Care Quality Commission

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Bramley Dental Practice - Main Street

Inspection Report

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Overall summary

We carried out this announced inspection on 4 November 2019 under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a 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:

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.

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Bramley Dental Practice - Main Street is located in Bramley, Rotherham and provides NHS and private treatments to adults and children. The practice is a foundation dentist training practice.

Summary of findings

Access for wheelchair users and pushchairs is via a portable ramp into the reception area. Car parking spaces are available near the practice.

The dental team includes a principal dentist, a foundation training dentist and seven associate dentists, fourteen dental nurses (five of whom are trainees), one dental hygienist, two dental hygiene therapist and two receptionists and two practice managers. The practice has five treatment rooms.

The practice is owned by a partnership 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.

At the time of inspection there was no registered manager in post as required as a condition of registration. A registered manager is legally responsible for the delivery of services for which the practice is registered. We saw evidence on the day of inspection which confirmed that registration was in progress.

On the day of inspection, we collected 35 CQC comment cards filled in by patients. All comments reflected favourably on the service provided.

During the inspection we spoke with dentists, three dental nurses, one dental hygiene therapist, one receptionist and the practice managers. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open: Monday and Tuesday 9am - 6pm, Wednesday to Thursday 9am - 5pm. Friday 9am - 1pm

Our key findings were:

- The practice appeared to be visibly clean and well-maintained.
- The provider had infection control procedures which reflected published guidance.
- Improvements could be made to ensure clinical waste was managed in line with guidance.
- Legionella management systems were not carried out in line with guidance.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- Systems to help them manage risk to patients and staff could be improved.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- There was limited evidence to confirm that recruitment procedures reflected current legislation.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- The completion of patient care records could be improved.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- There was limited evidence to confirm that staff employed continued to meet the professional standards.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.
- Leadership and oversight could be improved to ensure guidance, regulations and standards are being met.
- Quality assurance systems could be improved to follow guidance and for learning and improvement.
- The provider asked staff and patients for feedback about the services they provided.
- The provider dealt with complaints positively and efficiently.
- The provider had 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 sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed

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

Summary of findings

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

- Take action to ensure the clinicians take into account the guidance provided by the Faculty of General Dental Practice when completing dental care records.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

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 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.

The impact of our concerns, in terms of the safety of clinical care, is minor for patients using the service. Once the shortcomings have been put right the likelihood of them occurring in the future is low.

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

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. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC. We saw limited evidence to demonstrate staff had received safeguarding training. Training certificates were confirmed for ten staff members during the inspection day, the provider submitted six further training certificates after the inspection. We were unable to confirm the status of training for 14 staff members.

The provider had an infection prevention and control policy and procedures. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care. We saw limited evidence to demonstrate staff had received training. Training certificates were confirmed for one staff member during the inspection day, the provider submitted four further training certificates after the inspection. The provider was unable to demonstrate the status of training for 21 staff members.

The provider had arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance. The provider had suitable numbers of dental instruments available for the clinical staff and measures were in place to ensure they were decontaminated and sterilised appropriately.

The staff carried out manual cleaning of dental instruments prior to them being sterilised. We advised the provider that manual cleaning is the least effective recognised cleaning method as it is the hardest to validate and carries an increased risk of an injury from a sharp instrument.

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.

A Legionella risk assessment was carried out February 2019. We reviewed the practice's Legionella management systems and found improvement was required to enhance staff awareness and oversight of processes to bring them in line with guidance and the risk assessment. For example:

- No hot and cold-water temperature testing was being carried out.
- No persons identified as the lead or deputy for legionella management.

On the day of inspection, we tested the water temperatures and found the hot water was not reaching the required temperature identified in the risk assessment. We highlighted this to staff, who took immediate action to rectify this. By the end of the inspection day, the hot water temperature was in line with the risk assessment.

We saw effective cleaning schedules to ensure the practice was kept clean. When we inspected we saw the practice was visibly clean.

The provider had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. We identified areas where further action was needed to align with guidance. For example:

- We noted clinical waste was not being disposed of into an appropriate clinical waste receptacle in one area of the practice.
- External clinical waste receptacles were not kept secured whilst in a public area.

Are services safe?

Infection prevention and control audits were not carried out twice a year as recommended in guidance. The latest audit dated July 2018 showed the practice was meeting the required standards. Improvement was needed to bring this process in line with guidance.

The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy. The practice had access to a Freedom to Speak Up Guardian and staff felt confident they could raise concerns without fear of recrimination.

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.

We reviewed the practice's recruitment procedures and found these were not in line with Schedule 3 of the Health and Social Care Act 2008. We reviewed 14 staff files and found the following areas of concern:

- 10 staff files had no employment history.
- Two had no photographic identification.
- 10 had no references.
- Five had no indemnity certification.
- Two had no professional registration certification.
- Where relevant, no employment contract was retained.
- No interview notes.

