

Dr Rajni Prasad

Rothwell Dental surgery

Inspection Report

4 Butcher Lane
Rothwell
Leeds
West Yorkshire
LS25 0DB
Tel: 01132822972
Website: www.rothwelldentalsurgery.co.uk

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Overall summary

We carried out this unannounced inspection on 31 July 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

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

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

Rothwell Dental surgery provides NHS and private treatment to adults and children.

There is level access at the rear of the building for people who use wheelchairs and pushchairs. Car parking spaces are available near the practice.

Summary of findings

The dental team includes one dentist, two trainee dental nurses, three dental hygiene therapists and a practice manager who is also a qualified dental nurse.

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.

During the inspection we spoke with the dentist, two trainee dental nurses, one dental hygiene therapist 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, Tuesday, Thursday 9am – 5pm

Wednesday 9am – 6pm

Friday 9am – 3pm

Our key findings were:

Due to the engagement from the registered provider and the practice manager the impact of our concerns, in terms of the safety of clinical care, is minor for patients using the service. We have taken appropriate action to safeguard service users whilst the practice continues to demonstrate improvement.

- The decontamination process did not always reflect published guidance. We found the zoning could be improved upon in the surgeries to clarify clean and dirty areas. Decontamination of instruments was not always effective. The practice had cluttered work surfaces and floors. We found improvements could be made to the segregation and disposal of clinical waste in accordance with relevant regulations taking into account guidance.
- The practice had systems to help them manage risk which could be improved upon.
- The practice did not have suitable safeguarding processes and staff did not know their responsibilities for safeguarding adults and children.
- The practice had inconsistent staff recruitment procedures and staff had not received adequate training including safeguarding and CPR.
- Appropriate medicines and life-saving equipment were available.

- The clinical staff were not aware of current guidelines in relation to delivering better oral health.
- The appointment system met patients' needs.
- Dental care records were not stored securely.
- Governance arrangements were not in place to support the smooth running of the practice. The practice did not have effective management or leadership in place.
- The practice asked staff and patients for feedback about the services they provided.
- The practice dealt with complaints positively and efficiently.

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

- Ensure the practice's infection control procedures and protocols are suitable giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'. Ensure the practice has systems in place for environmental cleaning taking into account current national guidelines.
- Ensure waste handling protocols are in place to ensure it is segregated and disposed of in accordance with relevant regulations taking into account guidance issued in the Health Technical Memorandum 07-01 (HTM 07-01).
- Ensure the practice's system for recording, investigating and reviewing incidents or significant events with a view to preventing further occurrences and ensuring that improvements are made as a result.
- Ensure the practice reviews the recruitment policy and procedures to ensure they are suitable and the recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.
- Ensure that the practice reviews all policies' procedures and training to ensure they are effective. This is in relation to legionella risk assessment and actions, fire risk assessment, mental capacity act, duty of candour and safeguarding vulnerable adults and children.

Summary of findings

- Ensure there are training, learning and development needs of individual staff members at appropriate intervals and ensure an effective process is established for the on-going assessment, supervision and appraisal of all staff. Ensure staff are aware of the requirements of the Mental Capacity Act (MCA) 2005, duty of candour responsibilities and ensure all staff are aware of their responsibilities under the Act as it relates to their role.
- Ensure dental care records are stored securely.
- Ensure the practice reviews its current audit protocols to ensure audits of key aspects of service delivery are undertaken at regular intervals and where applicable learning points are documented and shared with all relevant staff.

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

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

- Review the security of prescription pads in the practice and ensure there are systems in place to track and monitor their use. Review the storage of glucagon used as part of the medical emergency drugs which should be stored in line with the manufacturer's guidance and ensure the fridge temperature is monitored and recorded.
- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies, such as Public Health England (PHE).
- Review the systems for checking and monitoring electrical safety and gas safety taking into account current national guidance and ensure that all equipment is well maintained.
- Review the practice's protocols for the use of closed circuit television cameras (CCTV) taking into account guidelines published by the Information Commissioner's Office (ICO).
- Review the practice's protocols for completion of dental care records taking into account guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping. Review the practice's protocols for the use of rubber dam for root canal treatment taking into account guidelines issued by the British Endodontic Society.

