Sparkly Smile Limited

Sparklysmile

Inspection report

19 Montpelier Vale
Blackheath
London
SE3 0TA
Tel: 02088520442
www.sparklysmile.co.uk

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Overall summary

We carried out this announced inspection on 26 August 2021 under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to follow up on information of concern we received 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 CQC specialist dental advisor.

To get to the heart of patients' experiences of care and treatment, we usually ask five key questions, however due to the ongoing pandemic and to reduce time spent on site, only the following three questions were asked:

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 providing effective care in accordance with the relevant regulations.

Summary of findings

Are services well-led?

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

Background

Sparklysmile is in the London Borough of Lewisham and provides private dental care and treatment for adults and children.

The dental team includes the principal dentist, one associate dentist, three visiting dentists, four dental hygienists and three dental nurses. The clinical team are supported by one receptionist, one administrative assistant and the practice manager. The practice has four 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 Sparklysmile is the principal dentist.

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

The practice opening times are:

8.30am – 5.30pm Mondays to Fridays

Our key findings were:

- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The clinical staff provided patients' care and treatment in line with current guidelines. Improvements were needed to ensure that detailed dental care records were maintained.
- Staff provided preventive care and supported patients to ensure better oral health.
- Infection prevention and control procedures were not followed in accordance with national guidance.
- The provider had ineffective arrangements to ensure that equipment was tested, serviced and maintained in accordance with relevant guidelines.
- Staff knew how to deal with emergencies. However, emergency equipment and medicines were not available in accordance with the Resuscitation Council UK 2021 guidelines.
- The provider had ineffective systems to help them manage risks to patients and staff and to monitor staff training and learning needs.
- The provider had ineffective recruitment procedures.
- The provider had ineffective governance systems to monitor the day to day running of the practice and an ineffective leadership to support a culture of openness and 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.

Summary of findings

- 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.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

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

- Review the practice's policy and the storage of products identified under Control of Substances Hazardous to Health (COSHH) 2002 Regulations to ensure a risk assessment is undertaken and the products are stored securely .
- Review the security of medicines in the practice and ensure there are systems in place to track and monitor their use.
- 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 taking into account the guidance issued by the General Dental Council.

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

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?	**No 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 and Requirement 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.

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

The provider did not have systems that were operated effectively 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. This information was easily accessible and discussed during practice meetings. The information included contact details for the local child and adult safeguarding teams.

Staff knew about the signs and symptoms of abuse and neglect and how to report concerns. Improvements were needed to the systems to monitor that staff undertake safeguarding training. Records showed that the principal dentist, associate dentist and one dental nurse had undertaken safeguarding training shortly before the inspection. No records of prior training were available for these staff.

The provider had an infection prevention and control policy and procedures. Staff completed infection prevention and control training. Improvements were needed to ensure that staff undertook refresher training periodically.

Infection prevention and control procedures were not followed in accordance with 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.

During the inspection we observed the practices for cleaning and sterilising dental instruments. There were arrangements to ensure the sterilising equipment (autoclaves) were serviced annually.

There were some records available for the daily checks carried out on the autoclaves. However, these records were only available in respect of two weeks prior to our inspection. The principal dentist told us that all other records had recently been disposed of due to a lack of space. They were unable to provide assurances that the sterilising equipment was checked daily to ensure this equipment was operating effectively.

We were shown cleaning schedules to ensure the practice was kept clean. When we inspected, we saw that most areas of practice looked visibly clean.

The principal dentist told us there were procedures in relation to COVID-19 virus. Additional standard operating procedures had been implemented to protect patients and staff from Coronavirus. These included social distancing and screening measures which had been implemented. Staff had access to suitable personal protective equipment including filtering facepiece masks to minimise the spread of the virus

The principal dentist told us there were arrangements for fallow time (period of time allocated to allow aerosol to settle following treatments involving the use of aerosol generating procedures) and cleaning the treatment room following treatments using aerosol generating procedures (AGPs).

There were ineffective systems for cleaning treatment rooms following treatments involving aerosol generating procedures (AGPs). We noted that work surfaces in the treatment rooms where aerosol generating procedures were carried out, were cluttered with items making effective cleaning difficult to carry out.

Are services safe?

The staff had systems in place to ensure that patient-specific dental appliances were disinfected prior to being sent to a dental laboratory and before treatment was completed.

There were ineffective procedures to reduce the possibility of Legionella or other bacteria developing in the water systems. There were arrangements to flush and disinfect the dental unit water lines. However, we found that staff were not recording hot and cold water temperatures to assess and minimise the risk of bacterial growth in the water systems or the tank used to store water.