We highlighted these concerns to the practice managers who took action during and after the inspection day to gather the missing evidence, the majority of which was forwarded to us after the inspection.

Staff ensured facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions, including electrical and gas appliances.

A fire risk assessment was carried out in line with the legal requirements. We saw there were fire extinguishers and fire detection systems throughout the building and fire exits were kept clear. Systems were in place to regularly monitor fire safety equipment.

The practice arrangements to ensure the safety of the X-ray equipment could be improved; we noted there were recommendations listed in the 2016 radiation protection advisor report which had not been acted upon. For example: annual mechanical servicing of X-ray equipment.

We saw evidence the dentists justified, graded and reported on the radiographs they took. The provider carried out radiography audits every year following current guidance and legislation.

We saw relevant continuing professional development (CPD) certification in respect of dental radiography for one clinician. The provider sent six further training certificates after the inspection day. The provider was unable to demonstrate CPD validation for four clinicians.

Risks to patients

The provider had implemented systems to assess, monitor and manage risks to patient safety. We identified areas within risk management where improvements could be made. For example:

- Staff followed the relevant safety regulation when using needles. The risk assessment dated June 2019 did not include the reduction of risks for handling and disposing of all other sharp's items in use, such as matrices, scalpel blades and burs.
- Systems in place to ensure clinical staff had received appropriate vaccinations, including vaccination to protect them against the Hepatitis B virus were not effective. For example, vaccination records were available for 13 staff members and three additional records were sent after the inspection. The provider was unable to demonstrate vaccination effectiveness for nine clinical staff members.
- No risk assessment was in place to cover one staff member awaiting results of the vaccination.

The provider had current employer's liability insurance.

Staff had an awareness of the recognition, diagnosis and early management of sepsis. Sepsis prompts for staff and patient information posters were displayed throughout the practice. No training records were evidenced.

Staff knew how to respond to a medical emergency. Emergency equipment and medicines were available as described in recognised guidance. We found staff kept records of their checks of these to make sure they were available, within their expiry date, and in working order.

Are services safe?

Records confirmed that 23 staff members had completed annual training in emergency resuscitation and basic life support. Two additional training records were sent to us after the inspection, the provider was unable to demonstrate training records for five staff members.

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

The provider had risk assessments to minimise the risk that can be caused from substances that are hazardous to health.

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. The computerised dental care records we reviewed were complete and managed in a way that kept patients safe and complied with General Data Protection Regulation requirements. The practice was transitioning to an electronic records system.

The completion of the hand-written dental care records we reviewed could be improved and brought in line with guidance. We saw that a sticker system had been introduced to cover X-ray reporting, referrals and endodontic treatment but additional note taking was lacking in other areas. We found limited evidence of guidance being followed to confirm adequate consent was in place. For example:

- Inconsistent evidence to support that patients' medical history was updated.
- Inconsistent recording of treatment options and risks/ benefits.
- No evidence of social history (i.e. smoking and alcohol consumption).

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

Safe and appropriate use of medicines

We saw staff stored and kept records of NHS prescriptions as described in current guidance.

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

Track record on safety, and lessons learned and improvements

The provider had implemented systems for reviewing and investigating when things went wrong. We reviewed relevant records which showed learning and improvement was taking place to prevent such occurrences happening again. We discussed the areas of concerns we identified, and it was agreed these should be added into the system to enhance learning and improvement for the future.

The provider had a system for receiving and acting on safety alerts. A supporting protocol detailed relevant action to take but this was not being followed. For example: the folder contained a selection of safety alerts from 2017 and 2019, a comprehensive list was not evidenced and where there were safety alerts, action taken was not documented. We discussed this with the managers who told us the dentists used an application to review safety alerts. No evidence was available to assure us that there was a responsible person or that appropriate action was being taken to monitor and act upon safety alerts in line with the protocol.

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 dental implants. These were placed by the principal dentist who had undergone appropriate post-graduate training in the provision of dental implants. We saw the provision of dental implants was in accordance with national guidance. We noted the placement of dental implants had never been audited for quality assurance purposes and for learning and improvement.

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/clinicians where applicable, discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of dental products for sale and provided leaflets to help patients with their oral health.

The dentists and dental hygiene therapists 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.

Records showed patients with severe gum disease were recalled at more frequent intervals for review and to reinforce home care preventative advice.

Consent to care and treatment

Staff obtained consent to care and treatment in line with legislation and guidance.

The practice team understood the importance of obtaining and recording patients' consent to treatment. The staff were aware of the need to obtain proof of legal guardianship or Power of Attorney for patients who lacked capacity or for children who are looked after.

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. Patients confirmed their dentist listened to them and gave them clear information about their treatment.

