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# The Whitestar Dental Practice

## Inspection Report

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### Overall summary

We carried out this announced inspection on 27 February 2020 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**

The Whitestar Dental Practice in the London Borough of Harrow and provides NHS and private dental care and treatment for adults and children.

The dental team includes the principal dentist and one receptionist. At the time of our inspection the practice did not have a dental nurse and was using temporary agency nurses and a temporary agency dental hygienist. The practice has two treatment rooms.

# 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.

On the day of inspection, we collected 33 CQC comment cards filled in by patients.

During the inspection we spoke with the dentist, the receptionist and the agency dental nurse who was present on the day. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open between:

9am and 5.30pm on Mondays to Thursdays

9am and 1.00pm on Fridays  
Early morning appointments available on Fridays

## Our key findings were:

- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The appointment system took account of patients' needs.
- The provider asked staff and patients for feedback about the services they provided.
- The provider dealt with complaints positively and efficiently.
- The provider had suitable information governance arrangements.
- The provider had safeguarding processes. Improvements were needed to ensure staff undertook training and knew their responsibilities for safeguarding vulnerable adults and children.
- The provider had infection control procedures which reflected published guidance. However these were not adhered to consistently.
- The provider had staff recruitment procedures which reflected current legislation. Improvements were needed so that all the appropriate checks were carried out for agency staff who worked at the practice.

- There were ineffective systems to ensure that suitable numbers of appropriately skilled and trained staff were available to work at the practice.
- There were ineffective arrangements to deal with emergencies. Some life-saving equipment was not available on the day of the inspection and staff did not undertake training or fully understand how to deal with medical emergencies.
- There were ineffective systems to help assess and manage risk to patients and staff.
- The provider had ineffective leadership to support a culture of continuous improvement.
- There were ineffective systems to monitor staff learning needs and to ensure that they understood and followed relevant guidance, policies and procedures.

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.






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

- Improve the practice protocols regarding auditing patient dental care records to check that necessary information is recorded.
- Take action to ensure the service takes into account the needs of patients with disabilities and to comply with the requirements of the Equality Act 2010.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

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

# 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.

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

The dentist knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances including how to report concerns, including notification to the CQC.

The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. Improvements were needed to ensure that all staff received safeguarding training. The principal dentist had completed part of the required training. There were no training records available for the dental receptionist, who was unsure of their roles or responsibilities in relation to the safeguarding procedures.

The provider had an infection prevention and control policy. Improvements were needed to ensure that staff 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. The procedures in relation to segregation of clean and dirty areas within the decontamination room were not adhered to. We saw boxes, which were used to transport dirty dental instruments from the surgery placed in the designated clean area in the decontamination room.

The provider had procedures for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. Improvements were needed to ensure that staff followed these procedures when cleaning dental instruments. We saw that some sterilised dental instruments were stored in damaged pouches, some did not include the date on which they were cleaned and sterilised to provide assurances that items were sterile at the point of use.

The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance.

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.

The practice had policies and procedures to reduce the possibility of Legionella or other bacteria developing in the water systems. Improvements were needed to ensure that these procedures were reviewed, fully understood and adhered to. A Legionella risk assessment had been carried out on 3 November 2011. A number of areas where improvements were required had been identified at this time in relation to the hot and cold water systems. The principal dentist could not demonstrate that these issues had been addressed or that the risk assessment had been reviewed or and that there were suitable risk control measures in place.

The dentist told us that hot and cold water temperatures were monitored. We looked at the records maintained in respect of these measures. We found that there were no fluctuations in the temperatures for the hot and cold water within the previous 12 months and therefore the principal dentist could not be assured that the water temperatures were being monitored and recorded accurately as part of a system to effectively reduce the risk of Legionella.

On the day of our inspection there was no hot water in the premises. The principal dentist told us that an issue with the hot water system had occurred some days prior to our visit and that they had made arrangements for an engineer to visit and rectify the issue. We asked to see confirmation of these arrangements but the principal dentist could not provide these.

The practice had cleaning schedules and plans. When we inspected we saw that 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. Some of these were not routinely followed. There were no clinical bins available in the decontamination room. We observed the bag containing clinical waste tied to a door handle.

The principal dentist was the infection control lead. We saw that they had carried out infection prevention and control

# Are services safe?

audits annually since 2012. Improvements were needed so that these were carried out twice a year taking into account the guidelines issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices. The latest audit, which was carried out shortly before our inspection indicated the practice was meeting the required standards. However the audit did not identify areas where the practice infection control procedures were not being adhered to.

The provider had whistleblowing policies and procedure. The receptionist told us they felt confident they could raise concerns without fear of recrimination.

The dentist told us they 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 was completed.

