Arggen 1 Limited

Dentcare1 Boston

Inspection report

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Overall summary

We carried out this unannounced inspection on 13 October 2021 under section 60 of the Health and Social Care Act 2008 as a result of receiving concerns. We returned to the practice on 15 October 2021 to gather further evidence, but the practice was closed. We returned on 19 October 2021 when we were able to collect further evidence. We planned the inspection in response to concerns raised and 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 Care Quality Commission, (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 questions:

• Is it safe?

• Is it effective?

• 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 this practice was not providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services well-led?

Summary of findings

We found this practice was not providing well-led care in accordance with the relevant regulations.

Background

Dentcare 1 Boston is in the Lincolnshire market town of Boston and provides private dental care and treatment for adults and children.

There is level access to the rear of the practice for people who use wheelchairs and those with pushchairs. Car parking spaces, including dedicated parking for people with disabilities, are available near the practice.

The dental team includes two dentists and two dental nurses. The practice has two treatment rooms.

The practice is owned by a company and as a condition of registration must have a person registered with the CQC as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at Dentcare 1 Boston is the provider.

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

The practice is open: Monday, Tuesday, Thursday and Friday 9am to 5pm

Our key findings were:

- The practice was visibly unclean and poorly maintained.
- The provider had infection control procedures. These were not applied effectively or consistently. People were potentially exposed to the risk of unsafe treatment.
- Staff knew how to deal with medical emergencies. Appropriate medicines and life-saving equipment were not always available.
- The provider did not have safe systems in place for the treatment and assessment of patients undergoing sedation.
- The provider did not have safe systems for the use of X-ray equipment.
- The provider did not have effective systems in place to help them manage risk to patients and staff.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children. We did not see evidence staff had completed safeguarding training.
- The provider's staff recruitment procedures did not reflect current legislation or best practice.
- The clinical staff did not always provide patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect. Although, procedures to protect their privacy and personal information were not in place.
- The appointment system did not take into account patients' needs.
- The provider lacked effective leadership and a culture of continuous improvement.
- The provider dealt with complaints positively and efficiently.
- The provider did not have effective 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

Summary of findings

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

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

- Take action to ensure that all the staff have received training, to an appropriate level, in the safeguarding of children and vulnerable adults.
- Improve the practice's waste handling protocols to ensure waste is segregated and disposed of in compliance with the relevant regulations and taking into account the guidance issued in the Health Technical Memorandum 07-01.
- Improve the practice’s arrangements for ensuring good governance and leadership are sustained in the longer term.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**Enforcement action** 
Are services effective?	**Enforcement action** 
Are services well-led?	**Enforcement action** 

Are services safe?

Our findings

We found 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 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.

We have taken enforcement action in relation to the regulatory breaches identified and imposed conditions on the registration of the provider to prevent them from providing regulated activities from this location.

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

Clear systems were not in place 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 were not provided evidence that staff had received safeguarding training to an appropriate level. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC.

We did not see evidence, within dental care records, that the provider had a system to highlight vulnerable patients and patients who required other support such as with mobility or communication. This may expose people to the risk of receiving care that does not meet their needs.

The providers infection prevention and control policy 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. We found that procedures and implementation of the policy did not reflect guidance..

On the 13th October, we identified multiple dental instruments available for use that had been through the decontamination and cleaning process and remained visibly soiled. On the 19th October improvements had been made, however large number of visibly dirty instruments remained. We noted items identified as single use only were put through the cleaning and decontamination process and were available for reuse in the surgeries.

We did not see, and the provider did not supply, evidence that staff completed infection prevention and control training or received updates as required. Staff told us they did not receive regular training in decontamination processes.

The provider's arrangements for transporting, cleaning, checking, sterilising and storing instruments was not in line with HTM 01-05. No records were kept to evidence that equipment used by staff for cleaning and sterilising instruments was validated, maintained or used in line with the manufacturers' guidance. We asked the provider to supply evidence that these checks were completed. We did not receive any evidence. Suitable numbers of dental instruments were not always available for the clinical staff.

