Dr. Bryan Wilson

# Inglemire Dental Surgery

## Inspection Report

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## Overall summary

We carried out this announced inspection on 8 June 2017 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.

We told the NHS England area team and Healthwatch that we were inspecting the practice. They did not provide any information of concern.

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**

Inglemire dental practice is in Hull and provides NHS and minimal private treatment to adults and children.

There is a small step access for people who use wheelchairs and pushchairs. Car parking spaces are available near the practice.

The dental team includes two dentists, four dental nurses, a part time practice manager and a receptionist. 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 20 CQC comment cards filled in by patients and spoke with three other patients. This information gave us a positive view of the practice.

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

The practice is open:

Monday, Thursday & Friday 9am – 5pm

Tuesday 9am – 18:30

Wednesday 9am – 15:30

**Our key findings were:**

- The surgeries were cluttered and some equipment was visibly dirty.
- The decontamination process did not always reflect published guidance. We found the zoning could be improved upon in the surgeries to clarify clean and dirty areas. Decontamination of instruments was not always effective.
- We found improvements could be made to the segregation and disposal of clinical waste in accordance with relevant regulations taking into account guidance.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available apart from midazolam.
- The practice did not have systems in place to help them manage risk.
- The practice had safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- The practice did not have sufficiently robust staff recruitment procedures.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect.
- Dental care records were not stored securely.
- The appointment system met patients' needs in most cases but we were told they were often kept waiting.
- Governance arrangements were not in place to support the smooth running of the practice; the practice did not have a structured plan in place to audit quality and safety including infection control and radiography.
- The practice did not have effective leadership.
- The practice asked staff and patients for feedback about the services they provided.
- The practice dealt with complaints positively and efficiently.

We identified regulations the provider was not meeting. They must:

- Ensure the practice's infection control procedures and protocols are suitable giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- Ensure the practice has an effective policy regarding the storage of products identified under Control of Substances Hazardous to Health (COSHH) 2002 Regulations which ensures risk assessments are undertaken and that products are stored securely.
- Ensure waste handling protocols are in place to ensure it is segregated and disposed of in accordance with relevant regulations taking into account guidance issued in the Health Technical Memorandum 07-01 (HTM 07-01).
- Ensure the practice has protocols and procedures for use of X-ray equipment taking into account Guidance Notes for Dental Practitioners on the Safe Use of X-ray Equipment.
- Ensure the practice's sharps procedures are in compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Ensure the practice availability of medicines to manage medical emergencies taking into account guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Ensure the practice's system for recording, investigating and reviewing incidents or significant events with a view to preventing further occurrences and ensuring that improvements are made as a result.

# Summary of findings

- Ensure the practice implements risk assessments to monitor and mitigate the various risks arising from undertaking of the regulated activities.
- Ensure audits of various aspects of the service, such as radiography and infection prevention and control are undertaken at regular intervals to help improve the quality of service. Practice should also ensure that where appropriate audits have documented learning points and the resulting improvements can be demonstrated.
- Ensure the practice reviews the recruitment policy and procedures to ensure they are suitable and the recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.
- Ensure there are training, learning and development needs of individual staff members at appropriate intervals and ensure an effective process is established for the on-going assessment, supervision and appraisal of all staff.

**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:

- Review the security of prescription pads in the practice and ensure there are systems in place to track and monitor their use.
- Review the practice's systems in place for environmental cleaning taking into account current national guidelines.
- Review stocks of medicines and equipment and the system for identifying, disposing and replenishing of out-of-date stock.
- Review the practice's protocols for the use of rubber dam for root canal treatment taking into account guidelines issued by the British Endodontic Society.
- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies, such as Public Health England (PHE).
- Review the practice's protocols for completion of dental care records taking into account guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Introduce protocols regarding the prescribing and recording of antibiotic medicines taking into account guidance provided by the Faculty of General Dental Practice in respect of antimicrobial prescribing.
- Review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.
- Review the practice's storage of dental care records and records relating to people employed and the management of regulated activities having regard to legislation and taking into account current guidance.
- Review the processes and systems in place for seeking and learning from patient feedback with a view to monitoring and improving the quality of the service.