The practice's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who might not be able to make informed decisions. The policy also referred to Gillick competence, by which a child under the age of 16 years of age may give consent for themselves in certain circumstances. Staff were aware of the need to consider this when treating young people under 16 years of age.

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

Monitoring care and treatment

The provider had some quality assurance processes to encourage learning and continuous improvement. We found this could be improved to ensure audits were carried out in line with guidance and for learning and improvement purposes. Staff kept records of the results of these audits, the resulting action plans and improvements.

Effective staffing

Staff new to the practice had a structured induction programme. Not all relevant records and certification for clinical staff was available at the time of inspection to confirm they had completed the continuing professional development required for their registration with the General Dental Council.

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.

Are services caring?

Our findings

We found 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 lovely, helpful and professional. We saw staff treated patients use appropriate respectfully, appropriately and kindly and were friendly towards patients at the reception desk and over the telephone.

Patients said staff were compassionate and understanding.

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

Information folders, patient survey results and thank you cards were available for patients to read.

Privacy and dignity

Staff respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting areas provided limited privacy when reception staff were dealing with patients. If a patient asked for more privacy, the practice would respond appropriately. The reception computer screens were not visible to patients and staff did not leave patients' personal information where other patients might see it.

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

Involving people in decisions about care and treatment

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

We saw:

- Interpreter services were available for patients who did not speak or understand English.
- Staff communicated with patients in a way they could understand, and communication aids and easy-read materials were available.

Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Staff gave patients clear information to help them make informed choices about their treatment. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. A dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

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

The dentists described to us the methods they used to help patients understand treatment options discussed. These included study models and X-ray images to help them better understand the diagnosis and treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We found 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 about 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.

Two weeks before our inspection, CQC sent the practice 50 feedback comment cards, along with posters for the practice to display, encouraging patients to share their views of the service.

35 cards were completed, giving a patient response rate of 70%

100% of views expressed by patients were positive.

Common themes within the positive feedback were, patients always receive excellent care, accommodating with appointments and courteous and helpful staff. Other patients commented that they have confidence in the dentist and they were informative and helpful.

We shared this with the provider in our feedback.

The practice currently had some patients for whom they needed to make adjustments to enable them to receive treatment.

The practice had made reasonable adjustments for patients with disabilities. This included a portable ramp and ground floor treatment rooms and a ground floor toilet facility. An induction loop was on order and a staff member was learning sign language as an additional skill to help patients with limited hearing.

Staff had carried out a disability access audit and had formulated an action plan to continually improve access for patients.

Staff telephoned some patients on the morning of their appointment to make sure they could get to the practice. The practice used a text message appointment reminder service.

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 in the premises and included it in their information leaflet and on their website.

The practice had an appointment system to respond to patients' needs. Patients who requested an urgent appointment were offered an appointment the same day. Patients 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.

The staff took part in an emergency on-call arrangement with 111 out of hour's service and patients were directed to the appropriate out of hours service.

The practice's website, information leaflet and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open. Patients confirmed they could make routine and emergency appointments easily and were rarely kept waiting for their appointment.

Listening and learning from concerns and complaints

Staff told us the provider took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

The provider had a policy providing guidance to staff about how to handle a complaint. The practice information leaflet explained how to make a complaint.

The practice managers were responsible for dealing with these. Staff told us they would tell the practice managers about any formal or informal comments or concerns straight away so patients received a quick response.

The practice managers 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 managers had dealt with their concerns.

We looked at comments, compliments and complaints the practice received in the last 12 months.

Are services responsive to people's needs?

(for example, to feedback?)

These showed the practice responded to concerns 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.

At the time of inspection there was no registered manager in post as required as a condition of registration. A registered manager is legally responsible for the management of services for which the practice is registered.

Leadership capacity and capability

The dentists had the capacity to deliver high-quality, sustainable care. We found improvement was required to ensure leadership and oversight of clinical governance was brought in line with guidance, Regulation and standards.

Leaders were knowledgeable about issues and priorities relating to the quality and future of the service. They understood the challenges and were addressing them; the practice managers explained at the start of the inspection how the practice planned to implement positive change to enhance the delivery of care and support to staff in 2020. For example, completion of computerised patient care records, decoration throughout, updating the telephone system and the implementation of a new human resources IT system to help keep staff up-to-date with policy changes and training.

We identified throughout the inspection day that gaps in communication, oversight of risk and management systems could be improved to ensure good governance is being maintained in the longer term.

The provider had a strategy for delivering the service which was in line with health and social priorities across the region. Staff planned the services to meet the needs of the practice population.

Culture

Evidence reviewed during the inspection day showed the practice delivered high-quality sustainable clinical dental care.

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

Support staff had an annual appraisal, we saw evidence of this is staff files. No evidence of appraisal was seen in clinical staff files.

