Smilemaker Dental Practice Limited

Smilemaker Dental Practice

Inspection Report

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Overall summary

We carried out this announced inspection on 17 May 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 that this practice was not providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Smilemaker Dental Practice is in Orpington, in the London Borough of Bromley. The practice provides NHS and private treatment to adults and children.

There is no level step-free access for people who use wheelchairs or those with pushchairs. Car parking spaces are available on the premises.

The practice has two treatment rooms.

The dental team includes a practice manager (who also undertakes a dental nursing role), five dentists, two dental hygienists, two qualified dental nurses, and two receptionists.

The practice is owned by a company, and as a condition of registration must have a person registered with the CQC as the registered manager. Registered managers

Summary of findings

have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at practice is the principal dentist.

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

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

The practice is open at the following times:

Monday and Tuesday: 8:15am-5:45pm

Wednesday: 8:30am-5:30pm

Thursday: 8:15am-7:00pm

Friday: 8:00am-5:45pm

Saturday and Sunday: 10:00am-3:00pm

Our key findings were:

- The practice appeared clean.
- Staff felt supported and worked well as a team. They treated patients with respect and protected their privacy and personal information.
- The appointment system took account of patients' needs.
- The provider had procedures to help them deal with complaints.
- Staff knew their responsibilities for safeguarding vulnerable adults and children.
- The clinical staff provided patients' care and treatment in line with current guidelines. They were providing preventive care and supporting patients to ensure better oral health.
- The provider had not established thorough staff recruitment procedures.
- The provider had not implemented suitable systems for monitoring fire and electrical safety.
- The provider had not suitably assessed and mitigated risks. There was no sharps risk assessment. Risk assessments for hazardous chemicals were not fit for purpose.
- The provider had not undertaken a suitable Disability Access audit to continually assess how they could improve access for patients with enhanced needs.
- The provider's infection prevention and control procedures did not reflect published guidance in some areas.
- The practice did not follow current national guidance regarding staff training when undertaking dental treatment using conscious sedation.
- The provider had not ensured that suitable policies were available to staff.

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 persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

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

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 

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

Staff knew how to recognise the signs of abuse and escalate concerns. However, there was a lack of evidence of training in safeguarding children and vulnerable adults.

The provider had not completed essential recruitment checks for some staff.

The provider had emergency medicines. Some lifesaving equipment was not available as described in national guidance.

The provider was not assessing or mitigating risks effectively.

The provider had not carried out regular infection control audits and had not established suitable systems for preventing Legionella infection.

The premises were clean. The practice followed national guidance for cleaning, sterilising and storing dental instruments.

The provider had discussed a serious incident with staff to encourage learning and improve safety, but had not documented it. There was no suitable system for receiving, acting on and sharing with relevant staff national safety alerts relating to medicines and equipment.

Are services effective?

No action 

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

The dentists assessed patients' needs and provided care and treatment in line with recognised guidance.

Patients described the treatment they received as being of a high standard. The dentists discussed treatment with patients, so they could give informed consent and recorded this in their records.

The practice had clear arrangements for referring patients to other dental or health care professionals.

The provider had not established suitable systems for staff training, induction and appraisals.

Summary of findings

Are services caring?

No action

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

We received feedback about the practice from eight people. Patients were positive about all aspects of the service the practice provided. They told us staff were caring, friendly and polite. They said staff treated them with dignity and respect.

They said that they were given clear and informative advice about their dental care, and said their dentist listened to them.

Patients commented that they made them feel at ease, especially when they were anxious about visiting the dentist.

Staff protected patients' privacy and were aware of the importance of confidentiality.

Are services responsive to people's needs?

No action

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

The practice's appointment system took account of patients' needs. Patients could get an appointment quickly if they were experiencing dental pain.

The provider told us they usually relied on patients' friends, families or carers to translate for them if needed. They had commenced but not completed a Disability Access audit to assess how they could continually improve access for patients with enhanced needs.

The practice took patients views seriously. They valued compliments from patients and responded to concerns and complaints quickly and constructively.

Are services well-led?

Requirements notice 

We found that this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report).

Staff felt listened to, supported and appreciated. They told us the practice's principal was approachable.

The provider had not suitably assessed, monitored or mitigated risks or improved the quality and safety of the services being provided.

The provider had not sought assurance that three members of staff had achieved suitable immunity to the Hepatitis B virus. They had also not sought assurance that a staff member was suitably immunised.

The provider had not implemented suitable policies for staff. Several were not practice-specific and some contained outdated information.

Summary of findings

The practice had arrangements to ensure the smooth running of the service. These included systems for the practice team to discuss the quality and safety of the care and treatment provided.