We are now taking further action in relation to this provider and will report on this when it is completed. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes.

# Summary of findings

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

We always ask the following five questions of services.

**Are services safe?**

Enforcement action 

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).

The practice did not have systems and processes to provide safe care and treatment. They did not use learning from incidents and complaints to help them improve.

Staff received training in safeguarding and knew how to recognise the signs of abuse and how to report concerns.

Staff were qualified for their roles. The newest member of staff had not completed any recruitment checks.

We found prescription pads were not stored securely and no logs were in place to monitor their use.

Clinical waste was not stored appropriately. We found 26 unmarked containers in an accessible room within the practice which contained clinical waste including amalgam and capsules.

We found a significant quantity of out of date emergency and midazolam stored in accessible room and out of date materials within the surgeries.

Radiation equipment had not been serviced and local rules were not available for one machine.

Premises and equipment were not clean or properly maintained.

The practice followed national guidance for cleaning and sterilising but we found this could be improved upon.

The staff were unaware if any risk assessments for the practice had been completed including the safe use of sharps.

We had inconsistent information with regards MHRA; staff were unsure who received them and who actioned them.

The practice had suitable arrangements for dealing with medical and other emergencies, the equipment was in several locations within the practice and we found it difficult to easily identify which was new equipment and which was not in use.

The dentists did not use rubber dam when providing root canal treatment to patients.

**Are services effective?**

No action 

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

# Summary of findings

The dentists assessed patients' needs and provided care and treatment in line with recognised guidance. Patients described the treatment they received as pleasant and caring. The dentists discussed treatment with patients so they could give informed consent. This was not always recorded in their records.

There were areas of improvement with regards the recording of information within patient dental care records including the justification for antimicrobial prescribing.

The practice had clear arrangements when patients needed to be referred to other dental or health care professionals. There was no supporting log to ensure all referrals had been followed up.

The practice did not fully support staff to complete training relevant to their roles and staff told us they felt they were not up to date with training. There were no systems to help them monitor this.

**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 23 people. Patients were positive about all aspects of the service the practice provided. They told us staff were polite, helpful and caring. They said that they were given helpful, honest explanations about dental treatment, 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.

Patients said staff treated them with dignity and respect.

**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 was efficient and met patients' needs. Patients could get an appointment quickly if in pain. We were told clinics regularly ran late and patients commented they were often kept waiting.

Staff considered patients' different needs. This included providing facilities for disabled patients and families with children. The practice did not have access to interpreter services.

The practice recorded patients views through friends and family questionnaires, but comments were not shared within the practice.

**Are services well-led?**

**Enforcement action** 

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 section at the end of this report).

# Summary of findings

There were no defined leadership roles within the practice and staff did not feel supported. The practice did not have arrangements to ensure the smooth running of the service.

There were limited governance arrangements within the practice. Staff were unaware of policies and protocols in line with recognised guidance.

Dental care records were not always complete, clearly written or stored securely.

The practice did not monitor clinical and non-clinical areas of their work to help them improve and learn. There was minimal recorded audits, risk assessments and poor reporting processes.

# Are services safe?

## Our findings

**Reporting, learning and improvement from incidents**

The practice did not have policies and procedures to report, investigate, respond and learn from accidents, incidents and significant events. Staff were not fully aware of their responsibilities or understood their role in the process.

We were told informal discussions would take place but this was not recorded.

The staff were unsure who received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA). We were told the practice had not received any alerts with in the past 12 months and there was no supporting evidence to suggest any alerts had been acted on or stored for future reference.

**Reliable safety systems and processes (including safeguarding)**

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 practice had safeguarding policies and procedures but staff were not familiar with what the policy included. We saw evidence that staff received safeguarding training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns. The practice had a whistleblowing policy although staff were not familiar with it and did not know who to contact outside of the practice if it became necessary. Staff told us they felt confident they could raise concerns without fear of recrimination but were not confident the concerns would be acted upon.

We looked at the practice's arrangements for safe dental care and treatment. This did not include any risk assessments including the safe use of sharps. The dentists and staff told us they did not use rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment and no other safety measures were used.

