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Waldron Dental Clinic

Inspection Report

Waldron Dental Clinic
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Overall summary

We carried out this unannounced inspection on 22 July 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 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

Waldron Dental Clinic is in the London Borough of Lewisham and provides private dental treatment to patients of all ages.

There is level access for people who use wheelchairs and those with pushchairs.

The dental team includes three dentists, one dental nurse, one dental hygienist, one practice manager and one receptionist. The practice has two treatment rooms.

Summary of findings

The practice is owned by an individual who is the principal dentist there. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

On the day of inspection, we received feedback from two patients.

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

The practice is open: From 11.00am to 8.00pm Monday to Friday.

Our key findings were:

- The practice appeared clean and well maintained.
- The provider had suitable safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider had thorough staff recruitment procedures.
- Staff treated patients with dignity and respect and took care to protect their 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.
- 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.
- The provider had suitable information governance arrangements.
- The provider did not have infection control procedures which reflected published guidance.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were however not available.
- The practice did not have systems to help them manage risk to patients and staff.
- The clinical staff did not provide patients' care and treatment in line with current guidelines.
- The practice did not have effective leadership and a culture of continuous improvement.

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.

There were areas where the provider could make improvements. They should:

- Review the practice's responsibilities to take into account the needs of patients with disabilities and to comply with the requirements of the Equality Act 2010.

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?	**Enforcement action** 

Requirements notice

Are services safe?

Our findings

We found that this practice was not providing safe care in accordance with the relevant regulations. 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.

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.

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

Staff did not have 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 staff 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. Staff felt confident they could raise concerns without fear of recrimination.

The dentists used dental dams in line with guidance from the British Endodontic Society when providing root canal treatment. There was no process in place to verify when clamps used with dental dams were last sterilised. The clamps were un-pouched and stored in a container; however, there was no date to confirm when they had been sterilised. The provider could not ensure that the clamps they were using were sterile.

The provider had a business continuity plan describing how they would deal with events that could disrupt the normal running of the practice.

The provider had a recruitment policy and procedure to help them employ suitable staff. These reflected the relevant legislation. We looked at five 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 were regularly tested and serviced.

The practice had some arrangements to ensure the safety of the X-ray equipment and we saw information was in their radiation protection file. The radiography local rules had not been updated at regular intervals as they still listed an old member of staff as the relevant contact.

We saw evidence that the dentists justified, graded and reported on the radiographs they took. The dentists had not carried out radiography audits as per current guidance and legislation.

Clinical staff completed continuing professional development (CPD) in respect of dental radiography.

Risks to patients

There were some systems to assess, monitor and manage risks to patient safety.

The practice's health and safety policies, procedures and risk assessments were reviewed regularly to help manage potential risk. The provider had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The staff followed some relevant safety regulation when using needles and other sharp dental items. A sharps risk assessment had been undertaken and was updated annually. Only one of the two sharps bins were dated; the sharps bin that was dated had a date over six months old.

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.

Requirements notice

Are services safe?

There were ineffective arrangements in place to deal with medical emergencies. Staff completed training in emergency resuscitation and basic life support (BLS) every year. for Dental staff supporting dental treatment procedures under conscious sedation had not undertaken Immediate Life Support training (ILS).

The provider confirmed within 24 hours of the inspection that they would no longer be performing dental treatment procedures under conscious sedation at the practice.

Emergency equipment and medicines were not available as described in recognised guidance. We found staff did not keep records to make sure these were available, within their expiry date, and in working order. We found no in date medicines to treat a severe allergic reaction, an epileptic seizure, asthma and low blood sugar. There was no reversal agent for use when midazolam was used in conscious sedation. There was only one oxygen tank available at the practice. There were no masks available to use with the oxygen, no ports for the pocket masks, no size 0-4 oropharyngeal airways, no portable suction and no self-inflating bag with reservoir for adults and children. The defibrillator and its battery had not been opened/tested from its original packaging.

The provider within 24 hours of the inspection provided evidence that Glucagon, oxygen cylinder tubing for the face mask, Buccal Midazolam and Adrenaline had been purchased and were now available at the practice. Ports for the pocket masks, size 0-4 oropharyngeal airways, portable suction, self-inflating bag with reservoir for children and for adults had all been ordered.

A dental nurse worked with the dentists when they treated patients in line with General Dental Council (GDC) Standards for the Dental Team. A risk assessment was in place for when the dental hygienist worked without chairside support.

There were suitable numbers of dental instruments available for the clinical staff.

The provider had not undertaken a suitable risk assessment to minimise the risk that can be caused from substances that are hazardous to health.

The provider had an infection prevention and control policy and procedures. Practice staff did not always follow the 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.

The provider did not always have suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. There was no process in place to verify when clamps used with dental dams were last sterilised. The temperature of the water used for manual scrubbing of used dental instruments was not monitored. Metal bur brushes were used to scrub instruments. Dirty instruments were rinsed under running water in the same sink containing the solution for scrubbing them and not in a separate sink or bowl as per current national guidance.

