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T & T Dental

Inspection Report

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Overall summary

We carried out this unannounced inspection on 30 August 2019 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We returned on 9 September 2019 to complete the inspection, this second visit was announced. 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 not 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

T&T Dental is in the Walton area of Liverpool and provides NHS and private dental treatment to adults and children.

The dental team includes two dentists and five dental nurses (including two trainees) who also have administrative and reception duties. The practice has two treatment rooms and an instrument decontamination room. One of the treatment rooms is located on the ground floor. There is ramped access into the practice for people who use wheelchairs and those with pushchairs. Car parking spaces are available near the practice on local roads.

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.

Throughout the inspection, we collected 25 CQC comment cards filled in by patients.

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

The practice is open:

Monday, Tuesday and Wednesday: from 9am to 5.30pm

Thursday and Friday: from 9am to 5pm

Our key findings were:

- The practice appeared clean.
- Infection control procedures were not in line with published guidance.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- The systems to help them manage risk to patients and staff were not robust and required improvement.
- The use of amalgam was not in accordance with European Union Regulation 2017/852 for the use of mercury.
- Risk assessments had not been completed in line with the Control of Substances Hazardous to Health Regulations 2002.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children. However, staff training was overdue.
- The provider had followed their staff recruitment procedures.
- The clinical staff had not always provided patients' care and treatment in line with current guidelines. There was evidence of single use items being reused.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The provider could not demonstrate that regular fire drills were being held, or that staff were up-to-date with fire training.
- NHS prescriptions were not monitored or kept securely.
- Checks to ensure risks were mitigated in respect of Legionella had not been recorded.
- The appointment system took account of patients' needs.
- The provider did not have robust systems and processes to ask staff and patients for feedback about the services they provided.
- Policies and procedures were in need of review.
- The provider's systems for quality improvement were not robust.
- The provider had suitable information governance arrangements.

We identified regulations the provider was not complying with. They must:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure the care and treatment of patients is appropriate, meets their needs and reflects their preferences.

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

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

- Improve the practice's protocols and procedures for the use of X-ray equipment in compliance with The Ionising Radiations Regulations 2017 and Ionising Radiation (Medical Exposure) Regulations 2017 and taking into account the guidance for Dental Practitioners on the Safe Use of X-ray Equipment. In particular with regard to the use of rectangular collimation.
- Improve the practice's systems for assessing, monitoring and mitigating the various risks arising from the undertaking of the regulated activities. In particular through the use of dental dams when completing endodontic treatments in line with guidance from the British Endodontic Society.

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

Are services safe?

Our findings

We found that this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the 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.

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

Systems to keep patients safe were not effective.

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. There was a designated lead person for safeguarding alerts within the practice. The records showed that four staff members had completed safeguarding training, with the latest certificates dated July 2014. Guidance within the practice identified that safeguarding training should be updated every three years dependent on the person's role.

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. We saw examples of how this information was recorded within dental care records.

The provider had a whistleblowing policy. Staff felt confident they could raise concerns without fear of recrimination.

The dentists told us they did not use dental dams when providing root canal treatment, they used alternative means to ensure the patients' airway was protected. There were no documented risk assessments to support the alternatives used as opposed to following guidance from the British Endodontic Society in dental care records.

The provider had a business continuity plan describing how they would deal with events that could disrupt the normal running of the practice. We noted this had not been updated since 9 January 2017 and some information within this document was out-of-date. For example, the contact buddy dentist was known to have retired and no longer be a practicing dentist.

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. These showed the provider followed their recruitment procedure.

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. The five-year periodic inspection report for fixed wire electrical safety was overdue, with the most recent certificate dated 31 January 2010. The principal dentist told us they thought this was a ten-year requirement. The principal dentist assured us that this would be attended to as soon as possible.

Records showed that fire detection and firefighting equipment were regularly tested and serviced. A fire risk self-assessment had been completed internally in August 2016. The assessment identified that it should be reviewed annually. There were no records to demonstrate this had been completed. The records did not demonstrate that regular fire drills were being held, or that staff were up-to-date with fire training and evacuation procedures.