The provider had a recruitment policy and procedure to help them employ suitable staff and had checks in place for agency and locum staff. These reflected the relevant legislation. Improvements were needed so that these procedures were followed to ensure that suitable persons were employed to work at the practice. At the time of our inspection only the dental receptionist worked permanently at the practice. The principal dentist told us that the dental nurses and the dental hygienist were supplied by a temporary agency. There were no records to show that all of the appropriate checks including Disclosure and Barring Service checks (DBS), proof of identity and evidence of conduct in previous employment where applicable were carried out.

We observed that the dentist was qualified and registered with the General Dental Council and had professional indemnity cover.

Improvements were needed to ensure that equipment including gas and electrical installations and appliances were checked and maintained according to manufacturers' instructions. The dentist told us that the required five year fixed electrical test had not been carried out and no checks had been carried out for the portable electrical equipment. They also told us that no tests or checks had been carried out for the gas boiler.

A fire risk assessment had been carried out in March 2012. A number of areas where improvements were required were identified in relation to testing fire safety equipment. The principal dentist could provide assurances that these issues had been addressed or that the risk assessment had been reviewed as part of a risk management system. The principal dentist could not provide us with records to show that the fire safety equipment such as extinguishers, emergency lighting or smoke detectors were tested.

Improvements were needed to the arrangements to ensure the safety of the X-ray equipment. The required radiation protection information was not available including records to demonstrate that the three yearly radiological tests and the annual mechanical and electrical tests had been carried out for the dental X-ray units.

We saw evidence the dentist justified, graded and reported on the dental radiographs they took. Improvements were needed so that audits to assess the quality of dental radiograph images were carried out in compliance with Ionising Radiation (Medical Exposure) Regulations 2017.

The dentist told us they completed continuing professional development in respect of dental radiography. Records in respect of this training were not available on the day of our inspection. We requested these records following our inspection. These were not provided at the time of completing this report.

## Risks to patients

Improvements were needed to the systems to assess, monitor and manage risks to patient safety.

The practice's health and safety policies, procedures and risk assessments were not reviewed regularly. The majority of policies, procedures and risk assessments had not been reviewed since 2017.

The provider had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The dentist told us they followed the relevant safety regulation when using needles and other sharp dental items. Improvements were needed so that a sharps risk assessment is carried out to identify risks associated with the use and disposal of dental sharps.

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

# Are services safe?

We saw records were available for the principal dentist. Improvements were needed so that the principal dentist had assurances that agency nurses and the dental hygienist were suitably protected against the risk of infection.

Improvements were needed to ensure that staff knew how to respond to a medical emergency and completed training in emergency resuscitation and had basic life support training every year. The dentist had not undertaken training in basic life support since 2014. The receptionist could not recall when they had undertaken this training and they had limited knowledge or awareness of what they were expected to do in the event of a medical emergency.

Emergency medicines were not available as described in recognised guidance. Improvements were needed so that staff carried out and kept records of checks to make sure medicines were available and within their expiry date. One medicine used to treat cardiac conditions was not available and one was not available in the required formula. The medicine used to treat seizures was not available in the required formula. The medicine used to treat low blood sugar was stored in the refrigerator, however the temperature was not monitored to ensure that this medicine was stored at the recommended temperature.

The dentist told us that they did not have a permanent dental nurse at the practice since 2018. They told us that they relied upon dental nurses from a temporary agency for chairside support when they treated patients. The dentist told us that they had been regularly treating patients without a dental nurse which is contrary to General Dental Council Standards for the Dental Team.

The provider did not have suitable risk assessments to minimise the risk that can be caused from substances that are hazardous to health. There was a record of hazardous substances used at the practice. However the risks associated with use or accidental exposure to these items had not been assessed.

## 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 dental care records to confirm our findings and observed that individual records were written and managed in a way that kept patients safe. Dental care records we saw were complete and legible.

Records were kept securely and in compliance with General Data Protection Regulation requirements.

The dentist had suitable systems for referring patients with suspected oral cancer under the national two-week wait arrangements. These arrangements were initiated by National Institute for Health and Care Excellence to help make sure patients were seen quickly by a specialist. There were arrangements to check that the referral had been received and that the patient had been called for assessment or treatment.

## Safe and appropriate use of medicines

The provider had systems for appropriate and safe handling of medicines.

There was a stock control system of medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required.

The dentist was aware of current guidance with regards to prescribing medicines.

Improvements were needed so that antimicrobial prescribing audits were carried to demonstrate the dentist was following current guidelines.

## Track record on safety, and lessons learned and improvements

The practice had systems for reviewing and investigating should things go wrong.

In the previous 12 months there had been no safety incidents. The dentist told us that any safety incidents would be investigated, documented and discussed with the rest of the dental practice team to prevent such occurrences happening again.