The practice team kept complete patient dental care records which were, clearly written or typed and stored securely.

The provider had commenced a cycle of clinical and record keeping audits to help them improve and learn but they had not undertaken or reviewed the clinical audits regularly.

Are services safe?

Our findings

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

Staff we spoke with knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The practice had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse.

We saw evidence that eight of the practice's 12 staff had received safeguarding training. There was no evidence of this training for the remaining staff.

The staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the Care Quality Commission (CQC).

The practice had a system to highlight vulnerable patients on records e.g. adults and children where there were safeguarding concerns, people with enhanced learning needs or a mental health condition, or those who required other support such as with mobility or communication.

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

The dentists used dental dams in line with guidance from the British Endodontic Society when providing root canal treatment.

The provider had a business continuity plan describing how they would deal with events that could disrupt the normal running of the practice.

The practice had a recruitment policy and had checks in place for agency and locum staff. The recruitment policy did not give guidance to staff on undertaking criminal background checks for new staff. We checked recruitment records for all of the practice's staff. These showed the practice had not always followed their recruitment procedure or carried out key background checks for some staff:

- There was no photographic identification for five staff.
- There was a lack of assurances regarding the suitable conduct in previous employment for five staff.
- The provider had not undertaken criminal background checks for six staff.
- There was a lack of professional qualification documentation for two clinical staff.
- There was a lack of employment histories for two members of staff.

There was evidence of professional indemnity cover for all but three members of clinical staff.

The practice had suitable arrangements to ensure the safety of the radiography equipment and had the required information in their radiation protection file.

We saw evidence that the dentists justified, graded and reported on the radiographs they took. The provider had commenced a cycle of radiography audits but had not undertaken pr reviewed these regularly to identify areas for improvement.

There was evidence of continuing professional development in respect of dental radiography for two out of five dentists.

Risks to patients

There was a lack of suitable systems to assess, monitor and manage risks to patient safety. Risk assessments for hazardous substances were not fit for purpose as they did not provide guidance to staff on how to manage accidental exposure to harmful substances.

The provider did not use safer sharps and had not undertaken any sharps risk assessments. They told us they had undertaken a health and safety risk assessment immediately prior to the inspection, and that they were awaiting the assessment report.

The practice had not ensured that all equipment was suitably maintained. There were no safety inspection or servicing records for the compressor, electrical and gas appliances. They undertook inspection of the fixed wiring immediately after the inspection and told us they were in the process of completing the recommendations.

Fire extinguishers were regularly inspected. The provider had not implemented other suitable processes to prevent the spread of a fire. Staff did not carry out any fire safety checks or practice fire evacuation drills. They told us they had recently undertaken a fire risk assessment by themselves. However, they were not aware of requirements including those relating to fire doors, fire and smoke

detectors, emergency lighting, firefighting equipment, fire exists, fire compartmentalisation, arrangements for evacuating vulnerable people, and fire safety training. The principal dentist had completed fire safety training in 2011; this training had not been updated since. The provider told us they had booked fire safety training for all staff to be completed in July 2019. The provider had not ensured that smoke detectors were regularly tested to ensure they remained safe to use and in good working order.

Portable appliances had not been periodically tested for safety since the provider took over ownership of the practice in 2017. We saw evidence that the last portable appliance tests had been completed in 2009.

The provider had ensured that most clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked. They had, however, not ensured that a member of clinical staff had received the full course of vaccinations. They had not obtained assurances that this member of staff, and two others, had achieved suitable immunity against Hepatitis B.

The provider had not ensured that there were safe and effective processes for managing medical emergencies. There was a lack of evidence of training in emergency resuscitation and basic life support for four members of staff. The provider did not have three oropharyngeal airways (equipment used to prevent obstructed breathing in an emergency) or a paediatric ambulatory bag (a hand-held device commonly used to provide ventilation to patients who are not breathing or not breathing adequately) and mask available as per national guidance. Staff kept records of their checks of the emergency medicines and equipment to ensure they were in date and fit for use, but they had not identified the equipment that was not available.

A dental nurse worked with the dentists when they treated patients in line with General Dental Council's Standards for the Dental Team. A risk assessment was in place for when the dental hygienist worked without chairside support. There were measures in place to minimise risks including measures to ensure that dental instruments used by the hygienist were cleaned and sterilised in line with current recognised standards

The practice had an infection prevention and control policy and procedures for transporting, cleaning, checking, sterilising and storing instruments. 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.

Three staff had completed infection prevention and control (IPC) training, but there was no evidence of this training for the remaining staff. Another member of staff told us they had completed IPC training in 2018 but there was a lack of evidence of this. The provider told us they had booked IPC training for all staff to be completed in July 2019.