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 enforcement section at the end of this report).

Due to the engagement from the registered provider and the practice manager the impact of our concerns, in terms of the safety of clinical care, is minor for patients using the service.

The practice did not have systems and processes to provide safe care and treatment. We were told of several significant events which had not been recorded.

Two members of staff had received training in safeguarding but we found all staff did not know their role or how to report concerns and there were no policies in place to refer to.

Actions from risk assessments including fire and legionella had not been addressed and staff were unaware of their responsibilities. The practice had no electrical or gas safety certificates.

The practice had inconsistent information for recruitment checks.

We found several prescription pads and no logs were in place to monitor their use.

Clinical waste was not always stored in the correct identifiable bag.

The premises were visibly cluttered. The staff were unsure if they were following national guidance for cleaning and sterilising. Validation processes were inconsistent.

Staff were unaware what MHRA alerts were. So no alerts had been received or actioned.

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

The practice had suitable arrangements for dealing with medical and other emergencies.

The practice had carried out a sharps risk assessment but it did not include the steps taken to minimise the risk from other sharp instruments and devices.

Enforcement action



Are services effective?

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

The dentist assessed patients' needs but was unaware if they provided care and treatment in line with recognised guidance including delivering better oral health.

No action



Summary of findings

There were areas of improvement with regards the recording of information within patient dental care records.

The dentist discussed treatment with patients so they could give informed consent and recorded this in their records.

The practice did not have clear arrangements when patients needed to be referred to other dental or health care professionals. The staff did not have a robust process to ensure all referral were sent and staff were not aware of where urgent referral needed to be sent to.

The practice supported staff to complete training relevant to their roles but there was no system to help them monitor this.

Are services caring?

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

We reviewed feedback about the practice. Patients were positive about all aspects of the service the practice provided.

CCTV was in operation within the practice and we were told there were no policies in place for its justification and safe use. There was no supporting evidence to show the practice had registered the CCTV with the ICO or that their registration was in date.

We saw that staff protected patients' privacy but staff had not been trained on the importance of confidentiality.

No action



Are services responsive to people's needs?

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

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

Staff considered patients' different needs. This included providing facilities for disabled patients and families with children. The practice had access to telephone or face to face interpreter services and had arrangements to help patients with sight or hearing loss.

The practice took patients views seriously. They valued compliments from patients and responded to concerns and complaints quickly and constructively.

No action



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 enforcement section at the end of this report).

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

Enforcement action



Summary of findings

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

Staff were not aware of their responsibility under duty of candour or aware of the mental capacity act.

The dental care records were not stored securely. There were areas of improvement with regards the recording of information within patient dental care records.

The practice monitored clinical and non-clinical areas of their work but no action plans or learning outcomes were in place and results had not been shared with staff.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice did not have policies and procedures to report, investigate, respond and learn from accidents, incidents and significant events. Staff were not fully aware of their responsibilities and did not understand their role in the process. We were told of several events which could have been recorded as significant events but had not been.

The staff were unsure who received and what was a national patient safety and medicines alert from the Medicines and Healthcare Products Regulatory Authority (MHRA). We were told the practice had not received any alerts with in the past 12 months. We discussed this with the registered provider and they sent supporting information the next day to show they had registered and reviewed any historical alerts.

Reliable safety systems and processes (including safeguarding)

Staff did not know their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The practice did not have safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw that only two staff members had received safeguarding training. All staff who work in a clinical environment must have adequate training and be aware of their responsibilities.

The practice manager had implemented a new whistleblowing policy. Staff were unaware of this but told us they felt confident they could raise concerns without fear of recrimination.

We looked at the practice's arrangements for safe dental care and treatment. These included generic risk assessments which had not been adapted to meet the needs of the practice. The practice followed relevant safety laws when using needles and other sharp dental items. A basic sharps risk assessment had been carried out of the needles and syringes but this did not include the risk from other sharp dental items.

