

Freshbrook Dental Practice Limited

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Inspection Report

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Overall summary

We carried out an unannounced comprehensive inspection on 9 November 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

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

Freshbrook Dental Practice Limited provides private treatment and caters for both adults and children and has two dentists, a part time dental hygienist and six supporting staff. The practice is situated in a converted commercial property. The practice had three dental treatment rooms and a separate decontamination room for cleaning, sterilising and packing dental instruments and a reception and waiting area.

The practice owner is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

We carried out an unannounced comprehensive inspection on 9 November 2015 due to information of concern being shared with the Care Quality Commission. The inspection was carried out by a lead inspector and a dental specialist adviser.

Our key findings were:

Summary of findings

- The practice had systems to assess and manage risks to patients for infection prevention and control (IPC) and the management of medical emergencies.
- The practice had safeguarding processes and staff understood their responsibilities for safeguarding adults and children.
- Patients were given information and time to make informed decisions about their treatment and staff ensured patients gave their consent before treatment began.
- The content of dental care records was brief but included the essential information that would be expected to be recorded during a patient assessment.
- Staff had received training appropriate to their roles and were supported in their continued professional development (CPD).
- Patients were able to make routine and emergency appointments when needed. There were clear instructions for patients regarding out of hours care.
- Staff recruitment procedures did not ensure that all of the required checks for new staff were completed.
- Staff appraisals were not carried out.
- There were deficiencies in the management of medicines dispensed and administered by the practice.
- The practice was not consistently recording the quality of dental X-rays in accordance with IRMER 2000.

We identified regulations that were not being met and the provider must:

- Establish an effective system to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors. Specifically relating to policies and procedures for the safe use of dental sharps to reflect the requirements of the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 and the EU Directive on the safer use of sharps which came into force in 2013.
- Ensure the application of recruitment procedures which fully reflect the requirements of Regulation 19(3) and Schedule 3 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Introduce an effective programme of staff appraisals.
- Establish a system of stock control, secure storage and dispensing protocols for medicines supplied directly by the practice. This includes antibiotic and analgesic medicines.

You can see full details of the regulations not being met at the end of this report.

There were areas where the provider could make improvements and should:

- Consider recording more detail in the dental care records of the care and treatment provided to patients.
- Give due regard to the IRMER 2000 guidelines so that a record of the quality assessment score for each dental X-ray is made on every occasion.

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?

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).

The practice had arrangements for essential topics such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found that all the equipment used in the dental practice was maintained in accordance with current guidelines. There were sufficient numbers of suitably qualified staff working at the practice. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults. However, not all systems were implemented well enough to ensure patients were kept safe. Areas of concern found included, staff recruitment, medicines management and health and safety risk monitoring.

Are services effective?

We found that this practice was not providing effective 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).

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance to guide their practice. Patients were given time to consider and make informed decisions about which treatment option they wanted. The dental care records we looked at included details of the condition of the patient's teeth and soft tissues lining the mouth and gums.

Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration. The staff received professional training and development appropriate to their roles and learning needs. However the practice could not demonstrate that staff appraisals were carried out.

Are services caring?

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

Patients were positive about the care they received from the practice. They commented they were treated with respect and dignity. We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection.

Are services responsive to people's needs?

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

The dentist and staff were friendly and welcoming. Patients could access treatment and urgent and emergency care when required. The practice website provided information about opening times and how to access emergency treatment when the practice was closed.

We observed the waiting area and treatment rooms were large enough to accommodate patients with wheelchairs and prams.

Are services well-led?

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

Summary of findings

We found that the governance systems underpinning the care provided at the practice were poorly organised. The registered manager had delegated responsibility to the lead nurse/practice manager to organise and deliver these clinical governance arrangements for the practice. However we found that this individual did not have sufficient time to discharge these responsibilities as effectively as they could because they were concentrating on providing chairside clinical support to the registered manager.

Although the practice managed the disposal of contaminated sharps safely, their policy and procedure for the safe use of dental sharps did not reflect the requirements of the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 or the EU Directive on the safer use of sharps which came into force in 2013.