Improvements were needed to the arrangements for receiving and acting on safety alerts. The dentist told us that they received and reviewed information such as patient safety alerts. However they were unable to demonstrate that they had received or reviewed recently issued alerts in relation to medicines and equipment that may be in use at the practice.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment, care and treatment

The dentist told us that they kept up to date with current evidence-based practice to delivered care and treatment in line with current legislation, standards and guidance. Dental care records which we looked at showed that the dentist followed published guidelines when assessing and treating patients.

### Helping patients to live healthier lives

The dentist told us they provided preventive care and supported patients to ensure better oral health in line with the Delivering Better Oral Health toolkit. They said they prescribed high concentration fluoride products if a patient's risk of tooth decay indicated this would help them.

The dentist told us that where applicable, discussed smoking, alcohol consumption and diet with patients during appointments. They also 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. Details of these conversations were documented in the patient dental care records which we viewed.

### Consent to care and treatment

The practice's consent policy included information about the Mental Capacity Act 2005. The dentist understood their responsibilities under the act when treating adults who might not be able to make informed decisions. Patients confirmed the dentist listened to them and gave them clear information about their treatment.

### Monitoring care and treatment

The dentist described how they assessed patients' treatment needs in line with recognised guidance. The dental care records, which we sampled included details and information about the patients' current dental needs and past treatment.

Improvements were needed so that dental record audits were carried out as part of a quality assurance system.

### Effective staffing

Improvements were needed to ensure that suitable numbers of staff were employed and that staff had the skills, knowledge and experience to carry out their roles. The principal dentist told us that they regularly worked without a dental nurse for chairside support.

There were limited arrangements to ensure that the receptionist and agency staff working at the practice had undertaken training, understood and adhered to procedures in relation to areas such as infection control and managing medical emergencies.

We were unable to confirm the dentist completed the continuing professional development required for their registration with the General Dental Council as recent training records were unavailable on the day of the inspection and were not provided as requested following our inspection.

### Co-ordinating care and treatment

The dentist told us they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide. There were arrangements to make and monitor referrals to ensure that patients received timely and appropriate treatment. There were systems to follow up on referrals made to ensure that patients had been assessed or treated.



# 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 kind, caring, helpful and friendly. We saw the receptionist treated patients respectfully 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.

### **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 area was open plan in design. Staff were mindful when dealing

with patients in person or on the telephone. If a patient asked for more privacy, the practice would respond appropriately. Staff did not leave patients' personal information where other patients might see it.

Staff stored paper records securely.

### **Involving people in decisions about care and treatment**

The dentist told us they supported patients to be involved in decisions about their care. They were aware of the Accessible Information Standard and the requirements of the Equality Act.

- The principal dentist told us that they had not experienced any difficulties with patients who did not speak or understand English. They said that they would look into the availability of interpreter services if required.

Patients confirmed that the dentist listened to them, did not rush them and discussed options for treatment with them. The dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

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



# 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.

The principal dentist was clear about the importance of emotional support needed by patients when delivering care. They conveyed a good understanding of supporting more vulnerable members of society such as patients with dementia, and adults with a learning difficulty.

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.

33 cards were completed, giving a patient response rate of 66%

100% of views expressed by patients were positive.

Common themes within the positive feedback were satisfaction with dental care and treatment, easy access to dental appointments and the friendliness and helpfulness of staff.

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 layout of the practice which was located on the ground floor of the building provided step free access to the dental surgery. The size and layout of the premises did not afford provision for accessible toilet facilities. Improvements were needed to ensure that consideration was given to the needs of people who have a disability and reasonable adjustments made as practicable. The dentist told us that a disability access audit had been carried out some years

previous. This was not available on the day of inspection and the dentist could not demonstrate that this assessment had been reviewed or used to improve access for patients.

### 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 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.

Patients who required emergency dental treatments when the practice was closed had access to the NHS 111 out of hour's service.

The practice's answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open.

### Listening and learning from concerns and complaints

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

The principal dentist was responsible for dealing with these. The receptionist told us they would tell the dentist about any formal or informal comments or concerns straight away so patients received a quick response.

The practice 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 had dealt with their concerns.

We looked at comments, compliments and complaints the practice received within the previous 12 months. One complaint had been made about the practice within the previous 12 months and this was being investigated at the time of our inspection.

# Are services well-led?

## Our findings

We found this practice was not providing well led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement and Requirement Actions section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

We are considering enforcement action in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded

The dentist was knowledgeable about issues and priorities relating to the quality and future of the service. The dentist had told us that they struggled in recent months due to personal circumstances.

This was evidenced in the lack of some risk management and governance systems.

### Culture

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

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

The receptionist 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. Policies and procedures were available. However these were not reviewed regularly to ensure that they reflected

Improvements were needed to support good governance and management. The dentist acknowledged that they struggled to maintain all of the systems required for the effective management of the practice due to lack of support and recent personal issues.

