Dr. Uszama Zein and Dr. Hiba Al-Raslani

Prescot House Dental Surgery

Inspection Report

3 High Street
Prescot
Merseyside
Liverpool
L34 3LD
Tel: 0151 426 6460
Website: www.prescothousedental.co.uk

Date of inspection visit: 2 July 2019
Date of publication: 07/08/2019

Overall summary

We carried out this announced inspection on 2 July 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 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

Prescot House Dental Surgery is in Prescot, Merseyside and provides NHS and private treatment to adults and children.

Summary of findings

There is level access for people who use wheelchairs and those with pushchairs. Car parking spaces, including for blue badge holders, are available near the practice at a pay and display car park.

The dental team includes six dentists, eight dental nurses, one of whom is a trainee, and one dental hygiene therapist, and a practice manager.

The practice is owned by a partnership and as a condition of registration must have a person registered with the Care Quality Commission 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. The registered manager at Prescot House Dental Practice is the practice manager.

On the day of inspection, we collected 42 CQC comment cards filled in by patients. All feedback was highly positive about treatment and staff at the practice.

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

The practice is open: Monday to Friday, 9am to 1pm and from 2pm to 5.30pm. The practice provides extended opening hours on Wednesdays, when the practice is open until 8pm, and on Saturday morning from 9am to 1pm.

Our key findings were:

- The practice appeared clean and well maintained.
- The provider had infection control procedures which reflected published guidance. Some of these were not universally observed by all staff.
- Staff knew how to deal with emergencies.
- Appropriate medicines and life-saving equipment were not available, as described in recognised guidance.
- The provider had suitable safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider had staff recruitment procedures in place, but records to support this were not maintained.
- There was no effective system in place to receive, record and share safety alerts and clinical updates with all staff.
- 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.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.
- The leadership of the practice required improvement.
- Continuous improvement initiatives were in place, but not spread evenly across the practice, for example, audits of work did not cover all dentists.
- The provider asked patients for feedback about the services they provided. This evidence was not collated and shared with staff.
- The provider dealt with complaints positively and efficiently.
- The governance arrangements in place required improvement.

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

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure care and treatment is provided in a safe way to patients.

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

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

- Introduce protocols regarding the prescribing of antibiotic medicines taking into account the guidance provided by the Faculty of General Dental Practice.

Summary of findings

Are services safe?	**Enforcement action**
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 that this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement 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)

Staff had clear systems to keep patients safe.

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. We saw evidence that staff received safeguarding training. When reviewing training records, we saw that the safeguarding training for two of the dentists required updating, with the last training date for these staff members being January and September 2015. The recommendation is that this training is updated at least every three years. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC.

The provider had a system to highlight vulnerable patients and patients who required other support such as with mobility or communication within dental care records.

The provider 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. In instances where the 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.

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

The provider had a recruitment policy and procedure to help them employ suitable staff. These reflected the relevant legislation. We looked at staff recruitment records. These showed the provider did not always adhere to their recruitment procedure. Records of some required recruitment checks were not held by the provider. The provider confirmed that where this was the case, the check had not been applied to those staff members. For example, for five dental nurses, there was no record of immunity to Hepatitis B. The provider had put in place a risk assessment for one of these nurses. Risk assessments were still required for the other nurses. For two dentists, there was evidence of vaccination against Hepatitis B, but no evidence of immunity. The provider had put a risk assessment in place for one of these dentists. In the case of two of the most recently recruited nurses, one of whom was a trainee, there was no evidence of Disclosure and Barring Service (DBS) check. In the case of two dentists, there was no evidence of DBS check.

We noted that clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover.

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

Records showed that fire detection and firefighting equipment were regularly tested and serviced.

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

We saw evidence that the principal dentist justified, graded and reported on the radiographs they took. The provider had not carried out a full radiography audit every year, that covered all dentists, following current guidance and legislation.

Clinical staff completed continuing professional development (CPD) in respect of dental radiography.

Risks to patients

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

Are services safe?

The practice's health and safety policies, procedures and risk assessments were reviewed regularly to help manage potential risk. The provider had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The staff followed relevant safety regulation when using needles and other sharp dental items. A sharps risk assessment had been undertaken and was updated annually.

The provider did not have an effective system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked.

Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support (BLS) every year. We noted that BLS training for one of the dentists was out of date and due for renewal, with the last date for training being December 2017. The recommendation is that this training is reviewed annually.

Emergency equipment and medicines were not available as described in recognised guidance. We found staff were performing checks on emergency medicines and equipment, but that these were performed monthly rather than weekly, and had not identified that medicines were incorrectly stored and out of date. We found that, other than one adrenaline auto injector pen, medicines to treat a severe allergic reaction were out of date, and held in the fridge, contrary to manufacturers guidance. Medicines to treat asthma or other breathing difficulties, were incorrectly stored in the fridge. Buccal Midazolam (used to treat a person who has a seizure) was stored in the fridge rather than at an ambient temperature within the range described in manufacturer instructions and was also out of date (expired 2018). We found the oxygen cylinder available was of a size smaller than the recommended 460L, as described in recognised guidance, meaning the practice would not be able to supply a patient the recommended amount of oxygen for the prescribed time, before help arrived. There was no portable suction apparatus available.

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

There were suitable numbers of dental instruments available for the clinical staff. Some of the guidance for managing the decontamination process and cleaning of instruments was not being observed by all staff. We witnessed staff cleaning instruments manually in water that was not temperature tested, or of a temperature recommended for the effective use of the chosen detergent. There was no thermometer in the decontamination room for staff use. Staff we observed did not use personal protective equipment (PPE), for example, an apron or visor, and did not use the correct long handled brushes to clean instruments. When used instruments were being carried between the surgery and decontamination room, this was done so in an unsecured container.

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

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

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

The provider had an infection prevention and control policy and procedures. Staff could refer to guidance in The Health Technical Memorandum 01-05: Decontamination in care dental practices (HTM 01-05) published by the Department of Health and Social Care. Our observations of staff on the inspection day demonstrated that this guidance was not universally followed by all staff. Staff completed infection prevention and control training. When we reviewed training records, we saw that one of the dental nurses required updated infection control training, with the last course of training for that nurse being February 2016.

We saw staff had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. All recommendations had been actioned. When we reviewed records of water temperature testing, these were not available for 2019. Records of dental unit water line management were in place.

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

Are services safe?

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

The practice manager carried out infection prevention and control audits. We were told these had been done twice a year. Information sent to us following the inspection consisted of:

- An audit dated 18 November 2016, with a coversheet saying it was completed on 19 March 2018.
- Another copy of the same audit (dated 18 November 2016) with a coversheet saying it was completed on 24 November 2018.

Both these audits were scored at 100% compliance. None of the issues we highlighted in relation to infection control and decontamination of instruments, were identified by these audits.

The provider could not evidence infection control audits for the last 12 months.

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 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. When we reviewed dental care records we saw the majority of these were complete, legible, were kept securely and complied with General Data Protection Regulation (GDPR) requirements.

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

With the exception of emergency medicines, and a small number of items in one of the surgeries, the provider had reliable systems for appropriate stock control and safe handling of medicines. This ensured enough medicines were available if required. When checking surgeries, in one we found anaesthetic cartridges out of their blister pack and held loosely in a drawer, and root canal treatment packs that were out of date.

We saw the provider had a system in place for the safe storage and recording of NHS prescription pads issued. This could be further improved by ensuring that all pads and their log sheet were kept in a locked drawer when not in use.

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

Antimicrobial prescribing audits were not being carried out.

Track record on safety and Lessons learned and improvements

There were risk assessments in relation to safety issues. Staff monitored and reviewed incidents. This helped staff to understand risks, give a clear, accurate and current picture that led to safety improvements.

In the previous 12 months there had been one safety incident. We saw this was investigated, documented and discussed with the rest of the dental practice team to prevent such occurrences happening again in the future.

There were adequate systems for reviewing and investigating when things went wrong. The practice learned, and shared lessons identified themes and acted to improve safety in the practice.

