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INE Dental Practice

Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 25 October 2022 under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered practice 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 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:

- Staff provided preventive care and supported patients to ensure better oral health.
- Complaints were dealt with positively and efficiently.
- The dental clinic was not clean and well-maintained.
- The provider's infection control procedures did not reflect published guidance.
- Appropriate medicines and life-saving equipment were not available.
- The provider did not operate systems to help them manage risk to patients and staff.
- There were ineffective processes in place to prevent abuse of vulnerable adults and children.
- The practice did not have staff recruitment procedures which reflected current legislation.

Summary of findings

- Improvements were needed to ensure that clinical staff kept up to date with current guidelines, and information related to patient care was suitably recorded within the dental care records.
- Improvements were needed to protect patients' privacy within the treatment rooms
- The appointment system took account of patients' needs. There was scope to improve access to out of hours advice.
- There were ineffective systems to support continuous improvement.
- There were ineffective systems to ensure that staff were up to date with their training.
- There was ineffective leadership and a lack of oversight for the day-to-day management of the service.
- There were ineffective systems to ensure facilities were safe and equipment was serviced and maintained according to manufacturers` guidance.

Due to the nature of the concerns the provider was issued with a letter stating our intention to take urgent enforcement action. They were given an opportunity to submit (within one working day) an action plan as to how they would mitigate the risks identified by our inspection. The provider submitted an action plan after the deadline, which included the urgent actions they had taken and further improvements they had planned. We judged the improvements proposed were not of a sufficient nature to mitigate the risks we undertook immediate enforcement action. The provider's CQC registration to undertake regulated activities is suspended for a period of three months.

Following our inspection, the provider has submitted evidence of the action they have taken in response to the concerns we identified on inspection. We will be reviewing this at the follow up inspection.

Background

INE Dental Practice is in New Malden within the London Borough of Kingston-upon-Thames and provides private dental care and treatment for adults and children. The practice advised us that the majority of the patients are members of the local Korean community.

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

The dental team includes the principal dentist, a dental nurse, a receptionist and a practice manager. The practice has 2 treatment rooms.

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

The practice is open:

Monday, Tuesday, Thursday, Friday from 9.30am to 6pm

Saturday from 9.30 to 1.30pm

The practice is closed on Wednesdays.

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

- Ensure care and treatment is provided in a safe way to patients
- Ensure patients are protected from abuse and improper treatment

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 their duties
- Ensure specified information is available regarding each person employed.

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:

- Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the College of General Dentistry.

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?	**Enforcement action**
Are services caring?	**No action**
Are services responsive to people's needs?	**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.

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

The practice did not have safeguarding processes, and staff were unaware of their responsibilities for safeguarding vulnerable adults and children.

Information about current procedures, and guidance about raising concerns about abuse were not accessible to people who use the service and to staff.

The provider could not demonstrate that staff received safeguarding training at a suitable level for their role.

The practice did not have infection control procedures which reflected current published guidance.

We observed used single use items which should have been disposed of after use, in drawers and cupboards. These included for example orthodontic wires and matrix bands. We also observed used endodontic files retained for re-use. We found cotton wool rolls and burs with visible debris were stored in open soiled containers on the dental bracket tables. We saw that drawers containing dental instruments and materials were dirty. Local anaesthetic cartridges had been removed from their packaging, leaving them vulnerable to contamination. There were many items of expired dental materials in cupboards, drawers and the medicines refrigerator. We saw damage to equipment such as the overhead operating light handles, rendering them difficult to clean and we observed traces of blood on the handle of one operating light and within the spittoon of the less-used surgery.