There was no system in place to ensure that patient-specific dental appliances were disinfected prior to being sent to a dental laboratory and before treatment was completed.

We did not see evidence that provider had implemented effective systems that helped manage risk associated with the Covid 19 pandemic. Evidence was not available or submitted to show how the provider calculated and monitored the fallow time, a period when a treatment room is not in use to minimise the spread of airborne particles, between patients undergoing an aerosol generating procedure. We received information that the principal dentists discouraged staff from changing PPE between patients. We noted PPE was available in treatment rooms but not in the decontamination room. One treatment room did not have any equipment in place to assist with air exchange to reduce risk of airborne particles. The second treatment room had a very small air purifier that appeared to lack the power to effectively work in a room of that size.

Are services safe?

We did not see and where no provided with, evidence that staff had completed training on the management and mitigation of Covid 19.

Procedures to reduce the possibility of Legionella or other bacteria developing in the water systems were not in place. The provider had commissioned an assessment of risk for legionella, the findings and recommendations were not acted upon or implemented. Records of water testing and dental unit water line management were not available on the first day of our inspection. Staff told us they had never kept these records as they had not been told to. On the second day of our inspection we were provided with records of water temperature checks and assessments dating back several years. We did not have confidence that these documents were an accurate contemporaneous record of assessment.

The provider did not keep cleaning schedules which would enable monitoring and oversight of cleaning of the practice. We saw the practice was visibly dirty. We noted that surgery flooring was not sealed as per guidance, sections of flooring were missing, and other sections stained. we observed dirty surfaces and visible contamination of door and cupboard handles.

The provider had policies and procedures for the segregation and storage of clinical waste. We found these policies were not implemented effectively or monitored. We noted bins marked for clinical waste were lined with domestic bin liners. Clinical waste bags were not labelled to identify the practice and records did not identify how much waste was collected. We were not assured an effective clinical waste collection contract was in place.

The infection control lead told us they carried out infection prevention and control audits annually. Current guidance states these audits should be completed every six months. We did not see records of these audits. We were given sight of action plans developed from the preceding three audits. All three action plans identified issues that were not addressed and that we identified during this inspection.

The provider had a whistleblowing policy. Evidence submitted prior to and following our inspection indicated that staff did not always have confidence they would be free from recrimination if they raised a concern.

The dentists did not always use dental dam in line with guidance from the British Endodontic Society when providing root canal treatment. We noted that some rubber dam kits contained latex and one kit was over two years past its use by date.

In instances where dental dam was not used, such as for example refusal by the patient, and where other methods were used to protect the airway, we did not see any evidence of a risk assessment associated with this in care records. We found two clamps, used to secure rubber dam to teeth, were visibly soiled and prepared as available for use. We saw that the dentist had chosen to use dental floss to secure dental files for some patients. We found these single use files were put through the decontamination process and prepared as ready for reuse, with the dental floss still attached. Processes and safeguards to ensure the safe reuse of these items for the same individual were not followed. Pouches used to store these after cleaning were not always dated or labelled with the patient's name. We noted some that only included a surname. This storage method posed a sharps risk to staff.

The provider had a recruitment policy and procedure to help them employ suitable staff. We did not find evidence that this was applied. The practice occasionally used agency staff. Evidence of checks for agency and locum staff were not available. We observed that these staff did not regularly receive an induction to ensure they were familiar with the practice's procedures.

We looked at two staff recruitment records. These showed the provider had not followed their recruitment procedure with both missing evidence including DBS checks, photographic proof of identification and references.

We observed that clinical staff were registered with the General Dental Council and had professional indemnity cover.

The provider could not confirm facilities and equipment were safe or that equipment was maintained according to manufacturers' instructions.

Are services safe?

A fire risk assessment was carried out in line with the legal requirements. We saw there were fire extinguishers and fire detection systems throughout the building and fire exits were kept clear.