The practice did not have a business continuity plan describing how the practice would deal events which could disrupt the normal running of the practice.

**Medical emergencies**

Staff had self-funded a training session in February 2017 as they did not feel confident in responding to medical emergencies and were unsure when they had last completed training in medical emergencies. At the time of our inspection all staff knew what to do in a medical emergency and felt more confident as a result of training.

The majority of emergency equipment and medicines were available as described in recognised guidance. We found no buccal midazolam was available on the premises and evidence suggested this had expired in June 2016 and not been replaced; we were told an order had been placed. Staff kept monthly records of the emergency drugs; no records of checking either the medical oxygen or the AED were in place.

**Staff recruitment**

The practice did not have a staff recruitment policy and procedures to help them employ suitable staff. We looked at all staff recruitment files and found the newest member of staff had no information with regards their recruitment or any other supporting information to show they had been safely recruited. One dentist could not provide any supporting information with regards immunisation, indemnity, professional registration or training including radiation protection and CPR. We found it difficult to establish if the principal dentist was indemnified, held professional registration or had any immunisations. Supporting information was sent to the inspector for the principal dentist.

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

**Monitoring health & safety and responding to risks**

The practice had a health and safety policy. There were no risk assessments to help manage potential risk which can occur in a dental practice including the safe use and management of sharps, display screen equipment, pressure vessels and radiation. The practice had current employer's liability insurance and checked each year that the clinicians' professional indemnity insurance was up to date.

A dental nurse worked with the dentists when they treated patients.

**Infection control**

# Are services safe?

The practice had an infection prevention and control policy.

They were aware of the guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health. Evidence that staff had completed infection prevention and control training was inconsistent as one of the dentists could not provide any supporting evidence and staff were not confident in the infection control procedures.

We found improvements could be made to the cleaning, checking, sterilising and storing instruments in line with HTM01-05. Sterilised instruments were not always correctly packaged, sealed and dated. We found several instruments with retained residue and debris on after the decontamination process and several instruments with bands which can make it difficult to clean effectively.

We found evidence some single use items were being reused and stored inappropriately within patient dental care records; this could have caused a potential sharps injury and no evidence that the items were decontaminated. The registered provider was also unaware of the single use item mark.

Surgeries had cluttered work surfaces and could be difficult to clean effectively between patients.

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

The practice could not provide evidence they had carried out an infection prevention and control audit since 2013.

The practice had inconsistent procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment completed in 2011. When we spoke with staff we received mixed messages as to what everyone did on a daily basis to ensure the dental unit water lines were managed effectively. Hot and cold water tests were recorded but there was no evidence to show what temperature the water had achieved in the time recommended.

We did not see any cleaning schedules for the premises. We were told the cleaner provided their own equipment but there was no information available to ensure this was stored and used in the correct areas of the practice. The practice was cluttered and accessible rooms could pose a potential fire risk as there were COSHH materials including potential accelerants and combustible materials, general equipment and hazardous waste also stored there.

**Equipment and medicines**

We saw servicing documentation for some of the equipment used. Staff carried out checks in line with the manufacturers' recommendations. We found one of the X-ray machine which was overdue it service.

The practice did not keep any records of NHS prescriptions as described in current guidance and we found they were not stored securely. There was no method to show if all prescriptions were accounted for and no way to report if any were missing.

**Radiography (X-rays)**

The practice did not have suitable arrangements to ensure the safety of the X-ray equipment. There was no radiation protection file and one machine had not been checked since fitting in 2013 the other had been fully certificated in December 2014. There were no local rules available for this machine and the location and staff were not aware of who the RPA or RPS was or how to contact them.

We saw some evidence that the dentists justified, graded and reported on the X-rays they took. There was no evidence available to show an audit had been completed in line with current guidance and legislation.

Clinical staff completed continuous professional development in respect of dental radiography.

# Are services effective?

(for example, treatment is effective)

## Our findings

**Monitoring and improving outcomes for patients**

We found improvements could be made to ensure detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. This includes the recording of options, risk and benefits of treatment, the recording of gum scores and the justification of treatment or antibiotic prescribing. The dentists assessed patients' treatment needs in line with recognised guidance.

