous year an automated external defibrillator was not in place; and no risk assessment had been carried out in this regard.

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.

There was an infection control policy in place at the practice, and infection control audits were seen to be carried out every three months for the last four years.

We observed the dental nurse undertaking the decontamination process. Instruments were bought from the surgery in an appropriately marked, lidded box, and were manually washed in a designated sink. The water temperature was taken and logged (Water temperature of over 45 degrees Celsius could prevent the effective removal of protein contaminants from the instruments).

The instruments were then rinsed and inspected under a free-standing, illuminated magnifier, to confirm removal of all visible debris, before being sterilised.

Instruments were pouched and marked following sterilisation with the date at which the sterilisation would become ineffective. In pouches they remain sterile for one year.

The dental nurse showed us how the practice checked that the decontamination system was working effectively. They showed us the paperwork they used to record and monitor these checks. The tests were in accordance with HTM 01-05 guidance.

Infection control audits were carried out at regular intervals, and action plans drawn up to continuously monitor and improve the service.

The decontamination room and treatment room were found to be visibly clean and clutter free. The clinical areas had sealed flooring which was in good condition. Dental chairs were covered in non-porous material which aided effective cleaning.

Are services safe?

The practice manager and dental nurse took responsibility for the environmental cleaning of the non-clinical and clinical areas of the practice respectively. The practice followed the national colour coding scheme for cleaning materials and equipment in dental premises. This ensures that equipment used for cleaning is specific to the area that is being cleaned. For example, equipment used to clean clinical areas is different to equipment used to clean the kitchen.

A policy was in place regarding environmental cleaning, and general cleaning audits with action plans had been completed regularly for several years.

The practice demonstrated appropriate storage and disposal of clinical waste. Waste consignment notices were seen for clinical waste, amalgam, sharps, used X-ray developing fluids and gypsum. Clinical waste was stored in a locked cupboard prior to removal from the premises.

There were systems in place to protect staff, patients and visitors from the risk of water lines becoming contaminated with Legionella bacteria. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. An external assessment was carried out yearly, most recently in February 2015, from which an action plan was drawn up. In addition to the previous measures of checking the mains water temperatures, flushing the water lines in the surgery, and disinfecting them daily; the assessor made a requirement that the water lines were also flushed through daily in the surgeries that were not in use. We saw records to prove this was now taking place.

All clinical staff had been vaccinated against Hepatitis B (a virus that is carried in the blood and may be passed from person to person by blood on blood contact). Evidence of this was retained in the staff files.

Equipment and medicines

We saw that the practice had equipment to enable them to carry out a range of dental procedures.

Prescription medicines were kept securely and were dispensed by the dentist. Records were kept of batch numbers and expiry dates as well as details of patients who had needed medicine to be dispensed. In this way a particular batch of medicine could be traced to a particular patient in the event of a recall or alert.

Temperature sensitive medicines were kept in a designated medicines fridge, and the temperature of this fridge was checked daily to make sure that the medicines remained effective. Logs of the temperature checks were seen.

The practice had a schedule for equipment servicing, and had service contracts in place for several pieces of equipment including the autoclave and compressor. Servicing of all equipment was up to date with the exception of the X-ray equipment.

The practice carried out occasional conscious sedation (this is a technique 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).

Some essential equipment was available for this procedure for example a pulse oximeter (a finger probe that measures the amount of oxygen in the blood through the nail bed) and a blood pressure machine (sphygmomanometer). Others were missing, for example the reversal agent for the sedative drug (Flumazenil). The principal informed us that this had just expired and been discarded. We saw evidence of this in the sharps bin.

The practice principal was not up to date with the requirements of continuing learning to carry out sedation. We received assurances from the dentist that he did not intend to carry out any further conscious sedation procedures until he was up to date with all the relevant guidance.

Radiography (X-rays)

The practice could not demonstrate that they were working in accordance with the Ionising Radiation Regulations 1999 (IRR99).