The practice's arrangements to ensure the safety of the X-ray equipment were not robust and we noted that the required radiation protection information was out of date. For example, local rules had not been updated since 2015 and include the names of staff who no longer worked at the practice. The provider could not assure us or themselves, staff had undertaken continuing professional development requirement in respect of dental radiography..

We saw evidence the dentists justified, graded and reported on the radiographs they took. The system was ineffective as we found that the templates used for these assessments were pre-populated as 'Grade 1' the highest rating. The provider used an X-ray developer. We did not see evidence of regular maintenance or validation of this machine. X-rays we reviewed were not always clear and were not of adequate diagnostic value. as the rollers on the developer had left marks on some films obscuring the area under investigation. Staff told us they regularly observed poor radiographic images which would mean that they had to be repeated exposing patients to radiation.

Risks to patients

The provider had implemented 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 did not follow the relevant safety regulation when using needles and other sharp dental items. We identified that dentists did not always dispose of sharps at point of use, which had resulted in a staff member receiving a needle stick injury. We noted occasions where unprotected sharps were included in items sent to be decontaminated. A sharps management policy was in place. Guidance in this policy stated staff would be protected from receiving needle stick injuries by ensuring completion of annual sharps management training. We did not find evidence that staff had received any such training.

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

Clinical staff had not received training in or had knowledge of how to recognise, diagnosis and respond to early management of sepsis.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year. Immediate Life Support training with airway management for staff providing treatment under sedation was also completed

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 the practice did not have medicines to manage a severe allergic reaction or low blood sugar.

Airways used to support the breathing of an unconscious patient had exceeded the manufacturer's use by date. Medicine for use in an emergency including Adrenaline (used to manage a severe allergic reaction) and Glucagon (used to manage low blood sugar) had also exceeded the manufacturer's use by date. On the second day of our inspection, the provider had purchased new glucagon and was awaiting delivery of Adrenaline.

A dental nurse worked with the dentists when they treated patients in line with General Dental Council Standards for the Dental Team.

The provider had risk assessments to minimise the risk that can be caused from substances that are hazardous to health. The assessment we viewed was dated 2008. We did not see evidence that provider kept this file updated to ensure continued oversight of COSHH. an updated version. We identified that the provider did not follow written guidance

regarding the safe storage of radiograph developing fluid. We observed clear evidence of leakage of the fluid onto the worktops of the decontamination room, along with leakage onto the door and handles of the cupboard the containers were stored in. Additionally, the containers were not sealed as identified in guidance and we were not provided with evidence that these containers were collected by a waste contractor. This could expose staff to the risk of contact with a hazardous substance.

Information to deliver safe care and treatment

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

We discussed with a dentist how information to deliver safe care and treatment was handled and recorded. We looked at dental care records with clinicians to confirm our findings and observed that individual records were written and typed. Records were not managed in a way that kept patients safe.

The provider had systems for referring patients with suspected oral cancer under the national two-week wait arrangements. These arrangements were initiated by National Institute for Health and Care Excellence to help make sure patients were seen quickly by a specialist.

Safe and appropriate use of medicines

The provider's systems for handling of medicines were not always safe or appropriate.

The stock control system of medicines was not adequate and did not ensure that medicines did not pass their expiry date. We found numerous items that had exceeded their use by date by a number of years, including medicines used to treat patients in an emergency.

A fridge was used to store medicines and some dental materials. We noted the fridge was visibly dirty and stained inside and felt warm. We saw that one medicine, glucagon, had exceeded its safe use by date by nine months. We did not see any record that staff monitored fridge temperatures to ensure they were in an acceptable range. Staff confirmed these checks were never completed.

The provider issued private prescription forms. We found that the prescription forms were not stored securely and the system to monitor their use was not robust. Prescription forms we viewed were poor quality photocopies. This meant information such as the name and address of the practice was not legible.

The dentists were not aware of current guidance with regards to prescribing medicines.

We saw evidence of an Antimicrobial prescribing audit completed in November 2020. No issues were identified from this audit.