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 procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. There were no recommendations in the current risk assessment which had to be actioned. Records of water testing and dental unit water line management were 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 infection control lead had carried out one infection prevention and control audit. The audit showed the practice was not meeting the required standards. There was no analysis identifying the shortfalls and action plans to meet the shortcomings. It had been over six months since the last infection prevention and control had been undertaken.

Information to deliver safe care and treatment

Staff did not always have the information they needed to deliver safe care and treatment to patients.

Requirements notice

Are services safe?

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 for patients who had been treated using conscious sedation were not written and managed in a way that kept patients safe.

Other dental care records we saw of patients receiving general dental treatment were legible, were 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 did not always have reliable systems for appropriate and safe handling of medicines.

There was no suitable stock control system of medicines which were held on site. This did not ensure that medicines did not pass their expiry date and enough medicines were available if required.

Track record on safety and Lessons learned and improvements

Staff had a system to monitor and review incidents. This helped staff to understand risks, give a clear, accurate and current picture that led to safety improvements.

In the previous 12 months there had been no safety incidents. There were adequate systems in place for reviewing and investigating when things went wrong.

There was a system in place for receiving and acting on safety alerts. Staff learned from external safety events as well as patient and medicine safety alerts. We saw they were shared with the team.

No action

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

The practice had systems to keep dental practitioners up to date with current evidence-based practice. We saw that clinicians assessed patients' needs and delivered care and treatment (apart from for patients receiving treatment under conscious sedation) in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

Staff had access to an intra-oral scanner and single-lens reflex camera (SLR) to enhance the delivery of care.

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 clinicians where applicable, 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.

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.

Consent to care and treatment

Staff obtained patient 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 dentist gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions and there were records of consultations.

However, there was no evidence of written consent being obtained and suitably documented for patients receiving dental treatment under conscious sedation.

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.

Monitoring care and treatment

The practice did not always keep detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories.

The principal dentist offered dental treatment using conscious sedation for patients who were very nervous of dental treatment and those who needed complex or lengthy treatment. The practice systems for this were not in accordance with guidelines published by the Royal College of Surgeons and Royal College of Anaesthetists in 2015.

The practice's systems did not include checks before and after treatment, emergency equipment requirements, medicines management, sedation equipment checks, and staff availability and training. They also did not include patient checks and information such as consent, monitoring during treatment, discharge and post-operative instructions. There was only one oxygen cylinder available at the practice and there were no masks available to use with the oxygen. There was no reversal agent available for midazolam.

The staff did not assess patients appropriately for sedation. The dental care records showed that patients having sedation did not have important checks carried out first. These included a detailed medical history, blood pressure checks and an assessment of health using the American Society of Anaesthesiologists classification system in accordance with current guidelines. .

There was no record of consultations with the patients prior to them receiving sedation and no evidence of written

No action

Are services effective?

(for example, treatment is effective)

consent being obtained and suitably documented. There was no record of patients being provided with emergency contact information post sedation. There was no evidence of pre/post sedation vital signs being recorded for blood pressure, oxygen saturation and heart rate, the time of administration of sedation and midazolam titration during sedation treatment.

Effective staffing

Some staff members had the skills, knowledge and experience to carry out their roles. Staff new to the practice had a period of induction based on a structured programme. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council. There was no evidence of the second person assisting the dentist with sedation being suitably qualified in immediate life support or sedation. There was no evidence of the dentist undertaking sedation having completed an immediate life support course within the past 12 months.

Nursing and reception staff discussed their training needs at annual appraisals. We saw evidence of completed appraisals.

Co-ordinating care and treatment

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

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.

No action

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 friendly and kind. We saw that staff treated patients respectfully, appropriately 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 were available for patients to read.

Privacy and dignity

Staff respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting area was open plan in design and staff were mindful of this when interacting with patients in person or on the telephone. If a patient asked for more privacy, staff would take them into another room. The reception computer screens were not visible to patients and staff did not leave patients' personal information where other patients might see it.

Staff password protected patients' electronic care records and backed these up to secure storage. They stored paper records securely.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care and were aware of some of 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 at the practice spoke Guajarati and Hindi.
- Staff communicated with patients in a way that they could understand, and communication aids such as large font materials were available.

Patients confirmed that staff listened to them and did not rush them. Staff 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 photographs, models and X-ray images.

No action

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.

Patients described high levels of satisfaction with the responsive service provided by the practice.

The practice currently had no patients for whom they needed to make adjustments to enable them to receive treatment.

The practice had step free access and provided patients where required, large print leaflets.

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 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.

The practice's 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 practice manager was responsible for responding to complaints and concerns. The practice had a process to respond to them appropriately to improve the quality of care. They had a policy providing guidance to staff on how to handle a complaint.

The practice website explained how to make a complaint. Staff confirmed that they would tell the practice manager about any formal or informal comments or concerns straight away so patients received a quick response.

The practice had a process in place to respond to concerns appropriately, discuss outcomes with staff, share learning and improve the service

The practice manager aimed to settle complaints in-house and said they would invite 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 practice manager had dealt with their concerns.