The practice did not have a recruitment policy which would identify the pre-employment checks required to be undertaken for new staff. Evidence of checks specifically relating to obtaining satisfactory references prior to staff engagement, DBS checks and employment histories were not available.

There were deficiencies in the governance systems with respect to the storage, stock control and dispensing of medicines by the practice.

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Detailed findings

Background to this inspection

We carried out an unannounced, comprehensive inspection on 9 November 2015. The inspection was carried out by a lead inspector and a dental specialist adviser.

We informed NHS England area team and local authority that we were inspecting the practice.

During our inspection visit, we reviewed policy documents and staff records. We spoke to six members of staff, including the management team. We conducted a tour of the practice and looked at the storage arrangements for

emergency medicines, medicines and equipment. We were shown the decontamination procedures for dental instruments and the records management system that supported the maintenance of dental care records.

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 therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reliable safety systems and processes (including safeguarding)

We spoke to the lead dental nurse and a second dental nurse about the prevention of needle stick injuries. The practice had in place a safer sharps policy and staff understood how to manage a contaminated sharps injury and manage the disposal of sharps waste in accordance with current guidelines. However the policy did not have a section in relation to a protocol to be followed when using a safety device for recapping used needles following the delivery of a local anaesthetic injection to a patient. These criteria are required to satisfy the European Union (EU) Directive with respect to safe sharp guidelines 2013.

The registered manager told us that rubber dam was routinely used when root canal treatment was provided along with other treatment such as the placement of tooth coloured filling materials. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). Patients can be assured that the practice followed appropriate guidance by the British Endodontic Society in relation to the use of the rubber dam for root canal treatment. Radiographs and patient photographs we saw confirmed that rubber dam was being used routinely in the practice.

A policy was in place for staff to refer to in relation to children and adults who may be the victim of abuse. Information was available that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities. Records supplied to us after our inspection showed that all staff had received safeguarding training in children and vulnerable adults appropriate to their roles.

Reporting, learning and improvement from incidents

There was an effective system in place to learn from and make improvements following accidents or incidents. Staff told us they were confident about reporting incidents and accidents. We reviewed the accident record book and this indicated that all accidents had been investigated,

reviewed and subsequent action to prevent recurrence put in place if required. Staff had a clear knowledge of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

The staff we spoke with did not understand the duty of candour however, they confirmed that if patients were affected by something that went wrong, they would be given an apology and informed of any actions taken as a result.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. The practice had an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. The practice had in place the emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The Lead Nurse had put into place a system where each treatment room had its own set of emergency medicines for use in common medical emergencies.

The practice also had oxygen cylinders and other related items such as manual breathing aids and portable suction that were available in line with the Resuscitation Council UK. All emergency medicines and oxygen were in date. The expiry dates of medicines and equipment were monitored using a daily and monthly check sheet which enabled the staff to replace out of date drugs and equipment promptly.

Staff recruitment

The practice did not have a staff recruitment policy in place at the time of our visit. We looked at the recruitment records for four staff recruited since the practice registered with the Care Quality Commission and found that all had started to work at the practice without having evidence that appropriate recruitment checks had been undertaken prior to their employment

Checks missing included evidence of conduct in previous employment for all four, proof of identity for two, written employment histories for two, and the appropriate checks through the Disclosure and Barring Service for all four. These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Are services safe?

Monitoring health & safety and responding to risks

The practice had arrangements for the management of risks relating to essential topics such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found that all the equipment used in the dental practice was maintained in accordance with current guidelines. There were sufficient numbers of suitably qualified staff working at the practice.

The practice had a business continuity plan to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service.

Infection control

There were a number of systems in place to reduce the risk and spread of infection within the practice. We reviewed the end to end process, reviewed practice protocols and directly observed the process on the day of our visit. We saw that Health Technical Memorandum (HTM) 01 05 (national guidance for infection prevention control in dental practices') Essential Quality Requirements for infection control was being met. It was observed that a current audit of infection control processes confirmed compliance with HTM 01 05 guidelines.