Track record on safety, and lessons learned and improvements

The provider had implemented systems for reviewing and investigating when things went wrong, we did not see evidence that these were always implemented.

In the previous 12 months there had been one safety incidents we saw this was investigated, documented and discussed with the rest of the dental practice team to prevent such occurrences happening again.

The provider had a system 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 and acted upon if required.

Are services effective?

(for example, treatment is effective)

Our findings

We found this practice was not providing effective 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.

Effective needs assessment, care and treatment

We did not find, and the provider did not submit evidence of systems to keep dental professionals up to date with current evidence-based practice. We saw clinicians did not always assess patients' needs or deliver care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. Treatment plans lacked detail and diagnostic assessments were not always carried out.

The practice offered conscious sedation for patients. This included patients who were very anxious about dental treatment and those who needed complex or lengthy treatment. The practice did not have systems to ensure this was carried out safely or in accordance with guidelines published by the Royal College of Surgeons and Royal College of Anaesthetists in 2015. We did not see, and the provider did not provide, evidence that clinical staff had completed appropriate training or CPD to safely manage patients receiving sedation.

The practice's systems included checks before and after treatment, sedation equipment checks, and staff availability and training. They also included patient checks and information such as consent, monitoring during treatment, discharge and post-operative instructions. We noted that these checks were completed by an assisting nurse, who had not completed training to do this, rather than the dentist carrying out the sedation. We found that emergency equipment requirements and medicines management were not safe and did not reflect current guidance. The provider had not carried out a risk assessment regarding the requirement and availability of having a second oxygen cylinder at the practice when patients were undergoing sedation. available. We found a sedation medicines tray set up and ready for use in one of the surgeries on the second day of our inspection. We noted that the tray had midazolam and another unidentified product drawn up but not clearly labelled in syringes. Additionally, the suture pack was open and therefore unsterile and posing a potential sharps risk. It had also exceeded the manufacturers stated use by date.

The staff assessed patients for sedation. The dental care records showed that patients having sedation had important checks carried out first. These included a detailed medical history' blood pressure checks and an assessment of health using the guidance. However, the dental nurse undertaking these checks was not trained to do so.

The records showed that staff recorded important checks at regular intervals. These included pulse, blood pressure, breathing rates and the oxygen content of the blood.

We found the operator-sedationist was not always supported by a trained second individual.

The practice offered dental implants. These were placed by the principal dentist. The provider informed us the principal had had undergone appropriate post-graduate training in the provision of dental implants. We were not provided with evidence of this training or specific indemnity to carry out this treatment. We did not see evidence that instruments used were sterile or had undergone sufficient cleaning and safe storage prior to use. The provider did not have a vacuum autoclave as per guidance. The standard autoclave that was used for decontamination was clearly damaged and had not been serviced or validated.

Dental care records we saw were not always complete. We did not find evidence that basic periodontal examination (BPE) was carried out for all adults' assessments . Records were legible but were not kept securely or in a way that complied with General Data Protection Regulation requirements. Patient care records, including X-Rays, care records, invoices and letters were found in open filing cabinets in a room that was used by non-clinical contractors. Files containing peoples' confidential medical information was open and easily accessible to anyone.

Are services effective?

(for example, treatment is effective)

Helping patients to live healthier lives

The dentists/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 leaflets to help patients with their oral health. The dental care records we reviewed did not reflect and preventative advice provided. Staff were unaware of the delivering better oral health guidance. Plaque and gum bleeding scores or charts of the patient's gum condition were not routinely recorded.

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 staff were aware of the need to obtain proof of legal guardianship or Power of Attorney for patients who lacked capacity or for children who are looked after, so they could make informed decisions. We saw this documented in patients' dental care records.

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 in certain circumstances. Staff were aware of the need to consider this when treating young people under 16 years of age.

Monitoring care and treatment

The provider's quality assurance processes were not robust or effective. They did not encourage learning and continuous improvement. Audits were not carried out at recommended intervals and records were not always available. Action plans developed from completed audits were not always acted on.

