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Ham Dental Practice

Inspection Report

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Overall summary

We carried out this announced inspection on 26 June 2019 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a second CQC inspector and a specialist dental adviser.

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 form the framework for the areas we look at during the inspection.

Our findings were:

Are services safe?

We found that this practice was not 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

Ham Dental Practice is in London Borough of Kingston Upon Thames and provides NHS and private treatment to patients of all ages.

There is level access for people who use wheelchairs and those with pushchairs. Car parking spaces are available near the practice.

The dental team includes four dentists, two dental nurses, one trainee dental nurse, one dental hygienist and one receptionist. The practice has four treatment rooms, however only three treatment rooms are currently being used.

The practice is owned by a partnership and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting

Summary of findings

the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at the practice was the principal dentist.

On the day of inspection, we received feedback from 39 patients via comment cards and speaking with patients.

During the inspection we spoke with one dentist, two dental nurses and one receptionist. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open: 9:00am to 5:30pm Monday to Thursday. (The practice closed for lunch from 1:00am to 2:00pm) and 9:00am to 2:00pm on Friday.

Our key findings were:

- The practice appeared clean and well maintained.
- The provider had infection control procedures which reflected published guidance.
- Staff members knew how to deal with emergencies, however, there was limited evidence of staff training.
- Most medicines and life-saving equipment were available and in date.
- The practice did not have systems to help them manage risk to patients and staff.
- The provider had some suitable safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children, however, there was limited evidence of staff training.
- The provider had staff recruitment procedures, however, they were not reviewed at regular intervals or specific to the needs of the practice.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect
- Risks to protect patients' privacy and personal information.
- Staff were providing preventive care and supporting patients to ensure better oral health.
- The appointment system took account of patients' needs.
- The provider had effective leadership, however, there was limited evidence of a culture of continuous improvement.

- Staff felt involved and supported and worked well as a team.
- The provider asked staff and patients for feedback about the services they provided.
- The provider dealt with complaints positively and efficiently, however, there was no evidence of analysis or learning from complaints.
- The provider had some information governance arrangements.

We identified regulations the provider was not complying with, they must:

- Ensure care and treatment is provided in a safe way to patients
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.

Full details of the regulations the provider was not meeting are at the end of this report.






There were areas where the provider could make improvements, they should:

- Review the current staffing arrangements to ensure all dental care professionals are adequately supported by a trained member of the dental team when treating patients in a dental setting.
- Review the practice's protocols for the use of closed-circuit television cameras taking into account the guidelines published by the Information Commissioner's Office.
- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued by the Medicines and Healthcare products Regulatory Agency, the Central Alerting System and other relevant bodies, such as Public Health England.

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?	Requirements notice	
Are services effective?	No action	
Are services caring?	No action	
Are services responsive to people's needs?	No action	
Are services well-led?	Requirements notice	

Are services safe?

Our findings

We found that this practice was not providing safe 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 section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

The impact of our concerns, in terms of the safety of clinical care, is minor for patients using the service. Once the shortcomings have been put right the likelihood of them occurring in the future is low.

Safety systems and processes, including staff recruitment, equipment and premises and radiography (X-rays)

Staff had some systems to keep patients safe.

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw evidence that some staff members had received safeguarding training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC.

The provider had a system to highlight vulnerable patients and patients who required other support such as with mobility or communication within dental care records.

The provider had a whistleblowing policy; however, this was not up to date/personalised to the practice. Staff felt confident they could raise concerns without fear of reprimand.

The dentists used dental dams in line with guidance from the British Endodontic Society when providing root canal treatment. In instances where the dental dam was not used, such as for example refusal by the patient, and where other methods were used to protect the airway, we saw this was documented in the dental care record and a risk assessment completed.

The provider had a recruitment policy and procedure to help them employ suitable staff, however, this was not up to date/personalised to the practice. There was no evidence of any checks being in place for agency and

locum staff. We looked at seven staff recruitment records. These showed the provider had undertaken most checks for permanent staff members required by the relevant legislation, however, the interview notes were not available on any of staff recruitment records.

We noted that clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover.

Staff ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions, including electrical and gas appliances.

Records showed that fire detection and firefighting equipment was regularly serviced by the previous provider. However, there were no records of checks since March 2019 when the current provider had taken over. There was also no fire risk assessment to show that the provider had considered all potential risks and mitigated against them.

The practice had suitable arrangements to ensure the safety of the X-ray equipment and we saw the required information was in their radiation protection file.

We saw evidence that the dentists justified, graded and reported on the radiographs they took. The provider had not undertaken any radiography audits (Though at the time of the inspection the provider had been registered with the CQC for less than two months).