It was noted that the dental treatment rooms, waiting area, reception and toilets were clean and tidy. Clear zoning demarking clean from dirty areas was apparent the treatment rooms. Hand washing facilities were available including wall mounted liquid soap and gels and paper towels in each of the treatment rooms and toilets and bare below the elbow working was observed.

A dental nurse described to us the end to end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. They demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

The drawers of a treatment room were inspected in the presence of the nurse. These were clean, ordered and free from clutter. All of the instruments were pouched and it was obvious which items were single use and these items were clearly new. The treatment rooms had the appropriate routine personal protective equipment (PPE) available for staff and patient use.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings) they described the method they used which was in line with current HTM 01 05 guidelines. A Legionella risk assessment had been carried out at the practice by a competent person in September 2013 and a record of water testing checks was maintained. These measures ensured patients and staff were protected from the risk of infection due to Legionella.

The practice utilised a small separate decontamination room for instrument processing. This room was demarcated into a dirty area and a clean area. Displayed on the wall were protocols to remind staff of the processes to be followed at each stage of the decontamination process. The nurse was able to demonstrate to us the decontamination process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a system of manual scrubbing followed by ultrasonic cleaning bath for the initial cleaning process following inspection they were placed in an autoclave (a machine used to sterilise instruments). When instruments had been sterilised they were pouched and stored appropriately until required. All pouches were dated with an expiry date in accordance with current guidelines.

The nurse also demonstrated that systems were in place to ensure that the autoclaves and ultrasonic cleaning bath used in the decontamination process were working effectively. These included the automatic control test. It was observed that the data sheets used to record the essential daily validation checks of the sterilisation cycles were always complete and up to date.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained and was in accordance with current guidelines. The practice used an appropriate contractor to remove dental waste from the practice and it was stored in an appropriate area within the practice prior to collection by the waste

Are services safe?

contractor. Waste consignment notices were available for inspection. For example we saw consignment notices for 2015. Patients' could be assured that they were protected from the risk of infection from contaminated dental waste.

Equipment and medicines

We saw evidence that important equipment was being maintained regularly. For example we saw that the two X-ray machines had been inspected and certified in September 2015 with a further inspection planned in 2016 and the automatic X-ray developer was serviced in April 2015. The two autoclaves had been serviced and calibrated by a competent person in September 2014 with a review date of 2015. The normal inspection interval for autoclaves under the Pressure Vessels Regulations 2000 is 12-14 months. However although the practice assured us this had been carried out the new certificate was not available for inspection.

The practice dispensed its own stock of antibiotics and simple analgesics to patients. However we found that the stock control of these medicines were unsatisfactory. The medicines were stored in a room that was not generally accessed by the public but the cupboard they were stored in was not secure and the lack of stock control meant that medicines may be subject to unauthorised access or theft without the practice being aware. Also in this cupboard were stocks of medicines used for conscious sedation. These were Midazolam and the reversal agent Anexate. Again due to the lack of stock control measures there was a risk of unauthorised access to or theft of these medicines.

We were assured by the practice that conscious sedation had now been discontinued and we saw signs displayed in

the reception area that this was the case. In view of this fact we arranged for the proper disposal of these medicines by a local pharmacy on the day of our visit. A sample of dental care records showed that the batch numbers and expiry dates for local anaesthetics were recorded when these medicines were administered. This was also the case when conscious sedation medicines had been used. A procedure carried out in late September 2015 confirmed this was the case. However records of this procedure showed that when antibiotics were given in conjunction with the treatment the notes did not give details of the dose or duration of the course of the medicine. Also there did not appear to be an explicit justification for the antibiotics. It is good practice to record these details as part of good standards of dental care record keeping.