The staff focused on the needs of patients. The practice was very busy with a daily high throughput of patients, managed over two sites. On the day of inspection, we observed that appointments ran smoothly, and patients were treated in a timely manner.

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

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

Staff told us they could raise concerns and were encouraged to do so, and they had confidence that these would be addressed.

Governance and management

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

The practice had systems of clinical governance in place which included policies, protocols and procedures. We identified areas within these where improvements could be made to ensure they remained up-to-date with guidance, Regulations and standards. The practice managers told us how they had delegated some clinical responsibilities within the team to help bridge the gap between clinical and non-clinical staff to ensure the practice operates at its optimum. We found this system required more time to become embedded and effective due to the concerns we highlighted during the inspection day. For example:

- Risk management systems in respect to Legionella, safer sharps and response to patient's safety alerts were not effective.
- No awareness to mitigate role specific risks for staff without Hepatitis B vaccination results.
- Clinical waste management systems were not effective.
- Recommendations highlighted for improvement/ guidance were not acted upon.
- Systems to ensure staff employed continued to meet the professional standards were not effective.

Are services well-led?

- Systems to ensure documents were retained in line with Schedule 3 of the Health and Social Care Act 2008 were not effective.
- The systems to manage audit for quality assurance, learning and improvement were not effective.

Appropriate and accurate information

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

Engagement with patients, the public, staff and external partners

The provider used patient surveys to obtain staff and patients' views about the service.

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

The provider gathered feedback from staff through meetings, surveys, and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

Continuous improvement and innovation

The provider had systems and processes for learning, continuous improvement and innovation, we found these could be improved upon.

The practice was also a member of a good practice certification scheme.

Quality assurance processes to encourage learning and continuous improvement included audits of radiographs and infection prevention and control. Not all were completed in line with guidance.

Staff told us they completed 'highly recommended' training as per General Dental Council professional standards. We found limited evidence of this in staff files.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment must be provided in a safe way for service users.** **How the regulation was not being met**. Assessments of the risks to the health and safety of service users of receiving care or treatment were not being carried out. In particular: The registered person failed to comply with guidance to ensure Legionella management systems were effective: In particular: • Water temperature testing was not taking place. • There was no lead or trained person identified to oversee Legionella management. • A limited awareness of Legionella amongst staff had not been identified. The registered person failed to comply with regulations to ensure sharps management systems included the mitigation of risks for all sharps in use. The registered person had failed to implement an effective process to act upon patient safety alerts received from the Medicines and Healthcare products Regulatory Agency. The registered person had failed to comply with guidance to identify the risks associated with ineffective clinical waste processes: In particular:

Requirement notices

- Clinical waste was not being disposed of in compliance with guidance.
- External clinical waste receptacles were not kept secured whilst in a public area.

Recommendations made by the Radiation Protection Advisor in 2016 were not acted upon to ensure the safe use of X-ray machines.

Regulation 12 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Requirements in relation to staffing. **How the regulation was not being met** The registered person had failed to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed in order to meet the requirements of fundamental standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In particular: There was limited evidence of certification for: • Safeguarding adults and children. • Infection prevention and control. • Basic Life Support. • Ionising Radiation (Medical Exposure) Regulations 5-yearly update. Regulation 18 (1)

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 Persons employed for the purposes of carrying on a regulated activity must be fit and proper persons. **How the regulation was not being met**

This section is primarily information for the provider

Requirement notices

The registered person's recruitment procedures did not ensure that only persons of good character were employed. In particular:

There was limited evidence of:

- Professional certification.
- Professional indemnity.
- Past employment history/Curriculum Vitae.
- References.
- Photographic identification.
- Employment contracts.

Regulation 19 (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 17 HSCA (RA) Regulations 2014 Good governance **Good governance** **How the regulation was not being met** 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. 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: • Legionella management systems did not comply with guidance. • Safe sharps systems were not risk assessed and risks were not mitigated for all sharps items in use in line with current Regulations. • The system in place to receive and record action taken in response to a patient safety alert from the Medicines and Healthcare products Regulatory Agency was not effective. • Recommendations made by the Radiation Protection Advisor in 2016 were not acted upon. • A process to mitigate role specific risks for staff without Hepatitis B vaccination results was not in place. The system to ensure clinical waste was managed in line with guidance was not effective. In particular:

Enforcement actions

- Appropriate clinical waste segregation to the correct clinical waste receptacle.
- External clinical waste receptacles were not kept secured whilst in a public area.

There was a lack of oversight from the provider to ensure recruitment processes were conducted in line with Schedule 3 of the Health and Social Care Act 2008.

There was a lack of oversight from the provider to ensure staff employed continued to meet the professional standards.

There was additional evidence of poor governance. In particular:

- Leadership, effective communication and oversight of clinical governance and management systems were not effective.
- The systems to manage audit for quality assurance, learning and improvement were not effective.

Regulation 17(1)