The decontamination of instruments was not carried out in accordance with The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) guidance. There were no arrangements to monitor the temperature of the water used to clean dental instruments. The instruments were not fully immersed while being scrubbed, creating a risk of contaminated aerosol, and a wire brush was in use. Instruments were not inspected for cleanliness under a magnifying light. Instruments were not transported to the autoclave in securely lidded boxes and the hot instrument trays were removed from the autoclave using a tea-towel or cloth, instead of a suitable handle. Some instruments, such as matrix holders were not packaged before storage in the treatment rooms. The practice did not have a process in place to ensure that the maximum storage time of 1 day for unwrapped instruments stored in the clinical area was not exceeded. There was no protocol in place for disinfecting dental devices that had been returned from laboratories before placement in patients' mouths.

We did not see evidence that all clinical staff had completed training in infection prevention and control as recommended.

Records were not available to demonstrate that equipment used by staff for sterilising instruments was validated and used in line with the manufacturers' guidance. We saw that daily automatic control test strips stored in a pile in a drawer but not suitably logged, and records to demonstrate the success of each sterilisation cycle were not available. Staff were not aware of the need to do this or how it should be done. Staff could not demonstrate that periodic safety checks, including the weekly residual and air leakage tests were carried out on the autoclave in line with the manufacturer`s guidelines.

The practice did not have adequate procedures to reduce the risk of Legionella or other bacteria developing in water systems

Are services safe?

A risk assessment had not been undertaken nor a scheme of control had been implemented in respect of Legionella contamination.

Records were not available to demonstrate that water temperature monitoring was carried out; staff we spoke with confirmed that they did not undertake water testing and dental unit waterlines were not treated with appropriate disinfecting agents. We saw heavy scale deposits on taps in the storage cupboard indicating areas of water stagnation which can increase the risk of Legionella proliferation.

A Legionella risk assessment was arranged and took place since our inspection. The report is pending.

Clinical waste was not segregated and stored according to guidance. We observed that the external clinical waste bin was unlocked and unsecured. The amalgam separation sludge collection vessel was filled beyond capacity.

Systems were not in place to ensure the practice was kept clean and we noted the practice was not visibly clean, in particular, floors and walls were soiled. The provider has made arrangements to address the condition of the flooring to ensure they can be adequately cleaned.

The practice did not have a recruitment policy and procedure in accordance with relevant Legislation. Recruitment checks had not been carried out, in accordance with relevant legislation to help them employ suitable staff. In particular there were no Disclosure and Barring Service checks for staff at the time of recruitment. There was no risk assessment or reference checks to mitigate the risks. There was no evidence that staff who handled contaminated instruments had received Hepatitis B immunisation, contradicting the practice's health and safety policy.

Clinical staff were qualified, registered with the General Dental Council and had professional indemnity cover.

The practice did not ensure equipment was safe to use and maintained and serviced according to manufacturers' instructions. There were no records to demonstrate that the compressor, dental chairs and suction equipment had been serviced to ensure that they were operating safely and effectively. Following our inspection, the compressor and chairs have been serviced.

The practice did not ensure the facilities were maintained in accordance with regulations. There were no records to demonstrate that the electrical installation condition checks and gas safety checks had been carried out, and portable appliances had been tested for safe use. A gas safety check and electrical surveys were arranged immediately and have been completed following our inspection.

The provider did not have effective fire safety management procedures. In particular, there was no evidence to demonstrate that a fire risk assessment had been carried out and regularly reviewed by a person who had the qualification, skills, competence and experience to do so. There were no records to demonstrate that the fire detection system was regularly tested and serviced. In addition, there were no records to demonstrate that fire drills had been carried out or that staff had undertaken training in fire safety. A fire risk assessment was booked and completed following our inspection and the report we were informed is pending.

The practice did not have arrangements to ensure the safety of the X-ray equipment in accordance with Ionising Radiation (Medical Exposure) Regulations 2000/2018 [IRMER2000/2018] and The Ionising Radiations Regulations 2017 [IRR2017]. The required radiation protection information including local Rules, a Radiation Protection File, and information related to laser and handheld X-ray equipment was unavailable.