The results of critical examination testing of the two intra-oral X-ray units in use in the practice from April 2014 show that they failed in 'equipment performance' and 'patient dose'. This had been overlooked by the practice and no action had been taken to address this.

In addition the practice had not assigned a Radiation Protection Advisor (RPA). This person is usually a medical physicist and is required to advise on matters pertaining to ionising radiation.

Are services safe?

There was no evidence that the Health and Safety Executive (HSE) had been notified regarding the X-ray units on the premises. Maintenance logs were not up to date.

The practice had a DPT (Dental Panoramic Tomograph) machine, which takes a larger X-ray to show the whole of the jaws and teeth on one radiograph. We could find no records pertaining to this machine.

As a result of these finding the registered manager volunteered to stop taking radiographs immediately and until such point as they were compliant with the regulations.

Following our inspection we have received evidence that an RPA has now been appointed, the HSE have been notified and steps taken to make the X-rays sets compliant.

The practice demonstrated they were mostly working in accordance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IR (ME) R). Radiographs were quality assured and audited to ensure consistent good quality. The most recent audit of X-rays was 2015. Dental care records demonstrated the justification for taking X-rays, as well as a report on the X-rays findings.

We asked to see evidence that the dentist and dental nurse were up to date with the required continuing professional development on radiation safety as set out by the General Dental Council, and IR(ME)R. This could not be provided on the day of inspection. We have since received information that this training will be completed on 7 December 2015.

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 dentist and patient care records were examined. The practice kept paper dental care records. These were found to be detailed and accurate.

We reviewed five sets of dental care records which demonstrated that a medical history was taken and checked at every appointment. This kept the dentist reliably informed of any changes in the patients' health which may affect the treatment they received.

The dentist checked and recorded examination of the soft tissues of the mouth and neck. There was also assessment made of the patients' oral hygiene and advice offered when necessary.

The dentist regularly checked patients' gum health by undertaking a basic periodontal examination (BPE) at every check-up appointment. This is a screening tool that identifies concerns with gum health and triggers further examination or treatment if necessary.

One of the common themes resulting from the patient feedback that we received was that patients felt listened to, and were able to ask questions about their treatment. Options for treatment were always discussed with the patient. This was also evidenced through the dental care records.

Patients were given a written treatment plan with clear estimate of costs to take away and sign before treatment commenced. Unless the urgency of the situation prevented this, in which case verbal consent was noted in the patient care records.

Discussions with the dentist showed they were aware of the National Institute of Health and Care Excellence (NICE) guidelines, particularly in respect of recalls of patients, antibiotic prescribing and wisdom tooth removal. A review of the records identified that the dentist followed NICE guidelines in their treatment of patients.

The practice regularly undertook an audit of the clinical record keeping, which served to ensure that accurate contemporaneous records were maintained for all patients at the practice.

Health promotion & prevention

The practice took its commitment to health promotion and prevention very seriously. Dental care records indicated that an assessment of patients' oral hygiene was made and oral hygiene instruction given to patients when indicated.

A range of health promotion leaflets were available to patients in the waiting area, These included advice on smoking, diet and risk factors for oral cancer.

The practice engaged children in health promotion by use of the oral health company initiatives. Posters in the waiting room were aimed at children and they were encouraged to fill in a 'Tooth Defender Challenge' activity sheet whilst waiting for their appointment. Free samples of toothpaste were available in the waiting area, and we witnessed patients taking advantage of these.

Staffing

The practice was staffed by the provider, supported by a dental nurse and a practice manager/ receptionist. Prior to our visit we checked the registrations of the dental care professionals and found that they all had up to date registration with the General Dental Council (GDC).

Staff were supported to maintain the continuous professional development (CPD) requirements made by the GDC. A record of CPD undertaken was kept in the staff files, including records of in-house training. Evidence was seen of CPD pertaining to the requirements set out by the GDC, but this was not always complete.