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

Clinical staff completed continuing professional development (CPD) in respect of dental radiography. The provider had registered with the Health and Safety Executive in line with changes to legislation relating to radiography. Local rules for the X-ray units were available and both X-ray units had been serviced in line with current guidance. We noted that the X-ray machines had not been fitted with rectangular collimation which would help to reduce the dose of radiation as low as reasonably possible.

Are services safe?

Dental care records we reviewed showed that dentists did not always justify, grade or report on the radiographs they took. There were no audits of the quality of radiographs taken at the practice.

Risks to patients

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

The practice had health and safety policies, procedures and some risk assessments to help manage potential risk. We were not assured these were kept under regular review. The provider had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The staff followed relevant safety regulations when using needles and other sharp dental items.

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

Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support (BLS) every year.

Emergency equipment and medicines were available as described in recognised guidance. We found staff kept records of their checks of these to make sure these were available, within their expiry date, and in working order.

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

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

The provider did not have risk assessments to minimise the risk that can be caused from substances that are hazardous to health. We noted that not every product had a risk assessment to accompany the product data safety sheets. This was contrary to the Control of Substances Hazardous to Health Regulations 2002. In addition, bottled mercury was available for use and this had not been risk assessed. The manufacturer's instructions were not being followed for detergents used for manual cleaning.

The provider had an infection prevention and control policy and procedures. They were not in line with guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health and Social Care. Staff completed infection prevention and control training and received updates as required. We noted that the system for manual cleaning before sterilisation was not robust and staff did not follow the instructions for the correct use of instrument cleaning detergent. For example, the amount of cleaning solution in the scrubbing sink was not accurately measured, and the temperature of the water was not checked. Staff could not be sure of the water temperature and concentration of the solution. The guidance HTM 01-05 identifies that during manual cleaning the water temperature should not be above 45 degrees centigrade. There was no thermometer in the decontamination room to facilitate this.

We saw evidence that some single use items were reprocessed. For example, matrix bands which were in a treatment room ready to be reused were visibly mis-shaped and had evidence of dental cement on them.

There was a lead for infection control as recommended by the published guidance. The lead had undertaken infection control training in line with their continuing professional development. However, opportunities had been missed for the infection control lead to identify the concerns identified during this inspection.

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.

The provider had a Legionella risk assessment dated 22 September 2011 which had been completed by an external company. The risk assessment had been reviewed internally following this initial assessment in 2011, most recently in November 2018. The provider could not demonstrate that procedures to reduce the possibility of Legionella or other bacteria developing in the water systems were carried out, in line with their risk assessment. Records of dental unit waterline flushing, and water temperature checks were not up to date. Records of sentinel water temperature checks had previously been completed monthly, but none had been completed since April 2018. The most recent records to demonstrate that dental water lines had been flushed in line with the guidance HTM 01-05 were dated 30 November 2016.

Are services safe?

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.

Records demonstrated the practice had not carried out infection prevention and control audits in line with the guidance HTM 01-05. The most recent audit was dated January 2019. We identified some areas where the infection prevention and control systems were not robust, however these had not been identified in the most recent audit. The audit process had failed to identify reprocessing of single-use items.

Information to deliver safe care and treatment

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 dental care records did not always record sufficient detail about the discussions, risk assessment and treatment plan to ensure a clear and concise record was maintained. Consent was not always recorded, and X-rays were not justified, graded or reported on.

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

Patients updated their medical histories at each visit. The medical histories were then reviewed and checked by the dentist.

Safe and appropriate use of medicines

The provider did not have effective systems for appropriate and safe handling of medicines.

There was a stock control system of medicines which were held on site. This had failed to identify materials available for use in both treatment rooms which had passed their use by date. For example, fixative and whitening products. Local anaesthetics in both treatment rooms had been removed from their protective blister packs for ease of use, but this left them open to contamination.

We saw that NHS prescriptions were not stored as described in current guidance and systems were not in place to identify if any were missing. There was no log to record individual prescriptions and they had been pre-stamped with the practice stamp which compromised their security. We noted on our return visit no action had been taken to improve the security of the prescription pads.