The provider did not have an effective system for receiving and acting on safety alerts. When asked about recent alerts, the practice manager could refer to one that was from some time ago but was now outdated. The practice could not evidence that they were receiving, recording, sharing, and confirming staff understanding of alerts and updates in clinical practice, for example, from the Medicines and Healthcare Products Regulatory Agency (MHRA) and from the National Institute of Health and Care Excellence (NICE). The practice manager told us they thought there was a shortage of other medicines. When we questioned this, we found that this was the advice of their supplier, rather than up-to-date information from MHRA.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

The practice did not have effective systems to keep all dental practitioners up to date with current evidence-based practice. We found some dentists were receiving updates directly, but there was no system in place to ensure all staff, including the nurses, part-time dentists and the visiting dental hygiene therapist, had received and understood alerts and clinical updates.

We saw that 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 had an on-site laboratory for the manufacture of dental appliances and prosthetics.

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 if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for patients based on an assessment of the risk of tooth decay.

The dentists, 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.

Staff were aware of national oral health campaigns and local schemes in supporting patients to live healthier lives. For example, local stop smoking services. They directed patients to these schemes when necessary. We saw that the practice had received the Dementia Toolkit for dentists, but this had not been shared with the practice dentists. The material for this was in the practice office and had not been discussed with staff.

The dentists 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

Records showed patients with more 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 dentists gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions and we saw this documented in-patient 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. 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.

We saw the practice audited patients' dental care records to check that the dentists and dental hygiene therapist, recorded the necessary information. When we reviewed audits, we saw that the audits conducted did not cover all dentists in the practice. We reviewed a sample of dental care records which showed that for one of the dentists, records were not sufficiently detailed. The provider confirmed they would act on this immediately.

Effective staffing

Are services effective?

(for example, treatment is effective)

Staff had the skills, knowledge and experience to carry out their roles.

Staff new to the practice had a period of induction based on a structured programme. This was evidenced for dental nurses but not for new dentists joining the practice. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council. Some areas of training for some dentists required updating, for example, in relation to basic life support, infection control and for safeguarding of vulnerable adults and children.

Staff discussed their training needs at annual appraisals. The practice manager appraised dental nurses annually.

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.

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

The provider also had systems for referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist.

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

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

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

Patients commented positively that staff were approachable and caring. We saw that staff treated patients. 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 could choose whether they saw a male or female dentist.

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

Information folders 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 some privacy when reception staff were dealing with patients. If a patient asked for more privacy, staff would take them into another room. 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 and were aware of the

Accessible Information Standards and the requirements under the Equality Act

The Accessible Information Standard is a requirement to make sure that patients and their carers can access and understand the information they are given. We saw:

- Interpreter services were available for patients who did speak or understand English. Patients were also told about multi-lingual staff that might be able to support them.
- Staff communicated with patients in a way that they could understand, 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 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 for example photographs, models and X-ray images.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

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

Staff were clear on the importance of emotional support needed by patients when delivering care. Patients at the practice commented in CQC comment cards that dentists were supportive and took time to put them at ease before commencing any treatment.

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

.

The practice had made reasonable adjustments for patients with disabilities. This included step free access, and accessible toilet with hand rails and a call bell.

The practice had not completed a disability access audit. There was no action plan formulated to continually improve access for patients. There was no hearing loop at the practice, which could be used to assist patients with hearing loss.

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, on their website, and they were part of the message on the practice answering machine.

The practice had an appointment system to respond to patients' needs. Patients who requested an urgent appointment were seen 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 as part of the Emergency Access Scheme for the area. The practice provided extended opening hours on Wednesday evening until 8pm and on Saturday from 9am to 1pm. 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

The practice manager, who was the registered manager, 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. The practice information leaflet explained how to make a complaint.

The practice manager was responsible for dealing with these. Staff would tell the practice manager about any formal or informal comments or concerns straight away so patients received a quick response.

The practice manager 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 manager had dealt with their concerns.

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

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

Leadership capacity and capability

We found the principal dentist and associate dentists had the capacity and skills to deliver high-quality, sustainable care. They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.

We noted there had been a higher than expected turnover in staff, particularly dentists, which had an impact on team working. Development of leadership capacity and skills within the practice had not been able to develop.

Culture

The practice strived toward a culture of high-quality sustainable care. The staff focused on the needs of patients.

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

Governance and management

The practice manager had overall responsibility for governance. Whilst there were some clear responsibilities, roles and systems of accountability, these did not support good governance. Governance overall required improvement.

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 and management of staff. Staff knew the management arrangements and their roles and responsibilities.

