Mr. Edward Fisher

The Dental Surgery

Inspection Report

28 Delaunays Road
Crumpsall
Manchester
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Overall summary

We carried out this announced inspection on 24 October 2019 and a further announced inspection on the 29 October 2019 (which was a continuation of the inspection process) 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

The Dental Surgery is in Crumpsall, Manchester and provides NHS and private treatment to adults and children.

The practice is not accessible for people who use wheelchairs. On street parking is available near the practice.

The dental team includes two dentists, four dental nurses, a receptionist and a practice manager. The practice has three 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 13 CQC comment cards filled in by patients and spoke with one other patient.

During the inspection we spoke with the principal dentist, two 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 to Thursday 9am to 5pm

Friday 9am to 1pm

Our key findings were:

- The practice appeared clean and tidy. and well maintained.
- The provider had infection control procedures which reflected published guidance.
- Staff knew how to deal with emergencies. Medicines and life-saving equipment were not available in line with Resuscitation Council UK guidance.
- Systems to identify and manage risks were ineffective.
- The provider had safeguarding processes. Improvements were needed to ensure staff knew their responsibilities for safeguarding vulnerable adults and children and completed appropriate training.
- Staff recruitment procedures required improvement. Disclosure and Barring Service checks were not carried out. No checks were in place for agency staff.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- Staff provided preventive care and supporting patients to ensure better oral health.
- The appointment system took account of patients' needs.
- The provider asked staff and patients for feedback about the services they provided.
- The provider had suitable information governance arrangements.

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

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

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:

- Take action to ensure the availability of an interpreter service for patients who do not speak English as their first language.
- Take action to register the practice's use of dental x-ray equipment with the Health and Safety Executive in line with the Ionising Radiation Regulations 2017 (IRR17).

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Are services safe?

Our findings

We found 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 Requirement Notices section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

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

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

Staff had some 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 but this was not to the required level. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns. We found that the practice did not have effective systems to ensure children who were not brought to appointments, or had significant dental neglect were actively followed up and safeguarding considered. We highlighted that a notification should be sent to the CQC in certain circumstances as staff were not aware of this responsibility.

The provider had a system to highlight patients who required other support such as with mobility or communication within dental care records. Information about support available for domestic violence was displayed.

The provider had a whistleblowing policy but staff were unaware of how to access this. Staff felt confident they could raise concerns without fear of recrimination.

The dentists did not consistently use 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, other methods were not always used to protect the airway and risk assessments were not 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 followed their recruitment procedure with the exception of Disclosure and Barring Service (DBS) checks or a suitable risk assessment for new members of staff.

The practice occasionally used agency dental nurses. The provider did not carry out any checks or seek confirmation that the agency vetted these staff. There was no evidence that agency staff received an induction to ensure that they were familiar with the practice's procedures.

Clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover. Dental nurses who did not have their own indemnity were unsure if they were covered by the principal dentist's indemnity policy, and what cover this policy afforded them. The indemnity provider confirmed during the inspection that these staff were covered for vicarious liability. We discussed the importance of ensuring that staff are provided with clear information on the level of indemnity provided.

Staff ensured that equipment was safe, and that equipment was maintained according to manufacturers' instructions, including gas appliances. We noted during the inspection the floor in one of the ground floor surgeries sloped significantly and an area of the cellar floor had pooled water. The practice could not provide assurance this had been structurally assessed for safety and stability. the provider agreed a structural report would help provide reassurance. The surveyor's report provided reassurance that overall, the property was in a satisfactory and structurally stable condition but recommended further investigations to be made of the ground floor slab and supporting structures. The practice manager confirmed this was being arranged.

A fire risk assessment was carried out in line with the Regulatory Reform (Fire Safety) Order 2005 requirements.

Are services safe?

We saw there were fire extinguishers and emergency lighting throughout the building and fire exits were kept clear. fire detection systems were installed apart from the cellar. Whilst firefighting equipment were regularly serviced battery-operated smoke detectors had not been tested since June 2018.

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. The practice had not registered their practice's use of dental x-ray equipment with the Health and Safety Executive in line with the Ionising Radiation Regulations 2017 (IRR17).

The dentists did not consistently justify, grade and fully report on the radiographs they took. The provider carried out radiography audits every year following current guidance and legislation. These had not identified the concerns highlighted or led to improvements.