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

Antimicrobial prescribing audits had not been completed to provide an overview of prescribing habits or trends for individual dentists.

Track record on safety and lessons learned and improvements

The practice had systems for staff to report, monitor and review incidents

The practice had an accident book and a procedure for recording accidents. In the 12 months up to this inspection there had been no accidents recorded. There was a system for recording and analysing significant events.

There was a system for receiving and acting on safety alerts. The practice 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 that 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 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.

Effective needs assessment, care and treatment

The evidence identified the practice did not have systems to keep dental practitioners up to date with current evidence-based practice. For example, on our initial visit we noted the use of non-encapsulated mercury in the practice which was not in line with Article 10 of the European Union Regulation 2017/852 which came into force on 1 January 2019. Dental care records were not maintained in line with the Faculty of General Dental Practice recommendations, or guidance to similar effect, regarding clinical examinations and record keeping and the dentists did not always report on the clinical findings of the radiographs they took in line with Ionising Radiation (Medical Exposure) Regulations 2017.

Helping patients to live healthier lives

The dentist told us that where applicable they discussed smoking, alcohol consumption and diet with patients during appointments. The practice provided health promotion leaflets to help patients with their oral health. We saw limited evidence of these discussions in dental care records. For example, some dental care records had brief notes relating to health promotion, and did not always record the discussion that smoking, alcohol or diet could have a detrimental effect on oral health.

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 children and based on an assessment of the risk of tooth decay.

The practice was aware of national oral health campaigns and local schemes available in supporting patients to live healthier lives. For example, local stop smoking services. They had directed patients to these schemes in the past.

Consent to care and treatment

The systems to obtain consent to care and treatment required review. The dentists gave patients limited information about treatment options and the risks and benefits of these, so they could make informed decisions.

The practice's consent policy was a hospital (Trust) document which was not specific to either T&T Dental or dentistry. It included information about the Mental Capacity Act 2005 but made no reference to best interest decisions. The policy contained information on Gillick competence, by which a child under the age of 16 years of age may give consent for themselves.

We saw limited examples of consent having been recorded in dental care records.

Monitoring care and treatment

The practice used handwritten dental care records containing information about the patients' current dental needs, past treatment and medical histories. Improvements were needed to demonstrate that the dentists assessed patients' treatment needs in line with recognised guidance.

There were no audits relating to the dental care records to help identify failings, drive improvements or ensure consistency.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles, for example all staff had completed basic life support training, and this was updated annually.

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 information about dementia friendly dentistry in the practice. The principal dentist told us that there were plans for staff to attend relevant training, but this had not yet been arranged.

Co-ordinating care and treatment

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

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

Are services effective?

(for example, treatment is effective)

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.

The practice monitored referrals through an electronic referral and tracking system to make sure they were dealt with promptly.

Staff were aware of the risks associated with sepsis. The practice had raised awareness with staff and there were posters and risk assessments available within the practice.

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 absolutely marvelous, helpful and obliging. We saw that staff treated patients with dignity, respect and care. Staff were friendly towards patients at the reception desk and over the telephone.

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

The costs for NHS dental treatments were on display in the practice.

Patients said staff were compassionate and understanding.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting areas provided privacy when reception staff were dealing with patients. Staff told us that if a patient asked for more privacy they would take them into a private room near the reception desk. The staff did not leave patients' personal information where other patients might see it.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care and were aware of the Accessible Information Standards and the requirements under the Equality Act.

- The practice had access to an interpreting service, who could provide both face to face and telephone translations.
- Staff communicated with patients in a way that they could understand.

Patients confirmed that staff listened to them and they did not feel rushed. A dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

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

Staff were clear on the importance of emotional support needed by patients when delivering care.

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

The practice had some patients for whom they needed to make adjustments to enable them to receive treatment. These included having a ground floor treatment room available and an induction hearing loop for patients with reduced or restricted hearing.

Staff sent text messages and post cards to remind patients who had agreed to receive them when they had an appointment.

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 inside and outside the premises.