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

The practice had systems in place to ensure that any dental work was disinfected prior to being sent to a dental laboratory and before treatment was completed.

The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with water testing and dental unit water line management. However, they could not demonstrate that they had undertaken a Legionella risk assessment.

We saw cleaning schedules for the premises. The practice appeared visibly clean when we inspected it.

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

The provider had not carried out six-monthly IPC audits as per national guidance since they took ownership of the practice in 2017. They had completed only one IPC audit in 2019.

There were no handwashing facilities in the staff toilet; staff washed their hands in the kitchen sink.

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 checked a sample of dental care records to confirm our findings and noted that individual records were written and managed in a way that kept patients safe. Dental care records we saw were legible, kept securely, and complied with General Data Protection Regulation (GDPR) requirements.

Are services safe?

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

Safe and appropriate use of medicines

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

There was a suitable 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.

Track record on safety, lessons learned and improvements

Staff told us about a serious incident that had occurred in the last 12 months. The incident had not been documented or reviewed.

The provider had not established a system for receiving, acting on and disseminating to relevant staff, safety alerts relating to medicines and equipment.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The practice had systems to keep the dental practitioners up to date with current evidence-based clinical practice. We noted that clinicians assessed patients' needs and delivered dental care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

Helping patients to live healthier lives

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

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

The dental 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 health promotion leaflets to help patients with their oral health.

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

Patients with more severe gum disease were recalled at more frequent intervals for review and to reinforce home care preventative advice. They could also be referred to specialists wherever needed.

Consent to care and treatment

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

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentists gave patients information about treatment options and the risks and benefits of these so they could make informed decisions. 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 may 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. The 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 practice kept detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dentists assessed patients' treatment needs in line with recognised guidance.

The provider had begun the first audit of patients' dental care records to check that the dental clinicians recorded the necessary information.

The provider carried out conscious sedation for people who were very nervous of dental treatment.

The provider's systems included checks before and after treatment, emergency equipment requirements, medicines management, sedation equipment checks, and staff availability and training. They also included patient checks and information such as consent, monitoring during treatment, discharge and post-operative instructions.

The staff assessed patients appropriately for sedation. The dental care records showed that patients having sedation had important checks carried out first. These included a detailed medical history, blood pressure checks and an assessment of health using the American Society of Anaesthesiologists classification system in accordance with current guidelines.

The records showed that staff recorded important checks at regular intervals. These included pulse, blood pressure, breathing rates and the oxygen saturation of the blood

There was evidence of sedation training and continuing professional development, and immediate life support training for sedationist . The provider, however, had not established systems to ensure that dental nurses and the operating dentist were suitably trained in accordance with

Are services effective?

(for example, treatment is effective)

current national guidelines. The provider assured us they would cease the provision of dental treatments carried out under conscious sedation until staff had been suitably trained.

Effective staffing

There was evidence that the provider had completed an induction, based on a structured programme, for a member of staff. There were no induction records for four members of staff.

We found that clinical staff had completed some aspects of the continuing professional development required for their registration with the General Dental Council. However, the provider had not suitably monitored training needs. There was a lack of evidence of training in the following:

- Radiography training for two dentists.
- Infection prevention and control training for six staff. There was no evidence to show that this training had been updated since 2012 for another member of staff. The provider told us he had arranged for this training to be undertaken by all staff in July 2019.
- Medical emergencies training for four staff.
- Fire safety training for 10 staff.
- Safeguarding children and vulnerable adults training for four staff.
- Training in immediate life support and intravenous conscious sedation for those carrying out and assisting with dental treatments carried out under conscious sedation.

There were no performance review and staff appraisal records.

Co-ordinating care and treatment

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

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

The practice had systems to identify, manage, follow up and where required refer patients for specialist care when presenting with dental infections.

The practice also had systems for referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by the National Institute for health and Care Excellence (NICE) in 2005 to help make sure patients were seen quickly by a specialist.

The practice monitored all referrals to make sure they were dealt with promptly.

Are services caring?

Our findings

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. They were aware of their responsibility to respect people's diversity and human rights. They treated patients with kindness and respect; they were friendly towards patients at the reception desk and over the telephone.

We received feedback from eight patients. They commented positively that staff were caring, friendly and polite.

Patients who shared with us their anxieties about visiting the dentist told us staff made them feel reassured and at ease.

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

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of the reception and waiting areas provided privacy when reception staff were dealing with patients. If a patient asked for more privacy, staff told us they would take them into another room. The computer screens at the reception desk 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 described how they communicated with patients so that they could understand the information being explained to them. The provider was aware of the requirements under the Equality Act but could make improvements to ensure interpreting services were offered to patients. They told us the practice usually relied on patients' relatives or friends to translate for them.