A Radiation Protection Advisor (RPA) had not been appointed. The X-ray equipment had not been serviced and maintained according to manufacturer's requirements. The practice could not demonstrate that they had registered the use of radiographic equipment with the Health and Safety Executive (HSE). Following the inspection, the provider agreed to cease using the laser equipment, and an RPA contract has been put in place.

Risks to patients

Are services safe?

The practice had not implemented systems to assess, monitor and manage risks to patient and staff safety. In particular relating to sharps safety, as a safer sharps system was not in use and there was no risk assessment to reflect this.

Members of staff had not completed sepsis awareness training. Sepsis prompts to assist the staff to triage appointments and patient information posters were not displayed within the practice.

Emergency equipment and medicines were not available and checked in accordance with national guidance. In particular, there was inadequate and unsuitable provision of emergency oxygen used to treat respiratory distress. The Automated External Defibrillator (AED) was not functional and the provider had not assessed the risks arising from this. There was no oromucosal Midazolam, a medicine used to treat prolonged epileptic seizures and the adrenaline used to treat severe allergic reactions had expired in March 2022. The dispersible Aspirin used to treat heart attacks had expired in 2021. The Glucagon, a medicine used to treat low blood sugar, was stored at room temperature and the expiry date had not been adjusted to reflect this. Self-inflating bags and masks were unavailable and there were no oropharyngeal airways. The oxygen mask had no reservoir and there was no portable suction device.

The provider did not have effective monitoring systems in place to check the medical emergency and equipment. We were told that the receptionist checked the expiry dates of medical emergency medicines, however, no written records were available to confirm that these checks had been undertaken.

There were no records to demonstrate that staff, with the exception of the dental nurse, undertook training in medical emergency and basic life support.

The practice did not have adequate systems to minimise the risk that could be caused from substances that are hazardous to health. In particular, there were minimal risk assessments

in relation to the safe storage and handling of substances hazardous to health and staff did not know where the information could be accessed in the event of an emergency incident. Hazardous products were stored in an unlocked cupboard within the patient toilet.

Information to deliver safe care and treatment

The dental care records we saw were not complete or legible. In particular, dental care records did not consistently record medical history updates, radiographic reports, Basic Periodontal Examination (BPE) and documentation of discussions. We noted that the written language used in dental care records was not always English. The practice did not comply with General Data Protection Regulation requirements as they had not registered with the Information Commissioner's Office (ICO) to process data.

The dentist told us they had systems for referring patients with suspected oral cancer under the national two-week wait arrangements. There were no arrangements for monitoring or following up on referrals.

Safe and appropriate use of medicines

The practice did not have systems for appropriate and safe handling of medicines. Antimicrobial prescribing audits were not carried out. We saw medicines were not stored securely or monitored as described in current guidance. Patient information leaflets were not handed to patients with their prescribed medication.

Track record on safety, and lessons learned and improvements

The practice had implemented systems for reviewing and investigating incidents and accidents. We saw very good recording of incidents and accidents. The practice did not have a system for receiving and acting on safety alerts.

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

The practice did not have systems to keep dental professionals up to date with current evidence-based practice. In particular:

We saw the provision of dental implants was not in accordance with national guidance. The implants used were not CE marked (European Conformity) as required by the Medicines and Healthcare products Regulatory Agency (MHRA). The practice could not assure us that the performing clinician had undergone appropriate training in the provision of dental implants. Sterile drapes were not used during implant procedures. The dentist was not aware of the potential complications of providing dental implant treatment to patients who took bisphosphonate medicines to treat bone density.

The principal was unaware of the current diagnostic classifications and treatment protocols of periodontal disease and did not know of the restrictions for the use of dental amalgam.

Helping patients to live healthier lives

The practice provided preventive care and supported patients to ensure better oral health.

Consent to care and treatment

Staff obtained patients' consent to care and treatment in line with legislation and guidance. The dentist told us that they discussed with patients the treatment options, including risks, benefits and costs. However, we noted that dental care records did not include details of these discussions.