There was evidence of some clinical staff completing continuing professional development (CPD) in respect of dental radiography.

The premises, patient and staff information were not always secure. On the day of the inspection staff left for lunch leaving the premises unsecured. This included leaving documents such as staff training files and staff personnel files easily accessible as they were not stored in locked cabinets. Computers were also left accessible as they were not password protected.

We discussed this immediately with the provider and asked for urgent action. The provider acted promptly and arranged for staff recruitment files to be stored in a locked cabinet, password protected the computer, and arranged for locks to be fitted on the door separating the reception area and patient waiting area. Further arrangements needed to be made to ensure the glass slider window at the reception could be locked as well.

Are services safe?

Risks to patients

The practice's health and safety policies were available; however, these were not up to date and personalised to the practice.

The procedures and risk assessments were not all available and were not reviewed regularly to help manage potential risk. For example, there was no suitable risk assessment in place for legionella, fire risk and lone working for the hygienist. Also, the practice's general risk assessment did not encompass the justification for CCTV recording in the surgery on the first floor.

The provider had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The staff followed relevant safety regulation when using needles and other sharp dental items. A sharps risk assessment had been undertaken.

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked.

Staff knew how to respond to a medical emergency, however, not all staff members had completed training in emergency resuscitation and basic life support (BLS).

Most emergency equipment was available as described in recognised guidance; however, the adult and child oxygen masks were past their use-by date of January 2019. We found staff did not keep records to make sure these were available, within their expiry date, and in working order.

We noted that medicines to manage medical emergencies were available and in date.

A dental nurse worked with the dentists when they treated patients in line with General Dental Council (GDC) Standards for the Dental Team. There was no risk assessment in place for when the dental hygienist worked without chairside support. However, the practice had a suitable process in place to ensure there were suitable numbers of dental instruments available for the hygienist and measures were in place to ensure they were decontaminated and sterilised appropriately.

The provider had suitable risk assessments to minimise the risk that can be caused from substances that are hazardous to health.

The practice occasionally used agency staff. We noted that they did not receive an induction to ensure that they were familiar with the practice's procedures.

The provider had an infection prevention and control policy and procedures. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health and Social Care. Staff completed infection prevention and control training and received updates as required.

The provider had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance.

We found staff had systems in place to ensure that any work was disinfected prior to being sent to a dental laboratory and before treatment was completed.

We saw staff had some procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, however, they did not always record the results of water temperature checks. They also did not have a suitable risk assessment in place.

We saw cleaning schedules for the premises. The practice was visibly clean when we inspected.

The provider had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance.

The provider had not undertaken any infection prevention and control audits. However, the provider had only been registered with the CQC for two months so time had not elapsed for them to have undertaken audits in line with guidance.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at a sample of dental care records to confirm our findings and noted that individual records were written and

Are services safe?

managed in a way that kept patients safe. Dental care records we saw were complete, legible and kept securely and complied with General Data Protection Regulation (GDPR) requirements.

Patient referrals to other service providers contained specific information which allowed appropriate and timely referrals in line with practice protocols and current guidance.

Safe and appropriate use of medicines

The provider had reliable systems for appropriate and safe handling of medicines.

There was a suitable stock control system of medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required.

We saw staff stored and kept records of NHS prescriptions as described in current guidance.

The dentists were aware of current guidance with regards to prescribing medicines.

Track record on safety and Lessons learned and improvements

There was a risk assessment in relation to safety issues, however, this was not comprehensive. We saw evidence of staff recording customer service incidents, however, when spoken to staff were unaware of what constituted a serious incident. There was also no evidence of the practice monitoring and reviewing incidents, helping them to understand risks, give a clear, accurate and current picture that can lead to safety improvements.

In the previous 12 months there had been one safety incident. We did not see any evidence that this was investigated, documented and discussed with the rest of the dental practice team to prevent such occurrences happening again in the future.

There were no systems for reviewing and investigating when things went wrong. There was no process in place for the practice to learn and share lessons, identify themes and act to improve safety in the practice.

There was no system for receiving and acting on safety alerts. There was no evidence that staff learned from external safety events as well as patient and medicine safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

We saw that clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

Helping patients to live healthier lives

The practice was providing preventive care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentists prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for patients based on an assessment of the risk of tooth decay.

The dentists, discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of dental products for sale and provided health promotion leaflets to help patients with their oral health.

Staff were aware of national oral health campaigns and local schemes in supporting patients to live healthier lives. For example, local stop smoking services. They directed patients to these schemes when necessary.