Radiography (X-rays)

We were shown various documentation relating to the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). This included a copy of the local rules and the names of the Radiation Protection Advisor and the Radiation Protection Supervisor. We saw that the two X-ray sets had been regularly serviced and there was a history of quality assessing the radiographs in the practice. Records showed that a comprehensive X-ray logging system was in place during 2011-2013. However during the years 2014-15 there was only partial completion of the system, the area of deficiency related to the quality assessment scoring aspect of the logging system. However the quality of the radiographs we did see when reviewing records with the registered manager were of a good standard.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The registered manager carried out assessments and treatment in line with recognised general professional guidelines. The dentist described to us how they carried out their assessment. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the written medical history was scanned onto the computerised records system and updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of oral cancer. Following the clinical assessment the patient was given a range of options which we saw in a selection of dental care records used to corroborate that this was the case.

We saw dental care records that showed the basic details of the assessment and treatment carried out were recorded. We saw that the condition of the gums using the basic periodontal examination (BPE) scores was being carried out and that a soft tissue check of the lining of the mouth was also being recorded. The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need.

Health promotion & prevention

Patients attending the practice were advised during their consultation of steps to take to maintain healthy teeth. The practice employed a dental hygienist on a part time basis to facilitate this. Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general dental hygiene procedures such as brushing techniques or recommended tooth care products. This was facilitated through the use of models of mouths and demonstration brushes and patient information leaflets.

Staffing

All clinical staff had current registration with their professional body, the General Dental Council. Records

showed staff had undertaken training to demonstrate sufficient hours of working towards their continuing professional development (CPD) requirements to complete their five year cycle. Staff were responsible for making arrangements for their own CPD.

We asked the practice to provide details of staff appraisals. We were sent records which indicated that no staff had received an appraisal. We wrote to the manager who confirmed this to be the case.

Working with other services

The practice had a system in place showing how they worked with other services. Dentists are able to refer patients to a range of specialists in secondary and tertiary care services if the treatment required was not provided by the practice. The practice had a file containing a list of the secondary and tertiary care providers that dentists could refer patients to. This file contained the details of the referral criteria for each provider service where appropriate.

Consent to care and treatment

The registered manager had an understanding of consent issues. They explained how individual treatment options, risks, benefits and costs were discussed with each patient. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options. However the dental care records we saw were quite brief in the way that they documented the process of consent. More detailed record keeping can help defend the clinician in cases where there are medico-legal issues in relation to informed consent and complaints handling.

The dentist also explained how they would obtain consent from a patient who suffered with any mental impairment which may mean that they might be unable to fully understand the implications of their treatment. They explained that they would involve relatives and carers to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting area and we saw that doors were able to be closed at all times when patients were with the dentists or hygienist. Conversations between patients and clinicians could not be heard from outside the rooms which protected patient's privacy. Patients' dental care records were stored electronically and in paper form. Computers were password protected and regularly backed up to secure storage with paper records stored in a room not accessible to the general public at the back of the reception area. Practice computer screens at reception were not overlooked which ensured patients' confidential information could not be viewed at reception.

Patients were positive about the care they received from the practice. They commented they were treated with respect and dignity. We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection.

Involvement in decisions about care and treatment

The lead dentist used a 'picture book' of anonymised photographs that he had taken over a number of years to help explain to patients about the different types of dental treatment available to them. The pictures also enabled the dentist to explain the various stages of treatment and the clinical appearance of the basic dental diseases, dental decay and gum disease. The dentist was also able to use the photographs as a motivating factor to help patients maintain good oral health. The 'picture book' also facilitated the consent process because patients could actually see examples of the treatments proposed. It also gave patients an opportunity to discuss with the dentist any questions that they may have about the proposed treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we looked at examples of information available to patients. We saw that the practice waiting area displayed a variety of information that explained opening hours, emergency 'out of hours' contact details and how to make a complaint. This information was also available on the practice website.

The facilities and premises were appropriate to the wide range of dentistry the practice offered. Appointment times were scheduled so that there was enough time to assess and meet patient's needs. We looked at the appointment schedules for patients and found that patients were given adequate time slots for appointments of varying complexity of treatment. Longer appointments were given to older, frail and patients with poor mental health.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice was accessible to disabled patients who required level access. The practice was spacious and uncluttered throughout.

The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Treatment rooms were large and accessible to patients who could transfer from wheelchairs.