Staff did not fully understand their responsibilities under the Mental Capacity Act 2005.

Records were not available to demonstrate staff undertook training in patient consent and mental capacity. The provider showed a limited understanding of Gillick competence.

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

Monitoring care and treatment

The practice did not keep detailed dental care records in line with recognised guidance. We looked at five dental care records and found that they were missing details, such as medical history updates, Basic Periodontal Examination (BPE), risk assessments or discussion details. We noted that the written language used in dental care records was not always English.

Prior to our inspection, the provider had decided to convert the paper-based record system to a secure digital platform. This was implemented following our inspection.

We did not see evidence the dentist justified, graded and reported on the radiographs they took.

The practice did not carry out radiography audits six-monthly following current guidance.

Effective staffing

Are services effective?

(for example, treatment is effective)

Evidence was not available to demonstrate staff had the skills, knowledge and experience to carry out their roles. On the day of inspection, no recent training certificates for the principal dentist or the receptionist were available for review.

The practice did not carry out a structured induction for newly appointed staff. The practice did not have systems in place to ensure clinical staff had completed continuing professional development (CPD) as required for their registration with the General Dental Council. From our findings on the day, we could not be assured all staff had a thorough understanding of important subjects such as infection control, safeguarding, medical emergencies and basic life support.

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 for treatment the practice did not provide. However, improvements were needed to ensure the referrals were effectively monitored and tracked.

Are services caring?

Our findings

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

Kindness, respect and compassion

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

Privacy and dignity

Staff were unaware of the importance of privacy and confidentiality.

The practice was not set up to ensure patients' privacy and confidentiality could be observed. The door to the treatment rooms was open at all times, and conversations and treatments could be overheard.

They stored paper records securely.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care.

Staff gave patients clear information to help them make informed choices about their treatment.

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

The dentist described to us the methods they used to help patients understand treatment options discussed. These included for example photographs, study models, X-ray images and an intra-oral camera.

Are services responsive to people's needs?

Our findings

We found this practice was not providing responsive 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.

Responding to and meeting people's needs

Improvements were needed to the way the practice organised and delivered services to ensure it met the patients' needs.

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

Although the practice had not carried out a disability access audit, we saw some evidence they had made adjustments for patients with disabilities.

Timely access to services

Patients could access care and treatment from the practice within an acceptable timescale for their needs. Improvements were required as the practice had an appointment system that was ineffective at responding to patients' needs. In particular there were no arrangements for patients to access care or advice elsewhere when the practice was closed during holiday periods.

Listening and learning from concerns and complaints

The practice responded to concerns and complaints appropriately and discussed outcomes with staff to share learning and improve the service.

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 that there was ineffective leadership which impacted on the practice`s ability to deliver safe, high quality care. The principal dentist could not assure us that they understood risks pertaining to the management of the service and the delivery of care.

We saw that the staff members worked well together but systems and processes were not embedded among staff. For example, staff were unaware of the processes in relation to infection control and dealing with medical emergencies.

The inspection highlighted issues and omissions. For example, in relation to fire safety procedures, radiation protection arrangements, Legionella risks and dealing with medical emergencies.

The information and evidence presented during the inspection process was disorganised and poorly documented. Improvements were needed to ensure that records in relation to the management of regulated activities are readily available and easily accessible to all members of staff and those who would need to review them.

Culture

Staff stated they enjoyed working at the practice and their opinions were valued.

There were no records to demonstrate that individual training needs during annual appraisals or one to one meeting had been discussed. The practice did not ensure that staff training was up-to-date and reviewed at the required intervals.