The practice did not obtain evidence that clinical staff completed the appropriate level of continuing professional development (CPD) in respect of dental radiography.

Risks to patients

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

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. An external company was engaged to carry out health and safety risk assessments as required.

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, A sharps policy was in place. Protocols were in place to ensure staff accessed appropriate care and advice in the event of a sharps injury and staff were aware of the importance of reporting inoculation injuries.

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus. Evidence of the effectiveness of the vaccination was not in place for two clinical members of staff. Evidence reviewed for a further clinical member of staff showed they did not have an adequate response to the vaccinations. The provider was unaware of this or if any follow up action had been taken.

Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support (BLS) every year. Evidence of up to date training was not available for two of the dentists. One of them provided evidence of up to date training after the inspection.

Emergency equipment and medicines were not available as described in recognised guidance. We found checklists to make sure these were available, within their expiry date, and in working order were ineffective. There were insufficient medicine (adrenaline) to treat a severe allergic reaction and medicine (buccal midazolam) to treat a seizure and low blood sugar treatment (glucagon) had expired. The provider was able to obtain sufficient adrenaline during the inspection and order buccal midazolam. Glucagon was later discovered in the fridge but staff were unaware of this.

The practice did not have an automated external defibrillator (AED). Staff told us they could access the AED at a local GP practice. The practice manager had obtained detailed instructions for the location of this within the GP practice and instructions for its use but these were in a file in the office and staff were not aware of this. A risk assessment and practice scenarios had not been carried out to ensure the AED was immediately available as specified in Resuscitation Council UK guidance and GDC standards.

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

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. 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. Staff completed infection prevention and control training and received updates as required.

Are services safe?

There were suitable numbers of dental instruments available for the clinical staff and measures were in place to ensure they were decontaminated and sterilised appropriately.

The provider had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance.

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.

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. Not all of the recommendations had been actioned. For example, a disused sink was not flushed weekly. Records of water temperature and quality testing and dental unit water line management were in place. We highlighted that the temperature of hot water should be 55c. Staff confirmed they would adjust the boiler to raise the temperature from the current 50c setting.

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

The provider had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. Gypsum waste was stored in the wet cellar. Staff were unaware that this should be disposed of in the hard waste container located in the decontamination room. The practice manager confirmed they had made arrangements for the cellar to be cleared out.

The provider carried out infection prevention and control audits annually. There was no evidence the findings of these were analysed to identify where any improvements were needed. We spoke with the practice manager about carrying out six-monthly audits in line with the guidance in HTM01-05.

Information to deliver safe care and treatment

We discussed with the principal dentist how information to deliver safe care and treatment was handled and recorded and looked at a sample of dental care records to confirm our findings. We noted that individual records were written and managed in a way that kept patients safe. Dental care records we saw were 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

The provider had 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.

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

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

Track record on safety and Lessons learned and improvements

There were risk assessments in relation to safety issues. Staff did not document and monitor all incidents to understand risks, give a clear, accurate and current picture that led to safety improvements. The provider did not ensure that the CQC were informed about events and incidents that affect their service.

We found that incidents were not always documented to ensure the practice learned, shared lessons, identified themes and acted to improve safety in the practice. For example, a break in at the premises. Where safety incidents were reported, we saw these were investigated, documented and discussed with the rest of the dental practice team to prevent such occurrences happening again in the future.

The practice did not have a system for receiving and acting on safety alerts. We highlighted the ways to ensure they received all relevant patient and medicine safety alerts. The practice manager gave assurance that they would ensure that future alerts are received, acted upon and retained for reference.

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 systems to keep dental practitioners up to date with current evidence-based practice could be improved. The clinicians did not consistently assess patients' needs and delivered care and treatment in line with current legislation, standards and guidance. For example, there were inconsistencies in the use of dental radiography, periodontal assessments and endodontic treatment.

The provider had previously engaged with an NHS England dental clinical advisor. We noted that improvements had been made by the introduction of templates and protocols to carry out dental examinations. We discussed how further involvement in quality improvement initiatives including peer review and audit would facilitate further improvement.

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.

