Dr. Parkash Photay

Dr Parkash Photay - Midfield Parade

Inspection Report

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Overall summary

We carried out this announced comprehensive inspection on 23 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 Care Quality Commission (CQC) inspector who was supported by a specialist dental adviser.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions form the framework for the areas we look at during the inspection.

Our findings were:

Are services safe?

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

Are services effective?

We found that this practice was not 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

Dr Parkash Photay – Midfield Parade is in Bexleyheath, in the London borough of Bexley. It provides private treatment to patients of all ages.

Summary of findings

There is level access for people who use wheelchairs and those with pushchairs. Car parking spaces are available near the practice.

The dental team includes a dentist, three trainee dental nurses, and a receptionist/trainee dental nurse. The practice has one treatment room. The provider informed us a second dentist occasionally treated patients at the practice on a locum basis, and a third dentist (the principal dentist) occasionally attended the practice to perform dental treatments.

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 two CQC comment cards filled in by patients. This information gave us a positive view of the practice.

During the inspection we spoke with the dentist and receptionist/trainee dental nurse. We looked at practice policies and procedures and other records about how the service is managed, and we observed practice.

The practice is open from 9am to 6pm on Mondays, Tuesdays, Thursdays and Fridays, and from 9am to 8pm on Wednesdays. The dentist works at the practice on Mondays and Wednesdays; on Tuesdays Thursdays and Fridays the receptionist is available.

Our key findings were:

- The practice was clean.
- Staff took care to protect patients' privacy and personal information.
- The appointment system met patients' needs.
- The practice had not established thorough staff recruitment procedures.
- The practice was not able to demonstrate that all staff had received key training.
- Improvements were needed to ensure dental care records were maintained in line with current guidelines.
- The practice had safeguarding processes, though improvements could be made to ensure staff knew whom to report concerns to externally, and policies needed to be updated with key information.
- Appropriate medicines were available, though some life-saving equipment as per current recommendations was not available.
- The practice had some systems to help them manage risk, though improvements were needed to ensure these were dated, comprehensive and regularly reviewed.
- The practice had infection control procedures in place, though improvements were needed to ensure they reflected published guidance.
- The practice had not maintained several records pertaining to the running of the service and staff employed at the practice.
- Governance and leadership at the practice required improvements across several areas.
- Some staff did not feel supported.

Shortly after the inspection the provider took steps to begin to address our concerns.

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

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out their duties.
- Ensure specified information is available regarding each person employed.

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

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

Summary of findings

- Review the practice's waste handling protocols to ensure waste 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).
- Review the 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requirements notice 

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

The practice had limited systems and processes to provide safe care and treatment. Improvements could be made to ensure there was a protocol in place for reporting, formally documenting and sharing learning from incidents.

Staff knew how to recognise the signs of abuse, though they were not clear on how to report concerns to external safeguarding contacts. Evidence of safeguarding training was not available for all staff members.

There were no records to show that all staff working at the practice were qualified for their roles. The provider was not able to demonstrate that they had completed essential recruitment checks for all staff.

General and clinical areas of the premises and equipment were clean, though some equipment was not appropriately maintained, and the practice did not follow national guidance for cleaning, sterilising and storing dental instruments.

The practice had arrangements for dealing with medical and other emergencies, though we found there were medicines that were out of date and their stock of emergency equipment and medicines was not in line with recommendations.

Shortly after the inspection the provider took steps to begin to address our concerns.

Are services effective?

Requirements notice 

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 Requirements Notice section at the end of this report).

The dentist assessed patients' needs, though improvements could be made to ensure dental care records were maintained in line with current guidelines.

The practice had not established clear arrangements for managing and monitoring the referral of patients to other dental or health care professionals.

There was no evidence to demonstrate that all staff had completed key training; several records of training were not available. There were no systems in place to help the practice monitor this.

Are services caring?

No action

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

Summary of findings

We received feedback about the practice from two people who were positive about aspects of the service the practice provided.

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

Are services responsive to people's needs?

No action

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

The practice's appointment system met patients' needs. Patients could get an appointment quickly if in pain.

Staff told us they considered patients' different needs. There were facilities for wheelchair users and families with children. The practice did not have access to interpreter services and had no arrangements to help patients with sight or hearing loss.

The practice told us they took patients views seriously and valued compliments from patients.

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 Requirements Notice section at the end of this report).

The provider had arrangements to ensure the smooth running of the service, though we found improvements were needed in several areas such as those for assessing and monitoring safety, ensuring appropriate policies and procedures were available and established, maintaining records, and ensuring staff received key training.