Conscious sedation training had been undertaken by the dentist, but required refresher sessions had not been carried out. In addition the dental nurse had not undergone a sedation training course. These training requirements are made by The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015. We discussed our concerns with the principal dentist who assured us that he would not carry out any further conscious sedation treatments until the practice complied with all the latest guidance.

Annual appraisals took place for the staff, during which their competencies were assessed and training needs discussed. Records were kept of these meetings and staff found them to be useful overall.

Working with other services

Are services effective?

(for example, treatment is effective)

The practice worked with other professionals in the care of the patients where this was in the best interest of the patient. Referrals were made to hospital for complex oral surgical and oral medical conditions. Urgent referrals were made if oral cancer was suspected. The practice also referred children or adults with uneven or crooked teeth to orthodontic services.

The practice benefitted from having a sedation service nearby. They referred most of the patients who requested sedation to this service.

The practice did not keep a log of referrals made by the dentist, and were therefore unable to chase these up until the patient raised a concern that they hadn't heard anything. After we mentioned this the practice manager agreed that this would be a good thing to implement.

Consent to care and treatment

Evidence was seen that patients were given a written treatment plan, with estimate of costs to take away and sign to signify consent. When verbal consent was given, this was noted in the dental care records.

Patients we spoke with commented that risks and benefits of treatment were explained to them in detail, and opportunity afforded for them to ask any questions before they agreed to treatment.

We spoke with staff and found they had a reasonable understanding of the Mental Capacity Act 2005 (MCA) and its relevance in obtaining consent. The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Although staff had not undertaken any specific training on the MCA, we found evidence that how to support patients with physical and mental disabilities had been a recent topic discussed during in-house training.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We were provided with feedback from 21 patients. Patients were overwhelmingly positive about the service they received at the practice. Particular themes included, that the staff were friendly, kind and caring, the staff were able to put nervous patients at ease and patients felt listened to regarding their concerns.

Several patients commented that they do not live locally, but are happy to travel to come to this practice.

We observed patients attending the practice. They were welcomed in a friendly manner; staff clearly knew the patients well.

Staff had good understanding of the importance of data protection and confidentiality. The appointments book was kept obscured from anyone standing at the desk. Dental care records were kept behind the desk in locked cupboards.

A data protection and confidentiality policy was available in hard copy form for staff to refer to should they need to. Staff had signed a confidentiality agreement pertaining to these issues.

Involvement in decisions about care and treatment

Patients we spoke with, and CQC comments cards we received, indicated that patients felt they were involved in decisions about their dental care, and that the dentist explained treatments in a way that they could understand. They also received a written treatment plan outlining the treatments and costs.

Clinical audit was noted pertaining to patient care, involvement and consent most recently from March 2015 this demonstrated a commitment to continuous improvement of the service offered.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

As part of our inspection we conducted a tour of the practice and found the premises and facilities were appropriate for the services delivered.

We found the practice to have an efficient appointments system to allow enough time to assess and meet patients' needs. We witnessed emergency patients being fitted in on the day they called, and were informed by patients that the dentist would always go out of his way to accommodate patients with emergency dental needs.

Staff regularly undertook a waiting time survey to ensure that their appointments booking system was working effectively and patients were not waiting unacceptable amounts of time.

The practice website gave comprehensive descriptions of the treatments available to the patients, including, in some instances, the projected success rate of the treatment. Although we found that the website was not up to date regarding the staff currently employed.

The dentist responded to the needs of his patients regarding placement of dental implants. Previously patients were referred to a practice in Hemel Hempstead for placement of dental implants, but when his patients commented that this was too far to go he arranged for the implant surgeon to visit his practice to undertake this work.

Tackling inequity and promoting equality

Staff had undertaken equality and diversity training and welcomed patients from diverse backgrounds and cultures. At the time of the inspection the practice did not have any patients that would require translator, but were aware to contact a translating service should the need arise.

The practice was on the ground floor, with wheelchair access. There was also a disabled toilet. The practice manager described how carers of patients with limited mobility would be asked to bring the car around to the rear entrance of the premises where staff could walk them out, so that the patient would not have to walk to the car.