This impacted on the systems of clinical governance and oversight for the practice. Improvements were needed to

ensure that there were clear and effective processes for managing risks and issues. Some risk assessments were not carried out and others completed had not been acted on, reviewed or did not accurately reflect the procedures carried out within the practice.

### Appropriate and accurate information

Improvements were needed so that staff had access to and acted on appropriate and accurate information. Some audits were not carried out fully or consistently to give an accurate view of performance and adherence to guidance in relation to areas such as infection control procedures and effective record keeping.

Relevant safety information such as information in patient safety alerts was not available or used as part of an effective risk management system.

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. We saw examples of surveys which indicated that patients were very satisfied with the services they received.

### Continuous improvement and innovation

The provider had some systems and processes for learning, continuous improvement and innovation. There were regular staff meetings where information and the outcome of audits carried out were reviewed and discussed.

Improvements were needed so that all of the required audits and reviews were carried out robustly as part of a continuous improvement plan for the practice.

The dentist could not demonstrate that they completed the 'highly recommended' training as per General Dental Council professional standards.

## 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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>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:</p> <ul style="list-style-type: none"><li>• There were ineffective arrangements to ensure that the practice infection prevention and control procedures were sufficiently monitored or adhered to in relation to the storage of dental instruments to ensure that they remained sterile at the point of use and the storage of clinical waste.</li><li>• There were ineffective arrangements for assessing risks associated with the use and disposal of dental sharps.</li><li>• There were ineffective systems to respond appropriately to a medical emergency. Checks were not carried out to ensure that the recommended emergency medicines were available and stored in accordance with the manufacturer's instructions.</li><li>• There were ineffective systems to assess and mitigate the risks associated with the use or accidental exposure to hazardous substances.</li><li>• There were ineffective systems in place to ensure that staff were suitably protected against the risk of</li></ul>

## Requirement notices

vaccine preventable infections. The effectiveness of vaccines had not been assessed for the temporary dental hygienist or the temporary dental nurses who worked at the practice.

There was additional evidence that safe care and treatment was not being provided. In particular:

- There were ineffective systems to ensure that relevant safety information was accessed and used to minimise avoidable risks to patients.

### **Regulation 12(1)**

## Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

## Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed. In particular:

- There were ineffective systems to ensure that the required checks, as relevant, were undertaken such as checks in relation to identity, Disclosure and Barring Services checks and registration with the General Dental Council were carried out for temporary agency staff who worked at the practice.

### **Regulation 19 (1)**

## 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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>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. In particular:</p> <ul style="list-style-type: none"><li>• There were effective systems for checking and monitoring equipment taking into account relevant guidance and ensure that all equipment is well maintained.</li><li>• There were ineffective systems to ensure that the fire safety equipment such as smoke alarms and fire extinguishers were tested and checked or that a five-year electrical fixed wiring safety check had been carried out.</li><li>• There were ineffective systems to ensure that the gas boiler and the systems for heating water had been tested as part of an ongoing process to assess and mitigate the risks associated with Legionella or other bacterial growth in the water systems.</li><li>• There were ineffective arrangements to ensure that the dental X-ray equipment was tested, checked and serviced in accordance 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.</li></ul>

## Enforcement actions

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:

- There were ineffective arrangements to ensure that the issues identified in the fire safety risk assessment carried out in March 2012 had been effectively reviewed and appropriate actions taken to address these. The fire safety risk assessment was not reviewed as part of an ongoing process to assess and mitigate the risks associated with fire.
- There were ineffective arrangements to ensure that the issues identified in the Legionella risk assessment carried out in November 2011 had been effectively reviewed and appropriate actions taken to address these. The Legionella risk assessment was not reviewed as part of an ongoing process to assess and mitigate the risks associated with Legionella or other bacterial growth in the water systems.

Regulation 17 (1)

### Regulated activity

Diagnostic and screening procedures  
Surgical procedures  
Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The registered person had failed to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in order to carry out the regulated activities and to ensure that care and treatment is provided safely and effectively. In particular:

No permanent dental nurses have been employed at the practice since 2018.

- Reasonable steps had not been taken to employ dental nurses at the practice.

## Enforcement actions

- The principal dentist regularly assessed and treated patients without dental nurses to provide chairside assistance and support.

There were ineffective arrangements to ensure that persons employed by you to work at the practice receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. In particular:

- The registered person could provide us with assurances that they undertook training to meet ongoing continuing professional development in line with the General Dental Council professional standards.
- There were ineffective arrangements to appraise, assess or monitor staff training and development needs to ensure that the staff team undertook training and development to understand and carry out their roles effectively and safely.
- There were ineffective arrangements to ensure that staff had undertaken basic life support to an appropriate level in order to effectively manage medical emergencies.
- There were ineffective systems to ensure that staff had undertaken training in safeguarding children and adults in order to effectively respond to actual or suspected signs of abuse.

Regulation 18(1) (2)