There was a clearly defined management structure, though improvements could be made to ensure all staff felt supported.

The provider did not demonstrate how it monitored clinical and non-clinical areas of their work to help them improve and learn.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had an accident book. Improvements were needed to ensure they implemented policies and procedures to report, investigate, respond and learn from incidents and significant events. Staff we spoke with did not demonstrate any understanding of these and did not understand their role in the process.

There was no evidence to show that the practice recorded, responded to or discussed any incidents to reduce risk and support future learning. For example, an incident involving a patient becoming unwell after receiving a local anaesthetic injection, and another involving an injury with a sharp instrument had not been recorded or discussed to prevent similar incidents from occurring. Shortly after the inspection the provider sent us blank templates for recording incidents.

The dentist told us they did not receive national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA), and they did not understand their responsibilities in relation to this. There was no evidence to demonstrate that alerts were received, discussed with staff, acted on or stored for future reference.

Reliable safety systems and processes (including safeguarding)

Staff knew their responsibilities in relation to recognising signs of abuse and neglect in children, young people and adults who were vulnerable due to their circumstances. However, they were not clear on how to report concerns to external safeguarding teams. They told us that in the absence of the safeguarding lead they would report safeguarding concerns to a dentist who did not work at the practice. The dentist told us they did not have access to contacts for the relevant external organisations within the practice. The practice had a child protection policy and generic guidance documents to provide staff with information about identifying, reporting and dealing with suspected abuse; however they were not practice-specific and did not provide key information such as safeguarding leads or contact details for local safeguarding teams to whom concerns should be reported to.

Shortly after the inspection the provider sent us a safeguarding adults policy, and an amended safeguarding children policy. The safeguarding children policy still did not contain contact details for local safeguarding teams.

We did not see evidence that all staff working at the practice had received safeguarding children and adults training.

The practice had a whistleblowing policy. A member of staff told us they did not always feel confident they could raise concerns without fear of recrimination.

We looked at the practice's arrangements for safe dental care and treatment. These included risk assessments, though some were not dated to indicate when they had been completed, and they were not regularly reviewed. They did not always reflect what was happening in the practice. For example, the infection control risk assessment reviewed in 2017 incorrectly identified that the practice carried out regular water temperature checks using a thermometer. The practice did not follow relevant safety laws when using needles and other sharp dental items. They did not use safer sharps techniques, and an undated sharps risk assessment was not in line with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Control measures to ensure the safer use of sharps had not been completed.

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

Shortly after the inspection the provider sent us a business continuity plan they had created. This document was not available on the day and the dentist we spoke with did not understand the purpose of a business continuity plan.

Medical emergencies

We observed that staff were not confident in the use of the oxygen cylinder in a medical emergency. The dentist was not able to attach an ambulatory bag and mask to the oxygen cylinder. We found there was no evidence to demonstrate that all staff working at the practice had completed training in emergency resuscitation and basic life support every year.

Some emergency equipment and medicines were available, though several were not stocked as described in recognised guidance. For example, adrenaline was only available in the paediatric dose and the dose of aspirin was

Are services safe?

lower than recommended. There was no spacer, paediatric ambulatory bag, suction catheter, or yankauer sucker available. The automated external defibrillator did not have paediatric pads. The provider had not formally assessed the risks related to this equipment not being available. Staff kept records of their checks of the medicines and equipment, except the automated external defibrillator, on a monthly basis to make sure these were available, within their expiry date and in working order; however, we found that the oxygen cylinder staff told us was a back-up had a use by date of 2015. Staff had not identified this during their checks. Aspirin had an expiry date of June 2017 and there was no replacement pack available.

Shortly after the inspection the provider sent us photographic evidence to show the adult dose of adrenaline and the higher dose of aspirin had been ordered, and the yankauer sucker was now in place. They told us they had ordered additional emergency equipment but did not send evidence of this.

Staff recruitment

The provider had a staff recruitment policy to help them employ suitable staff. We checked all three of the practice's staff personnel records that were made available to us during the inspection. These showed the practice had not followed robust recruitment procedures or their own policy. For example, there was no evidence of identification, immunisation records, qualification, background checks, references, employment histories or registration with the appropriate bodies for dentists and trainee dental nurses that worked in the practice. Staff told us there were no employment contracts in place.

Shortly after the inspection the provider sent us one reference for a trainee dental nurse, though it was not dated to indicate when it was created or received. This reference was received from an organisation affiliated with the provider, from the same address as another practice owned by the same provider.