We checked the hot water temperatures on the day of our inspection. We noted that the water temperature was 48 degrees Celsius, which is below the recommended temperature of 55 degrees Celsius to minimise the risk of Legionella and bacterial growth in water systems in healthcare settings. The principal dentist showed us a Legionella risk assessment, which they had undertaken on 16 August 2021. This assessment lacked detail in respect of risks such as the measures to check hot and cold water temperatures and did not identify the issues with hot water at the practice.

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

The provider had ineffective arrangements to monitor the infection prevention control procedures at the practice. Infection prevention and control audits were not carried out twice a year in accordance with published guidance. The latest audit was carried out 18 August 2021. No other audit records were available, and the principal dentist was unable to tell us when the previous audit had been carried out. The audit did not identify a number of areas where improvements were needed, including those which we identified during the inspection.

The dentists used dental dam in line with guidance from the British Endodontic Society when providing root canal treatment. 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 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, these procedures were not followed so that staff were employed taking into account relevant legislation. We looked at records which were available for 15 members of staff. Improvements were needed to ensure that all of the required employment checks were carried out. There were no records of Disclosure and Barring Service (DBS) available for two dental nurses. There were no records in respect of conduct in previous employment (references) for the dentists or dental nurses. There were no records to prove identity for three dentists, the four dental hygienists and two dental nurses. The principal dentist told us a number of staff had worked at the practice for many years. Following our inspection they told us they had implemented a review system where staff had been employed for many years and references had not been sought at the time of employment.

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

There were ineffective procedures to ensure that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. There were no records to show that the compressor equipment had been serviced.

We noted that no there were no records available in respect of portable appliance tests or a test for the fixed wiring electrical installations. The principal dentist was unable to tell us when or if these tests had been carried out.

Improvements were needed to monitor and review dental materials used at the practice to ensure that these were disposed of once they passed the manufacturer's expiry date. We found a number of single use composite compules which had not been disposed.

Are services safe?

There were ineffective systems for assessing and managing risks of fire at the practice. Fire safety equipment was available including fire extinguishers and smoke detectors. We saw records to show that this equipment was tested.

We were shown one fire risk assessment dated November 2020. This risk assessment was carried out by the principal dentist. The risk assessment did not take into consideration risks such as the fabric and layout of the building, fire evacuation arrangements or the risk associated with electrical systems within the practice.

We were shown a list of dates for fire evacuation exercises. However, these did not include any details of the evacuation exercises such as the members of staff present, time of exercise or any areas for improvement identified.

The practice did not have effective arrangements to ensure the safety of the X-ray equipment. Records showed the three yearly radiological tests was carried out for the dental X-ray equipment in 2017. The principal dentist told us that new X-ray equipment was being installed at the practice and all the dental X-ray units would be tested at this time.

We saw evidence the dentists, with the exception of the principal dentist justified, graded and reported on the radiographs they took. However, there were ineffective systems to monitor and improve the quality of dental radiographs. Audits of dental radiographs were not carried out taking into account current guidance and legislation as part of a system for making improvements. We were shown an audit of dental radiographs which had been carried out in November 2020. This highlighted some areas for improvements. However, there were no action plans or arrangements to monitor and ensure that improvements were achieved.

Records showed that clinical staff completed continuing professional development in respect of dental radiography.

Risks to patients

The provider did not have effective systems to assess, monitor and manage risks to patient safety.

The practice's health and safety policies, procedures and risk assessments were reviewed regularly. The provider had current employer's liability insurance. However, risk assessments were not carried out to help minimise risks.

We looked at the practice's arrangements for safe dental care and treatment. There were procedures for the safe handling and disposal of 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 vaccination to protect them against the Hepatitis B virus. Records were available to show that clinical staff had receive vaccination against Hepatitis B virus and blood result to confirm the effectiveness of the vaccine.

We looked at the arrangements for dealing with medical emergencies. Improvements were needed to ensure that staff undertook training in emergency resuscitation and basic life support every year.

Emergency equipment and medicines were not available as described in accordance with the Resuscitation Council UK 2021 guidelines. We observed that one of the medicines used to treat low blood glucose (Glucagon injection) was stored in a refrigerator. However, the refrigerator temperature was not checked daily to ensure that this medicine was stored was stored in accordance with the manufacturer's instructions. There were no needles and syringes available to administer the medicine used to treat anaphylaxis (Adrenaline). There was no Volumatic spacer to administer the medicine to treat an asthma (Salbutamol aerosol inhaler).

We checked the emergency equipment including the automated external defibrillator, oxygen masks and tubing. This equipment was available for use in the event of a medical emergency.

The principal dentist told us a dental nurse worked with the dentists when they treated patients in line with General Dental Council Standards for the Dental Team. They told us that the dental hygienists worked without chairside support. There were no lone worker risk assessments carried out where staff worked without chairside support.

Are services safe?

The provider had risk assessments to minimise the risk that can be caused from substances that are hazardous to health. On the day of the inspection we noted that information in relation to the handling and disposal of hazardous materials was disorganised and not easily accessible to staff.