Effective staffing

We did not find that staff had the skills, knowledge and experience to carry out their roles safely and effectively.

Staff new to the practice, including agency staff, did not always receive a structured induction programme. We looked at records of newly employed staff and found their planned induction and training programme had not been completed. Records of completed training for all staff were not available.

Co-ordinating care and treatment

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

Are services well-led?

Our findings

We found 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 leaders lacked the capacity, values and skills to deliver high-quality, sustainable care. Systems and processes that would provide a structure for governance and oversight of the practice were not embedded and lines of accountability and communication were not clear or well developed.

Information we requested during and after the inspection was not available, difficult to access, out of date, inaccurate or lacked veracity. During both days of our inspection, the provider could not demonstrate how they would develop and sustain a high quality, continuously improving practice and did not supply us with such evidence or commitment following our inspection.

The provider displayed a lack of awareness of the issues we identified at the practice and did not demonstrate that they understood the challenges or had plans to address them.

Leaders were not a regular or visible presence at the practice. The provider was unable to confirm what days they attended the practice and what their regular schedule of management visits was. We observed that staff did not find leaders approachable.

The provider was unable to demonstrate that they had developed a strategy for delivering the service which was in line with health and social priorities across the region and reflected the needs of the local population.

We were unable to confirm staff had completed the continuing professional development required for their registration with the General Dental Council, as records were not available and evidence was not submitted by the provider.

Culture

The practice did not demonstrate a culture of high-quality sustainable care. We observed a reluctance to take accountability.

Staff stated they did not always feel respected, supported and valued.

Staff told us they had appraisal meetings with the principal. We did not see evidence of annual appraisals for staff or regular review or analysis of training needs. We did not see evidence that provider had invested in the training and development of staff.

We saw the provider had systems in place to deal with staff poor performance.

Staff felt unable to raise issues with the principal due to the unsupportive response they received. Leadership lacked compassion and inclusivity.

Governance and management

The principal dentist and registered manager had overall responsibility for the management and clinical leadership of the practice. The team leader was responsible for the day to day running of the service.

We were not assured that the provider's system for clinical governance was effective. Policies, protocols and procedures were in place but not always readily available or implemented consistently.

Appropriate and accurate information

Are services well-led?

The provider's information governance arrangements were not effective. Staff had not received training in the use and application of information governance guidelines.

Engagement with patients, the public, staff and external partners

We were not provided with evidence that staff involved patients, the public, staff and external partners to support the service.

The provider used online reviews to obtain staff and patients' views about the service. We were not provided with examples of suggestions from patients or staff the practice had acted on.

The provider gathered feedback from staff through meetings and informal discussions. We did not see evidence that this was always acted on.

Continuous improvement and innovation

The provider did not demonstrate or provide evidence to confirm that they had effective systems and processes for learning, continuous improvement or innovation.

Audits of dental care records, radiographs, sedation and infection prevention and control and anti-microbial prescribing were not regularly completed. Staff did not always keep records of the results of these audits and we found that any resulting action plans and suggestions for improvement were not acted on. For example, we noted the same issue was identified on infection control action plans for April 2019 and February 2020.

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
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 Safe Care and treatment 12(1) (2) Care and treatment must be provided in a safe way for service users There was no assessment of the risk or processes for preventing, detecting and controlling the spread of, infections, including those that are health care associated. In particular: • We found that you are failing to demonstrate effective and safe sedation oversight and management. Your registered manager did not provide when asked any training or validation certification for staff carrying out sedation procedures. We were told that sedation had not been provided since September 2020 however, on 19 October 2021 we found a tray of sedation instruments prepared for use. Sutures were opened which posed risks of sharps injury and infection prevention and control as the suture was no longer sterile. A controlled medicine, midazolam, was pre-drawn in a syringe ready for use this was not stored securely and there was no labelling to indicate the strength, content or expiry of this medicine. A second unlabelled syringe was drawn up with an unidentified liquid. • We found that that you do not have effective infection prevention and control processes. When we inspected on 13 October 2021 the premises were visibly dirty. You did not have adequate handwashing facilities in the decontamination room or treatment room two. Floors in treatment rooms two and three were stained and visibly dirty and the floor was not sealed. The head rest of the chair in treatment room two was ripped.