Governance and management

The practice did not have effective governance and management arrangements. We noted that the general Health and Safety policy had been updated and signed by staff in September 2022, but we found the contents of the policy to be inaccurate. For example it stated that the provider carried out electrical safety checks every three years and records were kept; that staff kept records of antibody status in staff folders; smoke detectors would be tested weekly; the compressor was inspected annually; medicines were stored in a cupboard in the treatment room; a Radiation Protection Advisor was appointed. None of these statements were substantiated in our findings on the day of inspection. The infection control policy stated that single use items must be identified and disposed of safely but evidence on the day of inspection contradicted this.

The processes for managing risks were ineffective. The practice did not have adequate systems in place for identifying, assessing and mitigating risks in areas such as sharps, fire safety, legionella and general health and safety.

Following our inspection, the provider informed us that they were now implementing systems and processes to ensure future good governance.

Appropriate and accurate information

The practice had ineffective information governance arrangements. In particular, we saw no evidence that the provider had registered to process data with the Information Commissioner's Office

Engagement with patients, the public, staff and external partners

There were no records to demonstrate that staff gathered feedback from patients, the public and external partners.

Are services well-led?

Continuous improvement and innovation

The practice did not have systems and processes in place for learning, continuous improvement and innovation.

The practice did not have appropriate quality assurance processes to encourage learning and continuous improvement.

The practice had not undertaken audits of disability access, radiographs and infection prevention and control in accordance with current guidance and legislation. We saw only one infection control (IPC) audit dated September 2022 which included some inaccurate statements. The provider could not demonstrate that IPC audits were carried out bi-annually prior to this date.

There was no evidence staff kept records of the results of these audits and any resulting action plans and improvements.

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.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person had failed to establish systems to prevent abuse. In particular: • Staff did not know how to raise concerns in the event of a safeguarding incident. • Information about current safeguarding procedures, and guidance about raising concerns about abuse were not accessible to people who use the service and to staff. • The provider could not demonstrate that staff received safeguarding training that was relevant, and at a suitable level for their role. Regulation 13 (1) & (2)

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 systems or processes in place that operated 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: • Radiographic audits were not completed correctly -and at the recommended intervals. • A disability access audit had not been carried out. • The infection prevention control audit was not comprehensive - and there was no evidence that this was carried out bi-annually.

This section is primarily information for the provider

Enforcement actions

The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:

- There were ineffective systems for monitoring the medicines and equipment used for the treatment of medical emergencies taking into account relevant guidance. The checks failed to identify that medicines and equipment needed in the event of a medical emergency was missing.
- There were no records to demonstrate that the compressor, dental chairs and suction equipment had been serviced in line with the manufacturers` guidance to ensure that they were operating safely and effectively.
- There were ineffective systems for assessing the risks relating to the handling and disposal of sharps, the storage and control of substances hazardous to health, fire, legionella and radiography.
- There were no arrangements for monitoring referrals made, including urgent referrals where there were suspicions of oral cancer.

There was limited information available to staff about substances hazardous to health. This was not in accordance with the Control of Substances Hazardous to Health (COSHH) Regulations 2002:

- There was an incomplete log of products used or risk assessments for COSHH products.
- There was no evidence that COSHH documentation was reviewed or organised in a way to be accessible to staff if required.

The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular:

This section is primarily information for the provider

Enforcement actions

- A sample of dental care records were missing details such as medical history updates, radiographic reports, Basic Periodontal Examination (BPE) and documentation of discussions.
- We noted that some entries had not been written in English.

There was additional evidence of poor governance. In particular:

- The provider had not registered as a data processor with the Information Commissioner's Office.
- The practice did not have effective out of hours arrangements to give advice to patients who may require urgent dental care.
- Patients' privacy was not protected during treatment
- The principal was not aware of some current clinical evidence-based treatment guidance.