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 dental care records with clinicians to confirm our findings and observed that the majority of individual records were typed and managed in a way that kept patients safe. Dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation requirements. Improvements were needed in respect of the detail of records maintained by the principal dentist.

The provider had ineffective 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. There were no systems for logging or following up on urgent referrals.

Safe and appropriate use of medicines

The dentist were aware of current guidance with regards to prescribing medicines. Prescriptions were printed at the point of issue and records of medicines prescribed were maintained in patients dental care records. The practice kept stocks of antibiotics which were dispensed to patients. Improvements were needed so that stock levels were checked to minimise risk of misuse.

Track record on safety, and lessons learned and improvements

The principal dentist told us they had systems for reviewing and investigating when things went wrong. There were policies and procedures for staff to follow and to report any safety related incidents.

There were ineffective systems for receiving and acting on safety information such as patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies, such as Public Health England (PHE). The principal dentist showed us some recently received patient safety alerts. However, these had only been sought and reviewed once our inspection visit was announced and there was not an ongoing system for reviewing such information to help minimise risks to patients.

Are services effective?

(for example, treatment is effective)

Our findings

We found 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 professionals up to date with current evidence-based practice. We saw clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

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 had systems to help them do this safely. These were in accordance with guidelines published by the Royal College of Surgeons and Royal College of Anaesthetists in 2015. Conscious sedation was carried out by a visiting sedationist and records were available in respect of the sedationists' qualifications and training.

The practice's systems included emergency equipment requirements, medicines management, 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.

There were arrangements so that patients were assessed safely and were suitable 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.

Improvements were needed so that patient records included details of important checks at regular intervals during treatment. These include pulse, blood pressure, breathing rates and the oxygen content of the blood.

The operator-sedationist was supported by a trained second individual. The name of this individual was recorded in the patients' dental care record.

Helping patients to live healthier lives

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

The dentists prescribed high concentration fluoride products if a patient's risk of tooth decay indicated this would help them.

The dentists and dental hygienists discussed smoking, alcohol consumption and diet with patients during appointments.

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

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. We saw this documented in patients' records.

Are services effective?

(for example, treatment is effective)

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 and staff undertook training in relation to mental capacity issues. 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 dentists, with the exception of the principal dentist kept detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dental care records which we viewed showed the principal dentist did not routinely record in detail patient assessments including records of caries and oral cancer risks treatment in line with recognised guidance.

Audits of dental care records, where carried were out were not used to identify and address areas for improvement in respect of recordkeeping.

Effective staffing

Improvements were needed to monitor staff training.

The practice manager told us that staff new to the practice had an induction programme. No records were available in respect of the induction processes. We looked at records to determine that clinical staff completed the continuing professional development (CPD) required for their registration with the General Dental Council (GDC). We noted that staff records had been recently reviewed and that this was not part of an ongoing system for monitoring and ensuring that staff were up to date with important training.

Co-ordinating care and treatment

The principal dentist confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide. There were ineffective arrangements to ensure that referrals were monitored so that patients received treatment in a timely way.

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 and Requirement 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

At the time of our inspection there was a lack of clear leadership and oversight arrangements for the day-to-day management the practice. The principal dentist had overall accountability for leadership and the day-to-day management of the service. The principal dentist told us about events which had occurred within the previous 12 months which had impacted on the management of the practice. They acknowledged that in recent months the practice had been managed in a reactive way. They were able to provide assurances that they had the capacity to address issues we identified as part of our inspection.

Following our inspection, the provider took steps to address the issues of concern we identified. These included employing a compliance consultant to assess and assist in rectifying the issues identified. The provider submitted a detailed action plan which set out how these issues will be addressed.

Culture

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

There was a culture to support learning and improvement at the practice. The principal dentist acknowledged that recent events had impacted on the running of the practice. Shortly before the inspection they had commenced an audit and identified a number of areas where improvements were needed. At the time of the inspection they were developing action plans to address these issues.

Staff told us that they were supported and proud of the services they delivered to patients.

Governance and management

There were ineffective processes for governance and managing risks. Staff had access to a range of policies and procedures in relation to governance and risk management. However, there were ineffective arrangements for assessing and minimising risks to patients and staff. This relates to the lack of monitoring infection prevention and control procedures, fire safety risk assessments and failure to monitor the arrangements for maintaining equipment and dealing with medical emergencies.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed. In particular:** • There were no records of Disclosure and Barring Service (DBS) available for two dental nurses. • There were no records in respect of conduct in previous employment (references) for the dentists or dental nurses. • There were no records to prove identity for three dentists, the four dental hygienists or two dental nurses. • **Regulation 19 (3)**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person had failed to take such action as is necessary and proportionate to ensure that persons employed continued to have the qualifications, competence, skills and experience necessary for the work to be performed by them. In particular:** **The provider has failed to establish an effective system to monitor staff training.** • A recent review of staff training records had been undertaken and staff had completed updates in areas such as safeguarding and fire safety. However, there no systems for ongoing reviewing and monitoring staff training.