We confirmed through our own enquiries that some clinical staff were qualified and registered with the General Dental Council (GDC). . Improvements could be made to ensure evidentiary documentation of this was available in the practice for all dentists working at the practice. There was no evidence that any dentist, except one, had professional indemnity cover in place.

Monitoring health & safety and responding to risks

The practice had a health and safety policy and health and safety risk assessment to help manage risk. The policy and risk assessment covered general workplace and specific dental topics.

We checked other risk assessments and found improvements were needed in processes for assessing, monitoring and mitigating risks related to the health, safety and welfare of people using the service and others who may be at risk.

The Control of Substances Hazardous to Health (COSHH) was not dated to indicate when it was completed, and it did not include comprehensive information on all hazardous products used in the practice with identification of the risk and how the risk should be mitigated.

The sharps risk assessment was not in line with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. It was not dated to indicate when it was conducted, and control measures to ensure the safer use of sharps had not been completed. There was no policy for the handling of sharps.

The 2015 fire risk assessment completed by two dentists was not comprehensive. For example it identified that emergency lighting was in place, however, the dentist told us corded emergency lighting was previously in place but had been removed. Means of escape had not been recorded, and sources of ignition such as portable heaters had not been identified. Sections of the fire risk assessment had not been completed. The fire risk assessment identified that additional signage was needed but there was no indication that this had been completed to minimise any associated risks.

Shortly after the inspection the provider sent us a fire escape diagram. They also updated the actions completed in relation to additional signage, and sent us a fire escape protocol.

The dentist told us they did not carry any emergency medicines when visiting patients in their homes, and the risks relating to this had not been formally assessed. Shortly after the inspection the provider told us they would stop providing the home visit service.

The practice had employer's liability insurance.

Are services safe?

Trainee dental nurses worked with the dentists when they treated patients.

Staff told us they had not participated in fire evacuation drills at the practice. Shortly after the inspection the provider sent us a fire drill log which had been backdated to 2015.

Infection control

The practice was clean when we inspected it.

The practice did not have an infection prevention and control policy and procedures to keep patients safe. Shortly after the inspection they sent an infection control policy to us, though improvements were needed to ensure it was practice-specific. For example it referred to a washer-disinfector, ultrasonic bath, and non-vacuum autoclave, none of which were in use at the practice.

The practice had arrangements for transporting, cleaning, checking, sterilising and storing instruments. We checked these processes and found they were not always in line with The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health in relation to the use of personal protective equipment and decontaminating dental instruments. The receptionist/ trainee dental nurse we observed told us instrument decontamination and sterilisation was not part of their usual role, though they told us they would assist if the dental nurse was not present, and that they would supervise the dental nurses in infection control procedures. We found unpouched dental instruments in the treatment room. A domiciliary visit box used on home visits for patients who were not able to attend the practice was used to transport both clean and contaminated instruments.

Shortly after the inspection the provider told us they would cease providing the home visit service.

There was evidence to show that some staff completed infection prevention and control training in June 2017 just before the inspection. Evidence of this training was not available for several other staff members who worked at the practice.

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

The practice carried out an infection prevention and control audit in 2012 and reviewed it once a year, instead of twice yearly in line with current guidelines. The latest review showed the practice was meeting the required standards, though it did not reflect what was happening in practice. For example, it had incorrectly identified that staff were regularly checking the water temperature, and that staff had received hand hygiene training periodically and as part of their induction.

The practice had some procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. However, there was no evidence to show that recommendations for safer practice from the 2012 Legionella risk assessment, such as monthly checks of the water temperature, had been addressed. Improvements could be made to ensure water lines were appropriately managed to minimise the risk of Legionella infection.

The provider could not demonstrate any current arrangements for the collection of hazardous waste. We requested waste control agreements for the practice but were only provided with evidence of this for a different practice in Belvedere that was owned by the provider.

Equipment and medicines

We saw documentation which showed the autoclave used to sterilise dental instruments had been regularly inspected and serviced, though there was none in place for the compressor purchased five years prior to the inspection.

We found that staff were not conducting daily fridge temperature checks for glucagon that was stored in the fridge, to ensure that it was stored within the recommended temperature range.

Radiography (X-rays)

The practice had limited arrangements to ensure the safety of the X-ray equipment, though improvements were needed to ensure they met current requirements of the Ionising Radiations Regulations 1999 regulations. For example, the provider had not assessed or mitigated the risk of not using a rectangular collimator to minimise the risk of radiation exposure to patients. There was no evidence that the engineering controls of the X-ray machine

Are services safe?

had been inspected or serviced to ensure they were in good working order, and there was no evidence that the Health and Safety Executive (HSE) had been informed that the machine was in use.