The principal dentist described to us the procedures they used to improve the outcomes for patients with gum disease. Patients with more severe gum disease were recalled at more frequent intervals for review and to reinforce home care preventative advice. We noted they did not consistently document a diagnosis, or whether patients were given preventative advice. Plaque and gum bleeding scores, and detailed charts of the patient's gum condition were not documented by all dentists.

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. Staff lacked awareness of Gillick competency, by which a child under the age of 16 years of age may give consent for themselves.

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 dental care records containing information about the patients' current dental needs, past treatment and medical histories. Improvements could be made to ensure the dentists assessed patients' treatment needs in line with recognised guidance.

Effective staffing

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. The practice did not obtain evidence that clinical staff completed the continuing professional development required for their registration with the General Dental Council.

Staff discussed their training needs informally and at annual appraisals. We saw evidence of completed appraisals but these did not demonstrate how the practice addressed the training requirements of staff.

Co-ordinating care and treatment

Are services effective?

(for example, treatment is effective)

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 systems to identify, manage, follow up and where required refer patients for specialist care when presenting with dental infections could be improved. Staff did not demonstrate an awareness of sepsis. We signposted them to the availability of sepsis awareness prompts and resources.

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 friendly, helpful 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.

Practice information and thank you cards were available for patients to read.

Privacy and dignity

Staff respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting areas provided limited privacy when reception staff were dealing with patients. If a patient asked for more privacy, staff would take them into another room. The reception computer screen was 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

requirements under the Equality Act. They were not familiar with the Accessible Information Standard. This is a requirement to make sure that patients and their carers can access and understand the information they are given.

Interpretation services were not available for patients who did speak or understand English. Patients were asked to bring English speaking family members to appointments. The provider gave assurance they would explore the availability of interpreter services.

Staff communicated with patients in a way that they could understand and easy read materials were available.

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 information leaflet provided patients with information about the range of treatments available at the practice.

The principal dentist described to us the methods they used to help patients understand treatment options discussed. These included for example X-ray images and study models of the tooth being examined or treated and shown to the patient/relative to help them better understand the diagnosis and treatment.

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. One of the treatment rooms had recently been renovated and refurbished.

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.

Staff told us that they currently had some patients for whom they needed to make adjustments to enable them to receive treatment. For example, patient notes were flagged if they were unable to access the first-floor surgery.

The premises were not accessible to wheelchair users. We discussed reasonable adjustments that could be made. For example, providing grab rails in the toilet and the front entrance.

Timely access to services

Patients could access care and treatment from the practice within an acceptable timescale for their needs.

The practice displayed its opening hours in the premises and included it in their information leaflet and on the NHS Choices website.

The practice had an appointment system to respond to patients' needs. Patients could choose to receive text message and email reminders for forthcoming appointments. Staff telephoned some patients before their appointment to make sure they could get to the practice. Patients who requested urgent advice or care were offered an appointment the same day. Patients had enough time during their appointment and did not feel rushed. Appointments ran smoothly on the day of the inspection and patients were not kept waiting.

The practice answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open. This information was also clearly displayed in the premises. 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 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. The practice displayed information which explained how to make a complaint.

The practice manager was responsible for dealing with these. Staff would tell them 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 had dealt with their concerns.

The practice had not received any complaints in the last 12 months. We looked at older complaints the practice 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

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 actions section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

Leadership capacity and capability

The practice lacked clear leadership. In the previous two years staff capacity had been significantly reduced and had impacted on systems to deliver high-quality, sustainable care and deliver the practice strategy and address risks to it. Additional permanent and agency staff had recently been employed to meet the needs of patients and the dental team.

The principal dentist did not demonstrate they were knowledgeable about issues and priorities relating to the quality and future of services. They engaged well during the inspection and were open to discussion and feedback to improve, taking immediate action where required. For example, obtaining emergency medicines and obtaining specialist advice about the structural safety of the premises. They understood the challenges and were in the process of addressing them. They had also previously engaged with an NHS England dental clinical advisor to support them to improve standards of care. They were open to engaging with them again.

Culture

Staff stated they felt respected, supported and valued. They gave examples of where the provider had shown compassion and understanding for personal issues and were proud to work in the practice.

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

Openness, honesty and transparency were demonstrated when responding to complaints. The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour. Improvements were needed to ensure all incidents were documented and investigated appropriately, and external organisations were informed where necessary.