This section is primarily information for the provider

Requirement notices

Regulation 18 (2)

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 **The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:** **Emergency medicines and equipment were not available in accordance with Resuscitation Council UK Guidelines 2021.** • One of the medicines use to treat low blood glucose (Glucagon injection) was not stored in accordance with the manufacturer's instructions. • There were no needles and syringes available to administer the medicine used to treat anaphylaxis (Adrenaline) • There was no Volumatic spacer to administer the medicine to treat an asthma (Salbutamol aerosol inhaler). **Risks in relation to the control and spread of infections had not been assessed and mitigated, in accordance with the Department of Health publication "Health Technical Memorandum 01-05: Decontamination in primary care dental practices".** • Records of the daily checks and tests staff perform to ensure that the sterilising equipment is functioning properly were not maintained. • We observed a large number of pouched dental instruments which were date stamped as having been sterilised on 23 August 2021. On checking the log of autoclave cycles for this date we noted that these were similar to previous and following days. We cannot be assured that these dental instruments were sterilised on this date.

This section is primarily information for the provider

Enforcement actions

- Infection prevention and control audits were not carried out every six months or used to monitor and improve infection prevention procedures where areas for improvements were identified.

- We noted that work surfaces, in both rooms where aerosol generating procedures were carried out, were cluttered with items such as boxes of disposable gloves making effective cleaning difficult to carry out.

The provider is failing to ensure that risks of fire are assessed and mitigated.

- We were shown one fire risk assessment dated November 2020. The risk assessment did not take into consideration risks such as the fabric and layout of the building or fire evacuation arrangements.
- We were shown as list of dates for fire evacuation exercises. However, these did not include any details of the evacuation exercises such as the members of staff present, time of exercise or any issues / areas for improvement identified.

The provider is failing to assess and mitigate risks in relation to Legionella.

- When we checked the temperature of the hot water during the inspection we noted that the water temperature was 48 degrees Celsius, which is below the recommended temperature of 55 degrees Celsius to minimise the risk of Legionella and bacterial growth in water systems in healthcare settings.

- We were shown a Legionella risk assessment which had been carried out 16 August 2021 by the principal dentist. The risk assessment lacked detail in respect of identifying risks such as the lack measures to check hot and cold water temperatures as part of a system to minimise risks.

The provider is failing to ensure systems to review and act on, where appropriate to patient safety alerts, recalls and rapid response reports issued from the

This section is primarily information for the provider

Enforcement actions

Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies, such as Public Health England (PHE).

- The principal dentist showed us some recently received patient safety alerts. However, these had only been sought and reviewed once our inspection visit was announced and there was not an ongoing system for reviewing such information to help minimise risks to patients.

Regulation 12 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:** **The provider is failing to monitor and ensure systems in relation to the maintenance of equipment used at the practice.** • The compressor equipment had last been tested on 21 October 2019. The provider told us that they had a contract for annual testing of this equipment. However, they had failed to ensure the equipment was tested. • The most recent three - yearly radiological test for the dental X-ray equipment had been carried out 2017. **The provider is failing to assess, monitor and improve quality in respect of dental radiography in accordance with The Ionising Radiations Regulations 2017 (IRR17) and Ionising Radiation (Medical Exposure) Regulations 2017 IR(ME)R 2017:** • The principal dentist did not record the justification for taking dental radiographs, report on the findings or record the grade (that the quality of dental radiographs were clinically acceptable).

This section is primarily information for the provider

Enforcement actions

- An audit of dental radiographs was carried out on 26 November 2020. The audit identified areas for improvements. However, there was no action plan to determine how the findings from the audit were to be reviewed or how the identified areas for improvement were to be addressed.

The provider is failing to ensure accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided:

- We looked at a sample of dental care records completed by the principal dentist. These were incomplete and areas including assessments in relation to caries risks, cancer risks and basic periodontal examinations were not completed consistently.

- We looked at a sample of dental care records for patients who had received treatment using conscious sedation techniques. These records did not include details of checks carried out in respect of observations made for blood oxygen saturation, pulse or blood pressure during treatment in accordance with Standards for Conscious Sedation in Provision of Dental Care: Report of the Intercollegiate Advisory Committee for Sedation in Dentistry (2015).
- We were shown a dental record audit, which was carried out on 20 August 2021. This consisted of a small sample of records completed by all dentists working at the practice. The audit did not include an analysis of the findings or identify areas where improvements were required.

The provider is failing to ensure that there is system for making and monitoring referrals where patients are referred to specialists in primary and secondary care for treatment the practice did not provide.

Regulation 17 (1)