The dentist told us they did not use rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment and no other safety measures were used.

Medical emergencies

We found not all staff knew what to do in a medical emergency and we found only one certificate available to show one member of staff had completed training in emergency resuscitation and basic life support in the past 12 months. We brought this to the attention of the practice manager who sent supporting information to show all, but the newest staff member had completed relevant training after the inspection. The GDC state two members of the team should be training and on the premises when treating patients.

Emergency equipment and medicines were available as described in recognised guidance. The trainee dental nurse was responsible individual and they had received no training with regards to the importance of this task.

We found the fridge used to store medical emergency drugs was reading above the recommended temperature and staff said this had been the case for some time. The temperatures had not been formally recorded. Staff were aware the temperature had exceeded the recommended levels. We were told that no action had been taken by the registered provider when this had been reported.

Staff recruitment

The practice did not have a staff recruitment policy and procedure to help them employ suitable staff. We looked at all staff recruitment files. This showed inconsistent information was gained for each new member of staff. We found six staff records did not contain any photographic identification, two staff did not have immunisation records and one member of staff had not fully responded to the immunisation and had not had a risk assessment put in place. Two staff members did not have any references. Two staff Disclosure and Barring Service checks were carried out at by previous employers and we found two staff members had not had a DBS check, this had not been done as part of the practice recruitment checks.

Clinical staff were qualified and registered with the General Dental Council (GDC). Two staff members did not have supporting information to show they were suitably indemnified. The registered provider sent through

Are services safe?

supporting documentation to the inspector after the inspection but we found the cover was not correct for their needs or staff members. This was discussed and rectified immediately.

Monitoring health & safety and responding to risks

The practice did not have health and safety policies in place.

The practice had out of date employer's liability insurance displayed. We discussed this with the practice manager who assured us this was in place but did not know which company this was through. They later sent the up to date certificate to the inspector.

We observed several occasions where the dental nurses were not chaperoning the dentist or dental hygiene therapist when treating patients. This was due to them decontaminating instruments.

The practice had completed a fire risk assessment in 2015 but the actions had not been addressed. During the inspection one of the smoke alarms was beeping and when we were asked staff said this had been ongoing for over four months and had not been addressed. We found inconsistent records to show emergency alarms and lighting had been checked.

Infection control

The practice did not have an infection prevention and control policy and procedures. Staff were unsure of the guidance from The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health.

We found no certificates to show staff had completed any infection prevention and control training.

The practice did not have suitable arrangements for cleaning, checking, sterilising and storing instruments in line with HTM01-05. The records were not always completed to show if all of the equipment had been validated effectively and we found several tests for the ultrasonic bath which had failed and no action had been taken. There was no light magnification and we were told this had broken a few months previously and had not been replaced. We found some instruments we looked at had visible debris on after the sterilisation process. We found numerous undated instrument bags. We could not tell

when they had been decontaminated and we were told that the date stamp had broken some time ago, had not been replaced and no other methods to date the processed instruments was being used.

Surgeries had cluttered work surfaces which could be difficult to clean effectively between patients and the decontamination room was cluttered with boxes and clothes on the floor.

Several members of staff could not provide evidence they had been fully immunised against hepatitis B.

The practice carried out infection prevention and control audits twice a year. None of the staff could confirm if they were completing the audit appropriately as they did not know about the guidance documents. There were no action plans or learning outcomes in place.

The practice had inconsistent procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment completed in 2015. When we spoke with staff we found they were unclear as to what they should do on a daily basis to ensure the dental unit water lines were managed effectively. Hot and cold water temperature tests were recorded but we were told the boiler was usually switched off and they had to put it on to take the water tests. Staff had not received any training with regards to Legionella. We were sent information after the inspection to show training had been booked for all staff to attend.

There were no cleaning schedules for the premises. The staff environmentally cleaned the premises but were unaware which mop cleaned which area. During the inspection we found a mop dripping over a materials fridge and over where radiographs were developed.