This section is primarily information for the provider

Enforcement actions

Cupboard and drawer handles in treatment rooms two and three were visibly soiled. The fridge in treatment room three showed signs of staining and the treatment lamp was held together with Sellotape making this difficult to clean between patients. Cleaning was not thorough, and no records were kept including; daily cleaning schedules, decontamination of instruments, fridge temperatures, cleaning of the treatment room between patients or flushing of dental water lines.

- Due to the concerns we identified above, we reviewed the arrangements to maintain infection prevention and control and found they were not in line with The Health Technical Memorandum 01-05: decontamination in primary dental care practices (HTM 01-05) published by the Department of Health and Social Care.

- We found concerns with insufficient numbers of suitably qualified, competent, skilled and experienced staff working at the practice. During the inspection we found only one dental nurse (staff member A) was qualified and registered with GDC. We were not assured that the knowledge and skills of staff member A was sufficient to undertake lead roles and responsibility for infection prevention and control.

- Staff did not demonstrate effective cleaning techniques of the contaminated dental instruments over the course of our inspection and had not received training in how to do so. On 13 October 2021 we noted that the illuminated magnifier used to aid visual inspection of instruments was covered in dust and not in working order. When we returned on 19 October 2021, we found the magnifier had not been cleaned or replaced.

- Numerous instruments were found that had been through the decontamination and cleaning process which remained visibly soiled during our inspection on the 13 October 2021. On the 19 October 2021 we found that improvements had been made, however a large number of visibly soiled instruments remained.

This section is primarily information for the provider

Enforcement actions

- In a drawer of treatment room three on the 13 October 2021 we found sterilisation bags with clean instruments that had been opened to remove an instrument, these had not been sent to the decontamination room for repossessing.

- We found multiple items marked as single use were cleaned and available in drawers in both treatment rooms for reuse including endodontic files, material mixing tips and matrix bands.

- We found that no record of cleaning of instruments was kept. Infection prevention and control audit had not been completed at correct intervals and records of the audits were not kept.

- Records of action plans we saw indicated infection control audits had been completed by staff member A on 04 February 2019, 07 February 2020 and 07 July 2021. We did not see evidence that the staff member A had received training in completion of such audits or had the knowledge and experience to do so.

- Action plans produced following audits were not always followed. The audit of 07 July 2021 identified the following failing “sharps filled beyond indicator mark / disposable needles and syringes discarded as a single unit.”

- We found that you were failing to provide safe care and treatment in line with statutory requirements, considering Public Health England (PHE) guidance and Covid-19 related updates. We were not assured that there were appropriate fallow times in place in line with PHE guidance. When we asked the registered manager for evidence to support how they had calculated the fallow time, we were not provided with any assurance, as no supporting standing operating procedures or policies were available, and staff were not aware of how fallow times had been calculated.

- We found that you do not have an effective system in place to ensure medical emergency equipment was available and checked in accordance with guidelines issued by the Resuscitation Council (UK) and the General Dental Council. We found size 0, 1, 2, 3 and 4

This section is primarily information for the provider

Enforcement actions

airways had passed their expiry date. Adult and child masks for the Ambibag were missing. One of the two medical oxygen cylinders was empty on the 13 October 2021 and then missing on the 19 October 2021. The available cylinder had a capacity of 400 litres as opposed the stated minimum of 460 litres. Regular monitoring checks of the medical emergency equipment was not carried out or recorded.

- We found that you do not to have an effective system in place to ensure equipment was maintained, serviced, validated and certificated. When asked, your registered manager could not provide evidence of the servicing and maintenance for the autoclave. On 13 October 2021 we found that the seal on the autoclave door had perished causing a leak which had been in place for such a time that limescale had developed.