The practice had an efficient appointment system to respond to patients' needs. The practice had emergency appointments for patients who were in pain or who telephoned in an emergency. Patients told us they had enough time during their appointment and did not feel rushed. Appointments ran smoothly on the day of the inspection and patients were not kept waiting.

If patients required emergency out-of-hours treatment, they could ring the NHS 111 emergency telephone line, or make an appointment with an emergency service provider. The contact details for both were displayed outside the practice.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and had systems to respond to them appropriately to improve the quality of care.

The practice had a policy providing guidance to staff on how to handle a complaint. This was displayed within the practice for the benefit of patients. The principal dentist was responsible for dealing with complaints. Staff told us they would tell the principal dentist about any formal or informal comments or concerns straight away so patients received a quick response. The complaints policy identified the time scale in which the practice would respond to any complaints received.

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

The records showed the practice had received no complaints in the year up to this inspection.

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

Improvements were required to ensure the principal dentist could deliver the practice strategy and address risks to it.

During the inspection we identified the practice was in the process of changing ownership and applying to establish a new legal entity for the management and administration.

The provider did not send any additional information or evidence to the Care Quality Commission in the period between the two inspection visits to identify action taken or to clarify issues raised.

Governance and management

The provider did not have effective systems to ensure staff knew their roles and responsibilities. For example, in relation to carrying out and documenting Legionella checks and fire safety procedures.

The system of clinical governance was not up to date, relevant to the practice or reviewed appropriately. This included policies, protocols and procedures that were accessible to all members of staff. We noted policies were not reviewed regularly, with examples of out-of-date information in policies. For example, the business continuity plan had not been updated, and the consent policy did not relate to the practice or dentistry. We identified where practice policies and procedures were not being followed in relation to safeguarding training and processes to review and assess risks.

Systems to identify and manage risks were not effective. We identified risks in relation to:

- The five-year periodic inspection report for fixed wire electrical safety was overdue, with the most recent certificate dated 31 January 2010.
- The records did not demonstrate that systems to assess and manage fire risks were in place, or that staff were up-to-date with fire training and evacuation procedures.
- Systems to assess the risks from hazardous substances were not in place. This was contrary to the Control of Substances Hazardous to Health Regulations 2002. There were no risk assessments in the practice relating to the presence of non-encapsulated mercury on the premises.
- Infection control procedures were not in line with the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health and Social Care. Infection prevention and control audits had failed to identify the concerns identified regarding manual cleaning of dental instruments.
- We saw evidence that staff reprocessed single use items for reuse. There were ineffective systems in place to prevent this from occurring.
- Systems to assess and manage the risk of Legionella could not be assured. Records of recommended water temperature checks and dental unit waterline flushing had ceased in November 2016 and April 2018 respectively.
- The security of NHS prescriptions was not robust. There was no clear audit trail, and individual prescriptions could not be tracked.

Appropriate and accurate information

We saw examples where staff had not acted on appropriate and accurate information. For example, policies and procedures had not been updated and audits were not being completed to provide clear and current information about the practice's level of performance. The records showed that staff meetings were not held regularly with the most recent minutes from 2015.

Dental care records did not always record sufficient detail about consent, including the discussions, risk assessment and treatment plan to ensure a clear and concise record was maintained. They did not follow the Faculty of General Dental Practice. The provider could not demonstrate that patients were informed of risks and benefits of treatments options proposed in line with General Dental Council standards for the dental team. Radiographs were not consistently justified, graded or reported on.

Are services well-led?

Systems were not in place to identify and remove expired materials in dental treatment rooms.

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

Patients were encouraged to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on NHS services they have used.

The practice used patient surveys and verbal comments to obtain patients' views about the service. There were no up-to-date records to demonstrate patients' views were being gathered on a regular basis or any analysis completed to inform the practice of how its patients perceived the service.

There had been two reviews posted on-line about the practice. One patient had provided positive feedback.

Continuous improvement and innovation

The practice's systems and processes for learning, continuous improvement and innovation were ineffective.