The practice gave patients 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. The principal dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

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

The principal dentist and dental hygienist described to us the methods they used to help patients understand treatment options discussed. These included the use of photographs, models, and radiograph images.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

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

The practice did not have step-free acess for wheelchair users. The provider had not suitably assessed how they could continually improve access for patients with enhanced needs; they had begun but not completed a Disability Access audit. The provider could also ensure that reasonable adjustments were made to meet the needs of people with hearing or visual limitations.

Timely access to services

Patients could access care and treatment from the practice within an acceptable timescale for their needs. They confirmed they could make routine and emergency appointments easily.

The provider displayed their opening hours in the premises and included it on their website.

The practice had an appointment system to suit patients' needs. Patients who requested an urgent appointment were usually seen the same day.

Information on the practice's front door, website, and 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

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 on how to handle a complaint. There was also information available to patients about how to make a complaint. Information was available about organisations patients could contact if they were not satisfied with the way the practice dealt with their concerns.

The principal dentist was responsible for dealing with complaints. They told us they aimed to settle complaints in-house and invited patients to speak with them in person to discuss these.

We checked two complaints the provider had received; 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

Leadership capacity and capability

The principal dentist had overall responsibility for the management and clinical leadership of the practice. The practice manager was responsible for the day to day running of the service.

Culture

The principal dentist and staff described a culture that was focused on team working, well-being, communication and customer service. They had processes in place to encourage behaviour that was in line with their culture.

Staff told us they felt respected, supported and valued. They appeared proud of the work they were carrying out in the practice. Staff we spoke with told us that they were able to raise concerns and were encouraged to do so; they had confidence that any concerns they raised would be addressed.

Staff showed openness, honesty and transparency when responding to complaints. They were aware of, and had systems to ensure compliance with, the requirements of the Duty of Candour.

Governance and management

The provider had not established clear and effective processes for managing risks, issues and performance. In particular they had not assessed or mitigated risks relating to the following:

- They had not ensured suitable policies were available to staff; several contained outdated information.
- They had not established a suitable system for recording serious incidents.
- They had not suitably considered the needs of patients with enhanced needs, such as those with restricted mobility, hearing and sight.

Appropriate and accurate information

The practice 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 told us they gathered feedback from staff through informal discussions. They told us they had recently begun to hold meetings to discuss any issues.

The provider obtained feedback from patients via satisfaction surveys. We checked surveys the provider gave to us but could not determine when they had been completed as they had not been dated.

Continuous improvement and innovation

The provider had implemented limited quality assurance systems and processes for learning and continuous improvement. They had carried out infection prevention and control audits and one radiography audit, but they had not been undertaken regularly.

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 The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: • The registered person had not established suitable processes to prevent the spread of infections. • The registered person did not have enough equipment available to manage medical emergencies. • The registered person had not established suitable systems for preventing injuries from sharp instruments. • The registered person's risk assessments pertaining to the use of substances hazardous to health had not been suitably completed • The registered person had not established a suitable system for receiving, acting on and sharing with staff relevant national safety alerts pertaining to medicines and equipment. • The registered person had not established suitable systems to mitigate the risks associated with electrical safety and the prevention of fire. • The registered person had not established suitable systems pertaining to gas safety. • Assurance of suitable immunity to Hepatitis B for two clinical staff. Lack of evidence of vaccination against Hepatitis B for one of these two staff. • The registered person could not demonstrate that the compressor had been serviced. **Regulation 12 (1)**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 **How the regulation was not met** There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • The registered person had not established a suitable system for recording serious incidents. • The registered person had not suitably considered the needs of patients with enhanced needs, such as those with restricted mobility, hearing and sight. • The registered person had not undertaken or reviewed radiography audits on a regular basis to identify areas for improvement. There was additional evidence of poor governance. In particular: • The registered person had not ensured suitable policies were available to staff. • The registered person had not sought evidence of indemnity insurance for three clinical staff. **Regulation 17 (1)**

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had failed to 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 was a lack of evidence of: • Appropriate training for some relevant staff in radiography, infection prevention and control, medical emergencies, fire safety, safeguarding children and vulnerable adults, immediate life support and intravenous conscious sedation. • Inductions and appraisals for all relevant staff. **Regulation 18 (2)**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed. In particular, there was a lack of evidence for relevant staff of: • Employment histories, proof of identity, satisfactory evidence of conduct in previous employment, professional qualifications and criminal background checks. **19 (1)(2)(3)**