The dentist described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition

Records showed patients with more severe gum disease were recalled at more frequent intervals for review and to reinforce home care preventative advice.

The practice carried out detailed oral health assessments which identified patient's individual risks. Patients were provided with detailed self-care treatment plans with dates for ongoing oral health reviews based upon their individual need and in line with recognised guidance.

Consent to care and treatment

Staff obtained consent to care and treatment in line with legislation and guidance.

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentists gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions and we saw this documented in patient records. Patients confirmed their dentists listened to them and gave them clear information about their treatment.

The practice's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who might not be able to make informed decisions. The policy also referred to Gillick competence, by which a child under the age of 16 years of age may give consent for themselves. Staff were aware of the need to consider this when treating young people under 16 years of age.

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

The practice kept detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dentists assessed patients' treatment needs in line with recognised guidance.

Effective staffing

Staff new to the practice had a period of induction based on a programme. However, there were no systems in place for temporary or locum staff to receive an induction. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council.

There were some systems in place for staff to discuss their training needs. Some staff required role specific training. We were not shown evidence of how the practice addressed the training requirements of all staff.

Not all staff members had completed 'highly recommended' training as per General Dental Council professional standards, included undertaking medical emergencies and basic life support training annually.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

Are services effective?

(for example, treatment is effective)

The dentist confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide.

Staff had systems to identify, manage, follow up and where required refer patients for specialist care when presenting with dental infections.

The provider also had systems for referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist.

Staff monitored all referrals to make sure they were dealt with promptly.

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

Staff were aware of their responsibility to respect people's diversity and human rights.

Patients commented positively that staff were kind and considerate. We saw that staff treated patients with care and understanding and were friendly towards patients at the reception desk and over the telephone.

Patients said staff were compassionate and understanding. Patients told us staff were kind and helpful when they were in pain, distress or discomfort.

Information folders and thank you cards were available for patients to read.

Privacy and dignity

Staff were not always aware of the importance of maintaining patient privacy and confidentiality. The premises, patient and staff information were not always kept secure. The practice closed for lunch. There were no systems in place to ensure that the premises or patient and staff information was left secure during this period.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care and were aware of the

Accessible Information Standards (a requirement to make sure that patients and their carers can access and understand the information they are given) and the requirements under the Equality Act, we saw:

- Interpretation services were available for patients who did not speak or understand English. Patients were also told about multi-lingual staff that might be able to support them. For example, staff spoke Slovakian, Sicilian and Italian.

Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment. Staff gave clear information to help them make informed choices about their treatment. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. A dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

The practice's website provided patients with information about the range of treatments available at the practice.

The dentist described to us the methods they used to help patients understand treatment options discussed. These included for example X-ray images shown to the patient/relative to help them better understand the diagnosis and treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

Staff were clear on the importance of emotional support needed by patients when delivering care. For example, patients with a learning difficulty and people living with dementia were booked in for double appointment slots.

Patients described satisfaction with the responsive service provided by the practice. The practice currently had some patients for whom they needed to make adjustments to enable them to receive treatment. For example, patients with mobility issues were booked for the ground floor clinical room .

The staff focused on the needs of patients. For example, young mums who may need buggy access to the practice were marked on the appointments system. They were then offered physical assistance to manoeuvre the baby buggy's around the practice.

A disability access audit had not been completed and no action plan had been formulated to continually improve access for patients.

Timely access to services

Patients could access care and treatment from the practice within an acceptable timescale for their needs.

The practice displayed its opening hours in the premises and included it in on their website.

The practice had an appointment system to respond to patients' needs. Patients who requested an urgent appointment were seen the same day. Patients had enough time during their appointment and did not feel rushed. Appointments ran smoothly on the day of the inspection and patients were not kept waiting.

The practice's website and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open. Patients confirmed they could make routine and emergency appointments easily and were rarely kept waiting for their appointment.

Listening and learning from concerns and complaints

The principal dentist took complaints and concerns seriously and responded to them appropriately to improve the quality of care. They had a policy providing guidance to staff on how to handle a complaints, however, this was not up to date/personalised to the practice.

The practice had a complaints leaflet explaining how to make a complaint, the principal dentist was responsible for dealing with these.

The principal dentist aimed to settle complaints in-house and invited patients to speak with them in person to discuss these. Information was available about organisations patients could contact if not satisfied with the way the principal dentist had dealt with their concerns.

We looked at comments, compliments and complaints, the practice had received two complaints in the past 12 months. The practice had a process in place to respond to concerns appropriately, however, there was no evidence that they discussed outcomes with staff, shared learning and improved the service.