We looked at comments, compliments and complaints; the practice had not received any complaints in the past 12 months.

Enforcement action

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 Enforcement Actions 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

We found the principal dentist did not have the capacity and skills to deliver high-quality, sustainable care. The principal dentist did not demonstrate that they had the experience, capacity and skills to deliver the practice strategy and address risks to it.

The provider did not have a recognised protocol in place, and risks associated with undertaking dental procedures under conscious sedation had not been suitably identified and mitigated.

The provider did not have suitable risk assessments to minimise the risk that can be caused from substances that are hazardous to health. There was no system to record or maintain a COSHH file (Control of Substances Hazardous to Health).

Culture

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

The provider had a process in place to respond to incidents and complaints in an open, honest and transparent manner. The provider was aware of and had 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 was not always clear responsibilities, roles and systems of accountability to support good governance and management. The radiography local rules had not been updated as they still listed an old member of staff as the relevant contact.

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

We saw there was lack of a clear and effective process for managing risks. The provider did not have a recognised protocol in place, and risks associated with undertaking dental procedures under conscious sedation had not been suitably identified and mitigated.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

The provider had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information.

Engagement with patients, the public, staff and external partners

Staff involved 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, upon patient suggestions the practice installed a fridge to provide cold water.

The provider gathered feedback from staff through meetings, surveys, and 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 systems and processes for learning, continuous improvement and innovation.

The provider did not have quality assurance processes to encourage learning and continuous improvement. The provider had not undertaken a disability access audit and regular radiography audits and it had been over six months since the last infection prevention and control had been undertaken.

The dental nurses and the receptionist had annual appraisals. They discussed learning needs, general wellbeing and aims for future professional development. We saw evidence of completed appraisals in the staff folders.

Enforcement action

Are services well-led?

Some staff members completed 'highly recommended' training as per General Dental Council professional standards. This included undertaking medical emergencies and basic life support training annually. There was no evidence of the second person assisting the dentist with sedation being suitably qualified in immediate life support or sedation. There was no evidence that the dentist undertaking dental procedures using conscious sedation had completed an immediate life support (ILS) course within the past 12 months.

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
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 12** **Safe Care and Treatment** Care and treatment must be provided in a safe way for service users to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were insufficient quantities of equipment to ensure the safety of service users and to meet their needs. In particular: · There was only one oxygen cylinder. · There was lack of · masks available to use with the oxygen, · ports for the pocket masks, · size 0-4 oropharyngeal airways. · portable suction. · self-inflating bag with reservoir for children. · self-inflating bag with reservoir for adults. · The defibrillator and its battery had not been opened/tested from its original packaging.

This section is primarily information for the provider

Requirement notices

There were insufficient quantities of medicines to ensure the safety of service users and to meet their needs.

In particular:

- There was no in date:

· adrenaline.

· buccal midazolam.

· glucagon injection.

· There was no reversal agent for midazolam.

There was no assessment of the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.

In particular:

- The provider had no suitable arrangements for cleaning, checking, sterilising and storing instruments in line with HTM 01-05:

· There was lack of assurance that the clamps used with dental dams were sterile when used.

· The temperature of the water used for manual scrubbing of used dental instruments was not monitored.

· Metal bur brushes are used to scrub instruments.

· Dirty instruments were rinsed under running water in the same sink containing the solution for scrubbing them.

· Only one of the two sharps bins were dated.

· The sharps bin that was dated was over 6 months old.

Regulated activity	Regulation
Surgical procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing
Treatment of disease, disorder or injury	

This section is primarily information for the provider

Requirement notices

Regulation 18

Staffing

Not all the people providing care and treatment had the qualifications, competence, skills and experience to do so safely.

In particular:

- There was no evidence of the second person assisting the dentist with sedation being suitably qualified in immediate life support or sedation.
- There was no evidence of the dentist performing dental procedures under conscious sedation having completed an immediate life support course within the past 12 months.
- There was no evidence of effective infection control training.

This section is primarily information for the provider

Enforcement actions

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
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 operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 • Risks associated with undertaking dental procedures under conscious sedation had not been suitably identified and mitigated. • The provider did not have a recognised protocol in place when undertaking sedation. • The provider did not have suitable risk assessments to minimise the risk that can be caused from substances that are hazardous to health. There was no system to record or maintain a COSHH file (Control of Substances Hazardous to Health). There were no systems or processes that ensured the registered person maintained securely such records as are necessary to be kept in relation to the management of the regulated activity or activities. In particular: • The radiography local rules had not been updated at regular intervals as they still listed an old member of staff as the relevant contact.

This section is primarily information for the provider

Enforcement actions

There were no systems or processes that enabled the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular:

- There was no record of consultations prior to sedation.
- There was no record of patients being provided with emergency contact information post sedation.
- There was no evidence of pre/post sedation vital signs being recorded for blood pressure, oxygen and heartrate.
- There was no evidence of written consent being obtained for all sedation patients.
- There was no record of the time of administration of sedation.
- There was no evidence of midazolam titration during sedation treatment.