The provider had a system of clinical governance in place which included policies, protocols and procedures, which had been adapted to suit the practice. These were kept in the practice managers office. It was not clear how accessible this made them for staff.

Processes for managing risks, issues and performance were not always effective. For example:

- Oversight of staff training required improvement. Some staff training was overdue for refreshing or updating.
- The provider did not always adhere to their recruitment procedure. Records of all required recruitment checks were not held by the provider.
- Where risk assessments were needed, these were not in place. For example, for some staff whose status in respect of Hepatitis B immunity was not known.
- Audits required improvement; audit of radiography did not cover all staff taking radiographs.
- Patient record audits required improved oversight.
- Checks on emergency medicines were ineffective.
- The practice manager had not identified guidance for staff to refer to, on what medicines and equipment should be held for use in an emergency.
- Guidance on the decontamination of dental instruments was not embedded and observed by all staff. Oversight in this area required improvement.
- Record keeping required improvement.
- Practice meetings did not facilitate the exchange of important information, for example, on medical alerts and updates, and updates and changes to clinical guidance.
- Information on initiatives to improve the experience of patient groups at the dentist, for example, those patients with dementia, was not shared.
- The provider had not completed a disability access audit.

Appropriate and accurate information

Quality and operational information was not always used to ensure and improve performance. Local and national initiatives to improve patients experience and outcomes in oral health care, for example, the Dementia Tool Kit, where not shared. Audits carried out did not cover all dentists, for example, radiograph audits and audits of patient dental care records.

Are services well-led?

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

Staff involved patients and partners to support high-quality sustainable services.

The provider used patient surveys to obtain patients' views about the service. Patients were encouraged to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on NHS services they have used. Results of this were entered into an NHS feedback return but were not kept by the practice and shared with staff. From feedback we reviewed on the day, we could see that patients were either likely or highly likely to recommend the practice to friends and family.

The provider gathered feedback from staff through meetings and at appraisals.

Continuous improvement and innovation

There were systems and processes for learning and encouraging continuous improvement. These could be further developed. These included audits of dental care records and radiographs. We reviewed historic audits of infection prevention and control, but records of audits on infection control for the last 12 months could not be provided.

The principal dentist showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff.

The dental nurses had annual appraisals. They discussed learning needs, general wellbeing and aims for future professional development.

Staff completed 'highly recommended' training as per General Dental Council professional standards. This included undertaking medical emergencies and basic life support training annually. Some staff where overdue for some updates to training, for example, in safeguarding and basic life support. The provider supported and encouraged staff to complete CPD.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 12 Safe care and treatment.** The practice did not have effective systems and processes in place to provide safe care and treatment. In particular: • Medicines and equipment for use in a medical emergency were not available as described in recognised guidance. Medical oxygen was not available in sufficient quantity and there was no portable suction apparatus. • Medical emergency medicines available were out of date. This included phials of adrenaline, adrenaline pens and Buccal Midazolam. • Medicines were not stored in accordance with manufacturer instructions. This included the refrigeration of medicines that should have been stored at ambient temperature. • All required recruitment checks were not in place for all staff. • The Hepatitis B immunity status was not confirmed for all staff, and; • risk assessments were not in place for all staff whose Hepatitis B status was unknown. • Staff did not use appropriate PPE when carrying out decontamination duties. Regulation 12(1)

This section is primarily information for the provider

Enforcement actions

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulation 17

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.

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:

- Oversight of staff training required improvement. We saw that training in safeguarding and basic life support was overdue for some dentists. Infection control training for one of the dental nurses required updating.
- The provider had ineffective recruitment checks and they did not follow their recruitment policy with regard to required checks, for all staff.
- Checks on emergency equipment and medicines were ineffective. These had failed to identify the absence of recommended equipment, medicines that were out of date and medicines incorrectly stored.
- Radiography audits did not cover all dentists carrying out radiographs
- Infection control audit was ineffective in that it failed to identify areas highlighted by this inspection. There were no records of infection control audit completed within the last 12 months.

This section is primarily information for the provider

Enforcement actions

- There was no effective system in place for the receipt, sharing and confirmed understanding of MHRA alerts and updates to NICE guidance.
- Communication across the practice was not effective. Meetings were not used to share essential updates.
- There was no disability access audit completed for the practice.

Regulation 17(1)(2)