Shortly after the inspection the provider sent us evidence they had ordered a universal collimator and made further enquiries to the HSE.

We saw evidence that the dentist and trainee dental nurses justified and graded the X-rays the dentist took. The practice carried out X-ray audits following current guidance and legislation, though these audits were not comprehensive. They only contained information on the grading of X-rays. They had also carried out an audit on the reporting of X-rays though this had not been reviewed and there was no evidence to show actions for improvement had been implemented.

There was no evidence to demonstrate that all clinical staff had completed continuous professional development in respect of dental radiography. The dentist we spoke with told us they had completed radiography training in 2013 as part of their Masters qualification, though there was no indication of the content or duration of this course.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We checked a sample of dental care records and found there were inconsistencies in the quality of dental care records we checked, and the provider had not established effective processes to monitor and improve the quality of record keeping.

Key information such as medical histories and information on extracted teeth had not been recorded on some records. On one occasion where a dentist had recorded a patient feeling unwell after the administration of a local anaesthetic, there was no record of the type, dose, batch number, or expiry date of the anaesthetic.

Dentists appeared to have made notes on other dentists' profiles without a clear audit trail. Some dental care records were missing and staff could not give any explanation as to why, or where the missing records might be.

Furthermore there were no notes (electronic or paper) corresponding to some appointments.

Health promotion & prevention

The practice provided preventative care and supported patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

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.

The dentists told us that where applicable they discussed smoking, alcohol consumption and diet with patients during appointments. The practice provided health promotion leaflets to help patients with their oral health.

Staffing

We checked personnel records and found that staff had signed an agreement stating they had read various policies.

There was no evidence to demonstrate that staff had completed a period of induction based on a structured induction programme. There was no evidence to show that all clinical staff that worked at the practice had completed the Continuous Professional Development required for their registration with the General Dental Council.

Staff told us they discussed general wellbeing at annual appraisals. We saw evidence of completed appraisals for two trainee dental nurses, though there was no evidence of this for other trainee dental nurses that worked at the practice.

Working with other services

The dentist told us they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide. This included referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by the National Institute for Health and Care Excellence (NICE) in 2005 to help make sure patients were seen quickly by a specialist. However, the dentist we spoke with told us, and we found, there was no system in place to log, manage and monitor patient referrals made to ensure they were dealt with appropriately.

Shortly after the inspection the provider sent us a blank referral form.

Consent to care and treatment

Staff we spoke with 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.

The practice's consent policy did not include information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who may not be able to make informed decisions. Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly. The policy did not refer to Gillick competence and the dentist we spoke with did not demonstrate an understanding of their responsibilities in relation to this.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

Patients commented positively that staff were caring and friendly.

Staff we spoke with told us they were aware of the importance of privacy and confidentiality. The layout of reception and waiting areas provided privacy when reception staff were dealing with patients. Staff told us that if a patient asked for more privacy they would take them into another room. The reception computer screens were not visible to patients and staff did not leave 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.

Music was played in the reception area and there were information leaflets in the waiting area for patients to read.

Involvement in decisions about care and treatment

A dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

The practice's website provided patients with information about the range of treatments available at the practice. These included general dentistry and treatments for gum disease and more complex treatment such as dental implants.

Each treatment room had a screen so the dentists could show patients photographs when they discussed treatment options.

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 had an efficient appointment system to respond to patients' needs. Staff told us that patients who requested an urgent appointment were seen the same day. Patients commented they had experienced a professional service, flexibility with appointment times, and a friendly receptionist. They also commented they had been treated with dignity and respect.

Promoting equality

The practice made some reasonable adjustments for patients with disabilities; this included step free access and an accessible patient toilet with hand rails. The toilet did not have a call bell. The provider had not conducted a formal risk assessment in relation to needs of patients with hearing difficulties.

Staff said they could occasionally provide verbal information in different languages to meet individual patients' needs. They did not have access to interpreter/ translation services to assist patients who did not speak or understand English.

Access to the service

The practice displayed its opening hours in the premises.

The practice told us they were committed to seeing patients experiencing dental pain on the same day. The practice's website and answerphone did not provide telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open.

Concerns & complaints

The practice had a complaints policy providing guidance to staff on how to handle a complaint, though one was for a different practice owned by the same provider. The principal dentist was responsible for dealing with complaints. Staff told us they would tell the principal dentist about any formal or informal comments or concerns straight away so patients received a quick response.

Information was available informing patients of the provider's complaints protocol.

Are services well-led?