We found all waste was disposed of in black bin liners and we were told this was then transferred in to the correct clinical waste bag. We found four bags of waste in the cellar and staff could not confirm if two of these were clinical or non-clinical. We also saw two sharps containers from March and May 2017 which had not been collected. Staff told us they did not segregate gypsum waste as this was disposed of in the clinical waste bags. We saw no evidence sharps boxes or amalgam waste were part of the waste contract arrangements.

Equipment and medicines

Are services safe?

We saw servicing documentation for the equipment used. Staff did not always carry out checks in line with the manufacturers' recommendations as they had not been fully trained and did not feel confident they were doing the right thing. We found the testing for the ultrasonic bath had failed since January 2017, this had not been actioned and validation records for the autoclaves had become merged. Staff could not identify which validation tests were done for each autoclave.

We found several open prescription pads with loose prescriptions. There was no log in place to ensure prescriptions were recorded effectively or if any were missing.

There was no electrical and gas safety certification in place.

Radiography (X-rays)

The practice had suitable arrangements to ensure the safety of the X-ray equipment. They met current radiation regulations and had the required information in their radiation protection file.

We saw evidence that the dentist justified, graded and reported on the X-rays they took. The practice carried out X-ray audits every year following current guidance and legislation.

There were no certificates available on the inspection day to show clinical staff completed continuous professional development in respect of dental radiography. We were sent supporting certification the day after the inspection to show the dentist had completed a course.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The staff used templates to record current dental needs, past treatment and medical histories. We found these were not always adapted for each patient to ensure they recorded the information and risk for that patient. The dentist assessed patients' treatment needs but was unaware of recognised guidance including delivering better oral health.

We spoke with the hygiene therapist who described to us the procedures they used to improve the outcome of periodontal treatment. This involved preventative advice and detailed charts of the patient's gum condition. Patients were provided with patient specific prevention advice regimes. Patients with more severe gum disease were recalled at more frequent intervals to review their compliance and reinforce home care preventative advice.

Health promotion & prevention

The staff believed in preventative care and supporting patients to ensure better oral health but were not aware of the Delivering Better Oral Health toolkit. The dentist told us they 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.

The dentist told us they prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them.

Staffing

The new practice manager had implemented a system to ensure new staff to the practice completed an induction

process. The staff were not aware of practice policies and procedures and we were told the new staff had not received sufficient training to ensure they were confident and competent in their roles.

There was inconsistent information available to show staff had completed continuous professional development required for their registration with the General Dental Council.

Working with other services

The dentist confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide. When we spoke with the dentist they were unclear of where they would refer 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. The practice did not monitor urgent or non-urgent referrals to make sure they were dealt with promptly.

Consent to care and treatment

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentist and hygiene therapist told us they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions. Patients confirmed their dentist listened to them and gave them clear information about their treatment.

The practice did not have a consent policy and staff were not fully aware of their responsibilities under the Mental Capacity Act 2005. Staff were aware of Gillick competence and the need to consider this when treating young people under 16. Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

We saw that staff treated patients respectfully and were friendly towards patients at the reception desk and over the telephone.

Nervous patients said staff were compassionate and understanding. Longer appointments were booked for children or nervous patients.

Staff were not fully 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. 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 did not store paper records securely as these were on open shelves and boxes behind reception.

Music was played in the treatment rooms and reception and there were magazines and an information screen in the waiting room.

Closed circuit television (CCTV) cameras were located in the practice. During the inspection we found CCTV signage was not easily visible to ensure patients and staff were aware of this. The practice did not have a policy, risk assessment or registration with the Information Commissioner's Office (ICO).

Involvement in decisions about care and treatment

The practice gave patients clear information to help them make informed choices. The 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.

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 appointment system to respond to patients' needs. We saw that the dentist tailored appointment lengths to patients' individual needs and patients could choose from morning and afternoon appointments. Staff told us that patients who requested an urgent appointment were seen the same day. Patients commented they 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.