Are services well-led?

Our findings

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 section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

Leadership capacity and capability

The principal dentist had the capacity and skills to deliver sustainable care. The principal dentist did not, however, demonstrate they had the experience, capacity and skills to deliver the practice strategy and address risks to it.

Culture

The practice had a culture of sustainable care.

Staff stated they felt respected, supported and valued. They were proud to work in the practice.

The provider had a process in place to record and respond to incidents and complaints in an open, honest and transparent manner; however, there was no evidence of learning or improvements being made following any incidents and complaints.

The provider was aware of and had some systems to ensure compliance with the requirements of the Duty of Candour.

Staff could raise concerns and were encouraged to do so, and they had confidence that these would be addressed.

Governance and management

There were clear responsibilities, roles and systems of accountability to support governance and management.

The principal dentist had overall responsibility for the management and clinical leadership of the practice, they were responsible for the day to day running of the service. Staff knew the management arrangements and their roles and responsibilities.

The provider had some systems of clinical governance in place which included policies, protocols and procedures; however, they were not reviewed at regular intervals and were not specific to the needs of the practice.

We saw there were some processes for managing risks, issues and performance, however, certain risk assessments such as; fire safety, legionella, CCTV recording, and lone working were not available.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

Quality and operational information was not always used to ensure and improve performance. Performance information was not always combined with the views of patients.

Staff demonstrated some awareness of the importance of protecting patients' personal information, however, this was not always implemented in practical terms, for example, the computer in the reception area was left open and unattended on the day of the inspection which meant patients information was accessible to unauthorised persons.

Engagement with patients, the public, staff and external partners

The provider used verbal comments from patients to obtain patients' views about the service. We saw examples of suggestions from patients the practice had acted on. For example, an old coffee table had been removed from the waiting area, creating a more spacious waiting area.

The provider gathered feedback from staff through meetings informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

Continuous improvement and innovation

There were no current systems and processes in place for learning, continuous improvement and innovation.

The provider had no quality assurance processes to encourage learning and continuous improvement. No audits had been undertaken by the practice, this included audits of disability access and infection prevention and control. However, at the time of the inspection the practice had been registered with the CQC for less than two months.

The principal dentist valued the contributions made to the team by individual members of staff. For example, suggestions and contributions made by staff resulted in the practice implementing a new computer system.

Are services well-led?

Not all staff members had completed 'highly recommended' training as per General Dental Council professional standards, included undertaking medical emergencies and basic life support training annually.

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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014</p> <p>Regulation 12</p> <p>Safe Care and Treatment</p> <p>How the regulation was not being met:</p> <p>The premises being used to care for and treat service users was not being used in a safe way.</p> <p>In particular:</p> <ul style="list-style-type: none">• There was a lack of security of the premises, and staff and patient records. <p>There was no proper and safe management of medicines.</p> <p>In particular:</p> <ul style="list-style-type: none">• There was lack of a proper system to review stocks of, and for identifying, disposing and replenishing of out-of-date stock of medicines. <p>There was additional evidence that safe care and treatment was not being provided.</p> <p>In particular:</p> <ul style="list-style-type: none">• There was lack of a system for recording, investigating and reviewing incidents or significant events with a view to preventing further occurrences and ensuring that improvements are made as a result <p>Regulation 12(1)</p>

Regulated activity	Regulation
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Requirement notices

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulation 17

Good Governance

Systems or processes must be established and operate effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social care Act 2008 (Regulated Activities) Regulation 2014

How the regulation was not being met:

There were no systems or processes that enabled the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.

In particular:

- There was no suitable risk assessment in place for fire safety.
- There was no record being maintained of fire safety equipment being checked at regular intervals.
- There was no suitable risk assessment in place for legionella.
- The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to maintain securely such records as are necessary to be kept in relation to the management of the regulated activity or activities.

In particular:

- The policies at the practice; including, whistleblowing, safeguarding, health and safety, complaints handling, and recruitment were not reviewed regularly and were not specific to the needs of the practice.

Requirement notices

There were no systems or processes that enabled the registered person to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services.

Regulation 17(1)

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Health and Social Care Act 2008 (Regulated Activities) 2014

Regulation 18

Staffing

How the regulation was not being met:

The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular:

- There was a lack of training and support for new staff members and locum staff.
- There was a lack of training to manage medical emergencies and safeguarding of children and vulnerable adults.
- There was a lack of practice protocols and procedures to ensure staff are up to date with their mandatory training and their continuing professional development.

Regulation 18(2)