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

Governance and management

Governance arrangements did not support the smooth running of the service. The practice did not have clear responsibilities, roles and systems of accountability to support good governance and management.

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. The provider had a system of clinical governance in place which included policies, protocols and procedures, some of which had been recently reviewed and updated by the practice manager.

Staff were not clear on the management arrangements and the resources sourced by the practice manager. For example, local safeguarding, medical emergency and whistleblowing arrangements.

Systems to identify and manage risks, issues and performance were ineffective. For example, in relation to ensuring the structural safety of the premises, Hepatitis B immunity, indemnity, arrangements to respond to medical emergencies, fire safety and systems to receive and act on patient safety alerts.

Appropriate and accurate information

Quality and operational information was not used to ensure and improve performance. Staff agreed that communication could be improved.

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, the public, staff and external partners to support high-quality sustainable services.

The provider used patient surveys and verbal comments 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.

Are services well-led?

The provider gathered feedback from staff through meetings and informal discussions. We noted that the majority of staff meetings in the previous months had centred around staffing to ensure that patients could continue to receive treatment in a timely way.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation. The provider had invested in improvements. For example, digital clinical and X-ray systems, refitting dental surgeries and renovating the reception area.

The provider had quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, radiographs and infection prevention and control. They had clear records of the results of these audits and the resulting action plans and improvements. These did not include reflections or action plans to support improvement. These failed to identify that the clinicians did not consistently assess patients' needs and delivered care and treatment in line with current legislation, standards and guidance.

The dental nurses had annual appraisals where capacity permitted. We saw evidence of completed appraisals in the staff folders.

Systems were not in place to obtain evidence that staff completed 'highly recommended' training as per General Dental Council professional standards. For example, medical emergency and basic life support, radiography and safeguarding training to the appropriate level. The practice did not ensure that personal development plans (PDPs) were in place in line with The Enhanced CPD Scheme 2018. The principal dentist did not have a PDP in place.

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 • Medical emergency arrangements were ineffective. Insufficient medicines were available. Arrangements to access the Automated External Defibrillator (AED) at the local GP practice were not robust to ensure that immediate access to an AED could be assured in line with Resuscitation Council UK guidelines and General Dental Council standards. • Incidents were not consistently documented or investigated to improve safety in the practice. • Fire safety checks were not carried out to ensure fire detection systems were in working order. • Staff did not demonstrate an awareness to enable them to recognise the signs and symptoms of sepsis. • Staff did not complete safeguarding training to the correct level and did not have effective systems to ensure children who were not brought to appointments, or had significant dental neglect were actively followed up and safeguarding considered. Regulation 12 (1)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **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:** • The systems to ensure staff could respond to medical emergencies were ineffective. Insufficient medicines were provided and arrangements to access the Automated External Defibrillator (AED) at the local GP practice were not robust. • Systems to identify and act on risk were ineffective. In particular, fire safety checks, recommendations in the Legionella risk assessment report were not acted on and the documentation and investigation of incidents. • The registered person did not have systems to receive patient safety alerts, recalls and rapid response reports issued by the Medicines and Healthcare products Regulatory Agency, the Central Alerting System and other relevant bodies, such as Public Health England. • Evidence of immunity to Hepatitis B was not checked for two members of staff and one low responder was not risk assessed or referred for further vaccinations or testing. • The registered person did not ensure that appropriate checks were completed prior to new or agency staff commencing employment at the practice. • The registered person did not ensure that the premises were fit for purpose in line with statutory requirements; or act on advice from the practice insurers to ensure electrical fixed wiring testing was carried out.

This section is primarily information for the provider

Enforcement actions

- The registered person did not ensure that governance systems remained effective. The system did not include scrutiny and overall responsibility by the registered person with legal responsibility for the practice.
- The registered person did not have effective systems and processes such as regular audits to assess, monitor and improve the quality and safety of the service.
- The registered person did not have systems to ensure that staff completed and were up to date with 'highly recommended' training as per General Dental Council professional standards.

Regulation 17 (1)

- Systems and processes to assess, monitor and improve the quality and safety of the service were ineffective. The clinicians did not consistently assess patients' needs and delivered care and treatment in line with current legislation, standards and guidance.

Regulation 17 (2)