The reception desk had a lower counter which accommodated wheelchair users without them needing to move to a separate area. The practice had an arrangement with the local community centre next door that provided wheelchair accessible toilet facilities and nappy changing as the layout of the practice did not allow for these facilities on site.

Access to the service

Appointments were available Monday to Thursday between 8.15am and 5.00pm and between 8.15am and 1pm on Fridays. The practice displayed its opening hours in their premises and on the practice website.

Appointments could be made in person or by telephone. The practice had a website which contained a section whereby a patient could contact the practice to send a variety of messages to the practice including arranging or changing appointments. Patients were very satisfied with the appointments system. Comments received from patients showed that those in need of emergency treatment had been able to make appointments on the same day of contacting the practice.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by a dentist who was on call. If patients called the practice when it was closed, an answerphone message gave patients information about specific arrangements for that day.

Concerns & complaints

The patients we spoke with knew how to raise concerns or make a complaint. Although patients were made aware how to complain, the patients we spoke with told us never felt the need to complain.

Information for patients about how to make a complaint was seen in the waiting area of the practice and the patient leaflet. The practice had a complaints policy and a procedure that set out how complaints would be addressed, who by, and the timeframes for responding. We were told that no complaints had been made in the previous 12 months.

Are services well-led?

Our findings

Governance arrangements

The practice maintained numerous files pertaining to various clinical systems and process used to deliver safe and effective care under the regulated activities in dentistry. However we found that these governance files underpinning the care provided at the practice were not always fully maintained. The files containing the various policies and protocols were in a number of cases lacking a proper process with little or no evidence that policy was being followed.

The registered manager had delegated responsibility to the lead nurse/practice manager to organise and deliver these clinical governance arrangements for the practice. However we found that they did not have sufficient time to discharge these responsibilities as effectively as they could because they were concentrating on providing chairside clinical support to the registered manager.

Leadership, openness and transparency

The lead and associate dentist had the experience, capacity and capability to ensure high quality care. The lead dentist was visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. The dentist encouraged a culture of openness and honesty.

Staff told us that regular team meetings were held, there was an open culture within the practice and they had the opportunity to raise any issues at team meetings, were confident in doing so and felt supported if they did. All staff were involved in discussions about how to manage and develop the practice, and the dentists encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Learning and improvement

Staff told us they had good access to training and staff working at the practice were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC). The dentists, dental nurses and dental hygienist working at the practice were registered with the GDC. The GDC registers all dental care professionals to make sure they are appropriately qualified and competent to work in the United Kingdom. The practice manager kept records to evidence that staff were up to date with their professional registration. National Patient Safety Alerts and notifications from the Medicine and Healthcare Regulatory Agency were acted on appropriately and cascaded to relevant staff.

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

We were told the practice had systems in place to seek and act upon feedback from patients using the service, including carrying out patient surveys and providing a suggestions box in the waiting room. We were unable to find the suggestion box and were told this was damaged and was being replaced. All the patients we spoke with were very happy with the standard of care they had received. They described how helpful and friendly the practice staff were. Patients were satisfied with appointment waiting times and the cleanliness of the practice.

Reception staff told us any suggestions or comments patients made directly to them were reported to the practice manager and discussed at practice meetings

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 Medicines Management We found that the registered person did not have effective systems in place to monitor medicines. This was in breach of regulation 12 (2) (b), (e) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Medicines were not stored securely and were not tracked through the practice.
Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staffing We found that the registered person did not have effective systems in place to support supervision and appraisal as is necessary to enable staff to carry out the duties they are employed to perform. This was in breach of regulation 18 (1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff appraisals had not been carried out.
Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Fit and Proper persons Employed We found that the registered person had not ensured that persons employed for the purposes of carrying on a

This section is primarily information for the provider

Requirement notices

regulated activity were of good character and that information specified in Schedule 3 was available in relation to each such person employed and such other information as appropriate.

This was in breach of Regulation 19 (1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Pre- employment checks missing included conduct in previous employment, eligibility to work in the UK, employment history, DBS check and photographic proof of identification.