Our findings

Governance arrangements

The principal dentist had overall responsibility for the management and clinical leadership of the practice. They were responsible for the day to day running of the service. Staff knew the management arrangements, though they demonstrated a lack of understanding of various protocols related to the running of the service. For example, staff were not aware of how to report concerns about vulnerable patients outside the practice. The dentist did not understand Gillick competence or their responsibilities in relation to it. They did not demonstrate any understanding of safety alerts, clinical incidents and significant events. They were not confident in using the oxygen cylinder.

Some policies and procedures were available, though they had not been regularly updated, several were not practice-specific, and some were not fit for purpose. Some policies were for a different dental practice owned by the same provider. Some policies contained information that was not consistent with what is happening in the practice. The dentist did not keep an inventory of equipment and dental instrument used on home visits or the registration of the car used in accordance with their own policy.

Shortly after the inspection the provider sent us evidence that they had implemented a safeguarding adults policy and amended the safeguarding children policy. They told us they would cease providing the home visit service.

Arrangements to monitor the quality of the service and make improvements were in place though they required improvement.

The provider had not established systems to ensure they maintained complete and contemporaneous records in relation to the running of the service and patients using the service.

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 knew who to raise any issues with, though some did not feel supported; they felt they could not raise concerns without fear of recrimination and did not feel confident that their views would be listened to or appropriately acted on.

The practice held meetings every six months where staff discussed concerns, infection control, referrals and staffing matters clinical and non-clinical updates. Immediate discussions were arranged to share urgent information.

Learning and improvement

The provider did not demonstrate a commitment, and had limited quality assurance processes in place, to encourage learning and continuous improvement.

The provider had not taken steps to assess the quality of dental care record keeping, such as by conducting regular comprehensive record keeping audits. A records audit was carried out, though it was not dated, did not identify dentists involved, had not been reviewed, and no action points had been identified.

Shortly after the inspection the provider sent us an analysis of the audit with action points but this was not dated. The provider had conducted X-ray audits, though these were again not comprehensive. Audits of infection prevention and control had not been carried out in line with current guidelines and they were not reflective of what was happening in the practice.

We reviewed personnel records and found there was no evidence of basic life support, safeguarding, fire safety, radiation protection or information governance training for several members of staff. The dentist told us neither they nor the principal dentist had completed fire safety training and there were no fire marshals in place. Infection control training had been completed by some clinical staff in June 2017 just before the inspection.

Two trainee dental nurses had received appraisals in 2016 and 2017 where they discussed performance and future goals. There were no other records available of appraisals for other trainee dental nurses.

The General Dental Council requires clinical staff to complete continuous professional development (CPD); we found there were limited records of CPD for the dentists working at the practice.

Are services well-led?

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

The practice used verbal comments to obtain staff and patients' views about the service.

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 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met** The service provider had failed to ensure that persons employed in the provision of a regulated activities received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular: • Continuous professional development records were not available for several staff. • There was no evidence to show that all clinical staff had completed key training. • There were no records of appraisals for some staff, and there was no evidence of personal development plans for all staff. • Policies were not appropriate. • Infection prevention and control training and associated staff supervision were ineffective as staff were not following national guidance while cleaning used dental instruments. **Regulation 18 (2)**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met**

This section is primarily information for the provider

Requirement notices

The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed. In particular:

- Evidence of recruitment checks such as employment history, Disclosure and Barring Service checks, immunisation records, identification, qualification, dental indemnity insurance, and qualification with the appropriate bodies were not in place for all staff working at the practice.

  Regulation 19 (3)

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 Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **How the regulation was not being met** The service provider had systems or processes in place that operated ineffectively, in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • There was no system in place for receiving and sharing safety alerts, or for managing clinical incidents and significant events. • There was no evidence that recommendations from risk assessments had been addressed. • Some risk assessments had not been regularly reviewed. • Equipment had not been checked or serviced in line with the manufacturer's guidance. • Staff were not following recognised national guidance when carrying out general cleaning, disinfecting and storing dental instruments. • Risks from the lack of suitable recruitment processes and training needs had not been identified and mitigated.

This section is primarily information for the provider

Enforcement actions

The registered person had systems or processes in place that operated 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 infection control audit and radiography audits had not been conducted in line with recognised national guidance.
- The practice had not audited their facilities to ensure they complied with the Equality Act 2010.

There were no systems or processes that enabled the provider to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user and the management of the regulated activities. In particular:

- Patients' dental care records had not been maintained in line with current guidelines; some were missing, and some did not contain the necessary information.

Regulation 17 (1)