Staff told us that they currently had some patients for whom they needed to make adjustments to enable them to receive treatment. The dentist told us they had installed an additional hand rail on the stairs for those with restricted mobility.

Tackling inequity and promoting equality

The practice had taken into consideration the needs of different groups of people, for example, people with disabilities, and put in place reasonable adjustments, for example, handrails to assist with mobility and step free access to the rear of the practice.

Staff said they could provide information in different formats and languages to meet individual patients' needs. They had access to interpreter and translation services which included British Sign Language and braille.

The practice was accessible to wheelchair users. One of the treatment rooms was located on the ground floor.

Access to the service

The practice displayed its opening hours in the premises, their information leaflet and on their website.

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

The practice was committed to seeing patients experiencing pain on the same day. The website, information leaflet and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open. Patients commented they could make routine and emergency appointments easily and were rarely kept waiting for their appointment.

Concerns & complaints

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

The practice manager told us they 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 dealt with their concerns.

We looked at comments, compliments and complaints the practice 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

Governance arrangements

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 practice did not have policies, procedures and risk assessments to support the management of the service and to protect patients and staff. There were no safeguarding adults and children, infection prevention and control, equality and diversity and health and safety policies available.

The practice had limited information governance (IG) arrangements. Staff had not received training in IG and were not fully aware of the importance of these in protecting patients' personal information. The principal dentist had completed the information governance toolkit required.

Leadership, openness and transparency

Staff were not fully aware of the duty of candour requirements to be open, honest and to offer an apology to patients if anything went wrong.

Staff told us there was an open, no blame culture at the practice. They said the practice manager encouraged them to raise any issues and felt confident they could do this. They knew who to raise any issues with and told us the new practice manager was approachable, would listen to their concerns and act appropriately.

The practice held meetings where staff could raise any concerns and discuss clinical and non-clinical updates. Immediate discussions were arranged to share urgent information.

Learning and improvement

The practice had quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, X-rays and infection prevention and control. There were no action plans or learning outcomes in place, where appropriate.

There was no process in place to show the registered provider showed a commitment to support staff with training and development and they told us were not up to date with all the training required.

There was limited evidence available to show that staff were up to date with their training and development arrangements. The General Dental Council requires clinical staff to complete continuous professional development.

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

The practice had a system in place to seek the views of patients about all areas of service delivery through the use of regular patient surveys and a suggestion box.

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.

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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12 HSCA (RA) Regulations 2014 Safe Care and Treatment</p> <p>How the regulation was not being met:</p> <p>The registered provider did not have systems in place to assess the risks to the health and safety of service users of receiving the care or treatment. They failed to do all that is reasonably practicable to mitigate any such risks.</p> <p>The registered provider failed to ensure infection control procedures and protocols are suitable.</p> <p>The registered provider did not have systems in place for effective waste handling protocols to ensure it is segregated and disposed of in accordance with relevant regulations.</p> <p>There was no effective process in place to review the on-going training, assessment, supervision and appraisal of all staff.</p> <p>The registered provider did not action practice risk assessments including fire, legionella and safe use of sharps.</p> <p>The registered provider did not have an effective system for recording, investigating and reviewing incidents or significant events.</p> <p>The registered provider was not aware of their responsibility under the Mental Capacity act and duty of candour requirements.</p> <p>The registered provider failed to ensure dental care records were stored securely.</p> <p>Regulation 12 (1)</p>

Enforcement actions

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014

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

Good Governance.

How the regulation was not being met:

The registered provider did not have systems to enable them to assess, monitor and mitigate risks relating to the health, safety and welfare of service users and others who may be at risk from using this service.

The registered provider failed to ensure suitable governance arrangements were in place.

The registered provider failed to ensure audits were completed at the recommended intervals and action plans and learning outcomes were in place.

Regulation 17 (1)

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2014

Fit and proper persons.

How the regulation was not being met:

The registered provider failed to ensure recruitment procedures were established and operated effectively in line with schedule 3.

Regulation 19 (1)