**Health promotion & prevention**

The practice believed in preventative care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit The dentists told us they discussed smoking, alcohol consumption and diet with patients during appointments, we saw some evidence this was not always recorded within the records. The practice had a selection of dental products for sale and provided health promotion leaflets to help patients with their oral health.

The dentists told us they prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for children based on an assessment of the risk of tooth decay for each child.

**Staffing**

We were told staff new to the practice had a period of induction based on a structured induction programme although when we spoke to the newest staff member they were unaware of policies and procedures within the practice and had not been through any induction.

We confirmed clinical staff completed the continuous professional development required for their registration with the General Dental Council. We found improvements could be made as this had been difficult to achieve as they were not given any time to complete this.

We saw evidence of completed appraisals. Staff told us they discussed training needs at annual appraisals, but nothing was ever followed up or support put in place. One member of staff had highlighted their wellbeing and discussed stress management. No action had been taken to ensure learning and improvements could be made and no follow up action was recorded.

**Working with other services**

Dentists confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide. These included 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. These referrals were monitored by the dentists. The practice did not monitor routine referrals to make sure they were dealt with or responded to, we were told the staff were so busy there was no way to identify if the process was effective and would only find out if a process had not worked when the patient came back for an appointment.

**Consent to care and treatment**

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentists told us they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions although this was not always recorded. 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. We found staff were not fully aware the processes to follow and their requirements when treating adults who may not be able to make informed decisions.

The policy referred to Gillick competence and the staff were aware of the need to consider this when treating young people under 16. Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

# Are services caring?

## Our findings

**Respect, dignity, compassion and empathy**

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

Patients commented positively that staff were kind and caring. We saw that staff treated patients respectfully and were friendly towards patients at the reception desk and over the telephone.

Nervous patients said staff were compassionate and understanding. Patients could choose whether they saw a male or female dentist.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting areas did not provide privacy when reception staff were dealing with patients as the reception and waiting areas were together. Staff told us that if a patient asked for more privacy they would take them into another room. We were told the decontamination room would be used for this, we asked if a risk assessment had been completed due to the equipment and instruments in there and this had not been done. The reception computer screens were not visible to patients. We found a high quantity of dental care records with personal information not stored securely in several locations around the practice.

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

Music was played in the treatment rooms and there were magazines in the waiting rooms.

**Involvement in decisions about care and treatment**

The practice gave patients clear information to help them make informed choices; this was not always recorded within the patient dental care records. 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.

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

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting patients' needs**

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

The practice did not have an efficient appointment system to respond to patients' needs, we were told patients were often kept waiting for appointments as sessions frequently ran late. The appointment system was designed to allow the dentists to see as many patients as possible on the day; it did lead to one of the dentists running late and patients being kept waiting for appointments. Staff told us that patients who requested an urgent appointment were seen the same day. Patients told us they had enough time during their appointment and did not feel rushed.

Staff told us that they currently had some patients for whom they needed to make adjustments to enable them to receive treatment.

**Promoting equality**

The practice made reasonable adjustments for patients with disabilities. These included a small step which was accessible for wheelchair users. There was no disability access audit in place to identify whether the practice could improve on their services and implement any other adjustments. This was brought to the attention of the registered provider.

Staff said they did not have information in different formats and languages to meet individual patients' needs. They did not have access to interpreter or translation services, we were told the need had never arisen.

**Access to the service**

The practice displayed its opening hours in the premises and their information leaflet

We confirmed the practice kept waiting times and cancellations to a minimum.

The practice was committed to seeing patients experiencing pain on the same day. Patients were asked to come and sit and wait due to the practice being very busy. The 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 but were often kept waiting for their appointment.

**Concerns & complaints**

The practice had a complaints policy providing guidance to staff on how to handle a complaint. The registered provider was responsible for dealing with these. Staff told us they would tell the practice manager or registered provider about any formal or informal comments or concerns straight away so patients received a quick response.