Access to the service

The practice was open from 9.00am to 6.15pm on Monday, Tuesday, Thursday and Friday. The practice is closed on Wednesday. However as a result of patient feedback the practice has agreed to trial Wednesday morning opening from the new year.

As the practice team is so small the practice is closed when they are not there. The staff all take annual leave at the same time to ensure that the surgery is closed for as short at time as possible. Arrangements are in place for a nearby dental practice to see the patients in an emergency.

Out of hours cover is also provided by the nearby dental practice and contact numbers for this service were displayed on the surgery door, as well as on an answerphone message.

Concerns & complaints

The practice had a complaints policy in place, and patients were informed on how to raise a complaint by information displayed on the wall of the waiting area.

Staff had undertaken training in complaint handling, and the complaint log indicated that there had been no complaints made to the practice in the last 12 months.

Patients we spoke with said they would feel comfortable to raise a concern should the situation arise.

Are services well-led?

Our findings

Governance arrangements

The provider took responsibility for the overall leadership in the practice, leading on clinical, management and quality monitoring roles including safeguarding and infection control. They were supported by the practice manager, who deputised in their absence.

Staff we spoke with were clear about their roles and responsibilities within the practice team, and they had good systems in place to ensure effective communication across the staff.

Three monthly staff meetings were undertaken, and we saw agendas and minutes of these meetings. Discussion of significant events and in-house training was included in these meetings and records kept for reference.

The practice had policies and procedures in place to support the management of the service, and these were readily available in hard copy form.

Policies were noted in infection control, health and safety, complaints handling, safeguarding children and vulnerable adults, information governance and whistleblowing. These were typically signed by staff members to confirm they had read and understood them, but they had not always been reviewed within the last year.

In addition risk assessments were in place to minimise risks to staff, patients and visitors to the practice; fire safety, and control of substances hazardous to health.

The practice had failed to recognise that X-ray equipment was working outside normal parameters, despite this being highlighted following routine testing of the equipment in April 2014. A Radiation Protection Advisor had not been appointed following the practice changing supplier in 2014.

The practice manager retained a schedule which documented when servicing for particular equipment was required, and when external assessment (for example pertaining to dental unit water lines) was due. In this way risks to staff, visitors and patients were mitigated.

Leadership, openness and transparency

The practice team was very small with only three permanent members of staff and the culture of the practice encouraged candour, openness and honesty.

Staff expressed that they felt comfortable to raise issues and concerns at any point with the dentist without fear of discrimination. All staff we spoke with said the practice was a relaxed and friendly place to work.

The practice had in place a whistleblowing policy, which had been recently discussed during a staff meeting. This gave guidance on how staff could go about raising concerns they may have about another's actions or behaviours.

Learning and improvement

Quality assurance processes were in place at the practice to ensure continuous improvement. The inspection team were shown audits that had been regularly repeated for the last four years These included infection control (carried out every three months), general cleaning, clinical record keeping, quality of radiographs, health and safety, treatment standards and emergency procedures.

Staff working at the practice were supported to maintain their continuous professional development as required by the General Dental Council. Training had been carried out in the last year. For example, pertaining to oral cancer and ethics.

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

The practice took into account the views of patients and visitors via feedback from patient surveys. We found evidence of these surveys having been logged, and action plans drawn up to respond to the wishes of the patient population.

Staff informed us of how they intend to make a change to the opening hours of the service in response to patient feedback that suggested opening five days a week, even if only for a half day was preferable to being closed all day on Wednesday.

Staff were regularly asked to fill in staff satisfaction questionnaires which the dentist was then able to use in conjunction with information received through informal discussions and staff meetings to gain insight into how to improve the service for visitors and staff.

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 There was not a system in operation to monitor and recognise concerns raised following routine testing of X-ray equipment. There was no system in operation to check that training and policy regarding the use of conscious sedation were up to date. This was in breach of Regulation 17 (1) (2) (a), (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.