Records showed that few audits had been completed within the practice. Where audits had been completed the results were open to question. For example, the most recent infection prevention and control audit had failed to report on issues with manual cleaning identified at this inspection. There was no evidence to show that audits were analysed, and learning points identified and actioned. There were no audits relating to the dental care records to help identify failings, drive improvements or ensure consistency. The provider did not have a radiography audit completed within the last 12 months. Opportunities were missed to review and identify the concerns identified during the inspection.

The provider did not have systems to ensure that dentists were following the up-to-date guidance regarding antibiotic prescribing.

The whole staff team 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. The appraisal system had failed to identify that staff were not up to date with safeguarding training.

Records demonstrated that staff had not always completed 'highly recommended' training as per the General Dental Council professional standards. There had been no safeguarding training since 2014. Staff had completed medical emergencies and basic life support training annually.

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 9 HSCA (RA) Regulations 2014 Person-centred care **How the regulation was not being met** There was insufficient evidence to demonstrate that care and treatment was being designed with a view to achieving service user preferences or ensuring their needs were met. In particular: Care was not carried out in compliance with current legislation, or relevant nationally recognised evidence-based standards and guidance. • Non-encapsulated mercury was in use in the practice which was not in line with Article 10 of the European Union Regulation 2017/852 which came into force on 1 January 2019. • Dentists were not following the up-to-date guidance regarding antibiotic prescribing. There were no audits to provide an overview of prescribing habits or trends. • The dentists did not always report on the clinical findings of the radiographs they took in line with Ionising Radiation (Medical Exposure) Regulations 2017. The registered person did not maintain dental care records in line with the Faculty of General Dental Practice regarding clinical examinations and record keeping or guidance to similar effect or better. • The dentists did not justify, grade or report on the clinical findings of the radiographs they took. Radiography audits were not carried out following current guidance and legislation. • The provider could not demonstrate that patients were informed of risks and benefits of treatments options proposed in line with General Dental Council standards for the dental team. **Regulation 9(1)**

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 **How the regulation was not being met** The registered persons 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 registered provider had not used encapsulated amalgam in accordance with European Union Regulation 2017/852 for the use of mercury. • The registered provider had not ensured all staff were up to date with safeguarding training and were aware of the potential risks posed to children and vulnerable adults. • The registered provider had failed to ensure dentists were using dental dams when providing root canal treatments. In line with guidance from the British Endodontic Society. There were no risk assessments to support the used alternative means to ensure the patients' airway was protected. • The five-year periodic inspection report for fixed wire electrical safety was overdue. This had last been completed in January 2010. • The fire risk assessment had not been reviewed since August 2016. The records did not demonstrate that regular fire drills were being held, or that staff were up-to-date with fire training. • The registered provider had failed to ensure that single use matrix bands were not reused. • The registered provider had failed to ensure that infection control procedures were in line with the

This section is primarily information for the provider

Enforcement actions

Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health and Social Care.

- The registered provider had failed to ensure the security of NHS prescriptions. They had been pre-stamped with the practice stamp, and there was no clear audit trail to account for individual prescriptions.

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 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. **How the regulation was not being met** The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • The registered person's systems for monitoring quality and safety at the practice were ineffective. The provider did not have a radiography audit completed within the last 12 months. The registered person could not demonstrate that infection prevention and control audits had been completed consistently on a six-monthly basis as identified in recognised guidance. Where audits were in place, there were no action plans or identified learning points.

This section is primarily information for the provider

Enforcement actions

- The registered person's system for assessing the risks associated with the Control of Substances Hazardous to Health (COSHH) was not effective. Not every substance had a risk assessment in place contrary to the Control of Substances Hazardous to Health Regulations (2002).
- The registered provider did not have risk assessments in place relating to the presence of non-encapsulated mercury on the premises.
- The registered provider did not have oversight with regard to staff training. Particularly in respect of safeguarding children and adults and fire safety.
- The registered provider did not have systems and processes to ensure the health and safety of patients and staff. Particularly in respect of fire safety checks and fire drills
- The registered provider did not have an effective system or process for assessing the quality of the service. There was no system for regular audits and records showed where audits had been completed they were not robust. There was no evidence to show that audits were analysed, and learning points identified and actioned.

Regulation 17(1) & (2)