The staff told us they aimed to settle complaints in-house and invited patients to speak with them in person to discuss these. Information was not available about organisations patients could contact if not satisfied with the way the practice dealt with their concerns and staff GDC details were not available.

There was no information available to show if any comments, compliments and complaints were received by the practice in the last 12 months.

# Are services well-led?

## Our findings

**Governance arrangements**

The principal dentist had overall responsibility for the management and clinical leadership of the practice.

The practice did not have policies, procedures and risk assessments to support the management of the service and to protect patients and staff.

The practice had no information governance (IG) arrangements. Staff had not received training in IG and were not fully aware of the importance of these in protecting patients' personal information. The principal dentist had also not completed the information governance toolkit required.

**Leadership, openness and transparency**

Staff were aware of the duty of candour requirements to be open, honest and to offer an apology to patients if anything went wrong.

Staff told us there was an open, no blame culture at the practice. They said the practice manager encouraged them to raise any issues and felt confident they could do this, although they were only at the practice one day per week. They knew who to raise any issues with and told us the practice manager was approachable, would listen to their concerns and share these with the registered provider. The practice did not hold staff meetings. We were told information would be discussed informally but there were no records to support this.

**Learning and improvement**

The practice did not have quality assurance processes to encourage learning and continuous improvement. There was no evidence to show a radiography audit had been completed on the day of the inspection. We were later shown an audit for one of the dentists which had been completed in June 2016 but there was no evidence the other dentist had ever completed an audit. During the inspection we found several radiographs had been taken using scratched sensors causing radiographs to have several marks. This had not been actioned or removed to prevent any further issues. We highlighted this with the registered provider who removed the sensor from use. We were told an infection prevention and control audit had been completed recently but there was no supporting evidence to show this. We found the last infection prevention audit was completed in 2013.

There was no evidence to suggest the registered provider showed a commitment to support staff with training and development. Annual appraisals were completed; we were told no action was taken from discussions or concerns raised.

Staff told us they completed highly recommended training, including medical emergencies and basic life support. The General Dental Council requires clinical staff to complete continuous professional development. Staff told us the practice did not provided support and encouragement for them to do so and felt they were not up to date with all the training required.

**Practice seeks and acts on feedback from its patients, the public and staff**

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. The information collated from the comments was not shared within the practice and there was no evidence of improvements made from suggestions from patients and staff.

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<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**Regulation 12 HSCA (RA) Regulations 2014 Safe Care and Treatment**<br>How the regulation was not being met:<br>The registered provider did not have systems in place to assess the risks to the health and safety of service users of receiving the care or treatment. They failed to do all that is reasonably practicable to mitigate any such risks.<br>The registered provider did not have systems in place to review the practice's responsibility in regards to the Control of Substance Hazardous to Health (COSHH) Regulations 2002 and to ensure all documentation is up to date and staff understand how to minimise risks associated with the use of and handling of these substances: including COSHH risk assessments.<br>The registered provider did not have systems in place for effective waste handling protocols to ensure it is segregated and disposed of in accordance with relevant regulations.<br>The registered provider did not have a practice risk assessments including fire and safe use of sharps.<br>The registered provider did not have an effective system for recording, investigating and reviewing incidents or significant events. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance |

This section is primarily information for the provider

# Enforcement actions

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014

The registered person did not have effective systems in place to ensure that the regulated activities at Inglemire dental practice were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

How the regulation was not being met:

The registered provider had not ensured checks of all medical emergency medicines and equipment are established to manage medical emergencies, giving due regard to guidelines issued by the British National Formulary, the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.

The registered provider did not ensure the practice's sharps handling procedures and protocols were in compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

The registered provider failed to ensure recruitment procedures were established and operated effectively. There was no effective process in place to review the on-going training, assessment, supervision and appraisal of all staff.

The registered provider did not have systems in place to provide support for training and professional development.

The registered provider did not have systems to enable them to assess, monitor and mitigate risks relating to the health, safety and welfare of service uses and others who may be at risk from using this service. The provider did not have an infection control and prevention audit or an annual X-ray audit in place. Steps were not fully taken to reduce the risk of Legionella in the premises.