- Your registered manager could not provide assurance of validation for the decontamination equipment and no pressure vessel certificates were made available when asked for on the 13 and 19 October 2021. The X-ray developer machine had not been appropriately maintained, we saw radiographs developed on the 19 October 2021 which were marked from the Velopex rollers not being cleaned and were therefore of poor diagnostic quality. We found due to the poor quality of radiographs and ineffective oversight radiographs had to be retaken. We identified one patient who was exposed to five repeated X-rays of the same location during one treatment session.

- We found that foil validation tests had last been completed for the ultrasonic cleaner on 16 June 2020. Guidance from HTM01 05 and the manufacturer's instructions state this should be completed quarterly to ensure they are working effectively.

- We found that legionella checks were not carried out when we inspected on the 13 October 2021. Risk assessments were recorded as completed at monthly intervals from 2016. Guidance from these stated water temperature checks should be completed. No water temperature testing of taps had ever been completed. On the 19 October 2021 we were provided with records labelled 'Water Temp for Decon room'. These

This section is primarily information for the provider

Enforcement actions

documents did not provide an adequate record of temperatures, include guidance on temperature range or action taken to address issues and we did not have confidence that they were a contemporaneous record of events.

- We were not provided with evidence that daily flushing of Dental unit water lines was carried out. The impact on patient safety in respect to safe water systems at the practice is significant if legionella management is not fully understood or managed appropriately.

- We found that clinical waste was not managed in accordance with the relevant regulations, taking into account the guidance issued in the Health Technical Memorandum 07-01. The last waste collection was recorded as 14 October 2021.On the 19 October 2021 we found clinical waste bins were overflowing and waste consignment notices we observed all stated no weight or bags collected.

- We found that there was no comprehensive system for a regularly reviewed sharps risk assessment in place in line with your legal obligations under the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Sharps were not disposed of close to the work area and were transported into the decontamination room for disposal. This was contrary to your own risk management procedures. Several sharps risks were identified within the drawers in treatment rooms two and three, including unsheathed needles, matrix bands, broken glass and rusty uncovered and filled bur trays. The sharps box in treatment room two was overflowing with a syringe and needle sticking out of the opening. The box had also exceeded the three month use period having been assembled on 15 November 2019.

- We found that your protocols and procedures for the use of X-ray equipment in were not in line with The Ionising Radiations Regulations 2017 and Ionising Radiation (Medical Exposure) Regulations 2017. Signage was not in place to warn staff and visitors to the practice that that X-rays were being taken. Chemicals

This section is primarily information for the provider

Enforcement actions

used to develop X-rays were not stored safely. The local rules had not been updated since 2015 and included the names of staff who no longer worked at the practice.

- We found insufficient support, training, professional development and supervision in place to enable staff to undertake their roles safely and effectively. We reviewed the staff files of staff members A and B. The file of staff member B did not contain evidence that any training or induction had been completed during the staff members employment. The file of Staff member A contained record of only two completed training courses. Fire safety in May 2017 and Immediate Life Support in 17 May 2019.

- We found that recruitment procedures and continued oversight of documents established were not operating effectively. Staff files were not held securely at the practice.

a. Disclosure barring service checks had not been completed for staff member B. We were not provided with evidence of recruitment checks for two of the five staff employed and there were no associated risk assessments to mitigate any potential risk.

b. You had no evidence of requesting references for any staff members.

c. You had no evidence of photographic identification for any staff members.

- We found that patient records were not stored securely or in line with information governance standards. We looked in a room on the first floor where building work was being carried out and saw several filing cabinets with their drawers unlocked and open that contained patients care records including X-rays, treatment plans and invoices.

- Effective systems and processes were not operated to make sure you assess and monitor the service against Regulations 4 to 20A of Part 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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Enforcement actions

We found there was a lack of managerial leadership and oversight by your Nominated individual / Registered manager to assess, monitor and improve the quality and safety of services provided.

Regulation 12 (1)