Regulation17 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular: • There were inadequate arrangements to assess staff learning and development needs. • There were ineffective arrangements for induction - of new staff. • Not all staff had completed training as per recommended national guidance for safeguarding, infection control, fire safety awareness, sepsis awareness and medical emergencies. Regulation 18 (2)

This section is primarily information for the provider

Enforcement actions

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: • Disclosure and Barring Service (DBS) checks had not been carried out for clinical staff. • Evidence of hepatitis B immunity was unavailable for all members of clinical staff. • There were no records in respect of conduct in previous employment (references) for the most recently recruited members of staff. Regulation 19 (3)

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: There were ineffective arrangements to deal with medical emergencies: • The oxygen was not suitable for medical use and was of an insufficient quantity • The automated external defibrillator (AED)was out of order and the adhesive electrode pads had expired. There was no arrangement to access an alternative AED in the event of emergency. • The adrenaline autoinjector used for treating anaphylaxis had expired. • There was no oromucosal midazolam to treat prolonged epileptic seizures • The dispersible Aspirin used to treat heart attacks had expired.

This section is primarily information for the provider

Enforcement actions

- The fridge where the Glucagon (a medicine used to treat low blood sugar) was not temperature monitored.
- There were no self-inflating resuscitation bags or oropharyngeal airways.
- The oxygen mask had no reservoir.
- There was no portable suction device.
- There were no records to demonstrate that all staff undertook training in medical emergency and basic life support.
- A gas safety check had not been carried out
- Fire drills had not taken place and there were no records to demonstrate that staff had undertaken fire safety training.
- There was no evidence of registration to work with ionising -radiation with the Health and Safety Executive - was implemented in line with IRR17.

There were ineffective arrangements to assess and mitigate the risk of fire at the practice:

- There was no fire risk assessment
- Fire safety checks were not routinely carried out.
- The five-year fixed wiring electrical safety test and Portable Appliance Testing (PAT)or equivalent had not been carried out.

There were ineffective arrangements to ensure the use of X-ray equipment was in accordance with Ionising radiation Regulations 2017 (IRR17) and Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER17):

- Three yearly performance tests had not been carried out.
- Annual electro-mechanical servicing had not been carried out.
- The provider had not consulted with a Radiation Protection Advisor (RPA) and had not completed necessary risk assessments and local rules.

There were no arrangements to ensure the safety of laser equipment.

The provider has failed to assess and mitigate risks in relation to the control and spread of infections, in

Enforcement actions

accordance with the Department of Health Publication Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05). In particular:

- There were no arrangements to monitor water temperature used to clean dental instruments.
- The instruments were not fully immersed during scrubbing.
- Instruments were not checked for visible debris as there was no illuminated magnification available
- Some instruments were stored unwrapped
- Cotton wool rolls were left uncovered
- Burs were stored in visibly soiled stands on the bracket tables
- There was no protocol for the disinfection of dental devices upon return from the laboratory before placement in patients' mouths.
- The cabinetry, floors, chairs, operating lights, spittoons were visibly dirty
- Drawers were cluttered and dusty
- Local anaesthetic cartridges were stored unpackaged
- Single use items had not been disposed of
- There were several expired dental materials.
- There was no autoclave logging system.

Handling of sharps was not in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013:

- Safer sharps were not in use and there was no risk assessment to reflect this.
- There was no evidence that staff who handled contaminated instruments and sharps had received Hepatitis B immunisation.

The risks associated with water systems and dental unit water lines (DUWLs) were not regularly reviewed and mitigated.

- No risk assessment in respect of legionella had been completed.
- There was no written scheme of control in place.
- Dental unit waterlines (DUWLs) were not treated with appropriate disinfecting agents.

This section is primarily information for the provider

Enforcement actions

- Water temperature monitoring was not carried out.
- There were heavy scale deposits on taps in the storage cupboard.

Clinical waste was not stored securely in accordance with the Department of Health publication “Health Technical Memorandum 07-01 safe management of healthcare waste”, (HTM07-01).

We found the medicines – were stored insecurely in the reception desk. Patient information leaflets were not given to patients. There was no stock control log for dispensed medicines.

Hazardous products were stored in an unlocked cupboard within the patient toilet

Regulation 12 (1)