Mr. Ketan Mehta

Hillside Dentalcare

Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 19 September 2023 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 practice 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 advisor.

To get to the heart of patients' experiences of care and treatment, we always ask the following 5 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:

- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system worked efficiently to respond to patients' needs.
- The frequency of appointments was agreed between the dentist and the patient, giving due regard to National Institute of Health and Care Excellence (NICE) guidelines.
- Staff felt involved and supported.
- Staff and patients were asked for feedback about the services provided.
- The dental clinic appeared generally clean. However, work surfaces in the clinical area and the decontamination room were cluttered and not impervious.
- The practice infection control procedures did not reflect published guidance.

Summary of findings

- Appropriate medicines and life-saving equipment were not available. Not all members of staff had completed training in emergency resuscitation and basic life support.
- The practice did not have effective systems to manage risks for patients, staff, equipment and the premises.
- There were ineffective processes in place to prevent abuse of vulnerable adults and children.
- The practice did not have suitable recruitment procedures to comply with current legislation.
- Improvements were needed to clinical staff`s understanding of the current clinical guidelines.
- Improvements were needed to ensure patient care records were complete and included adequate details of the care provided.
- There was ineffective leadership and systems in place to support continuous improvement were not effective.
- The practice did not have effective complaints procedures in place.
- Patients were treated with dignity and respect. Improvements were needed to ensure patient care records were stored securely.
- The practice did not have suitable information governance arrangements.

Background

Hillside Dentalcare is in the London Borough of Hillingdon and provides NHS and private dental care and treatment for adults and children.

There is step free access to the practice for people who use wheelchairs and those with pushchairs. The practice does not have an accessible toilet and they communicated this to new patients before booking. Car parking spaces are available near the practice.

The dental team includes the principal dentist, 2 associate dentists, 1 qualified dental nurse, 2 trainee dental nurses and 1 dental hygienist. The practice has 1 treatment room.

During the inspection we spoke with the principal dentist and one of the trainee dental nurses. We looked at practice policies, procedures and other records to assess how the service is managed.

The practice is open:

Monday, Tuesday, Thursday and Friday from 8.30am to 5.30pm

Wednesday from 8.30am to 4.30pm

Saturdays by appointment only.

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

- Ensure care and treatment is provided in a safe way to patients.
- Ensure patients are protected from abuse and improper treatment.
- 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 activities receive appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out their duties.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

Summary of findings

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:

- Take action to ensure audits of record keeping and antimicrobial prescribing are undertaken at regular intervals to improve the quality of the service. The practice should also ensure that, where appropriate, audits have documented learning points and the resulting improvements can be demonstrated.
- Implement a system to ensure patient referrals to other dental or health care professionals are centrally monitored to ensure they are received in a timely manner and not lost.
- Improve and develop staff awareness of autism and learning disabilities and ensure all staff receive appropriate training in this.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Are services safe?

Our findings

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

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

The practice did not have effective safeguarding processes to prevent abuse, and staff did not know their responsibilities for safeguarding vulnerable adults and children. The principal dentist, who was also the safeguarding lead, told us that if they were concerned that a child was being abused, they would carry out an investigation and contact the National Society for the Prevention of Cruelty to Children (NSPCC) for advice. Furthermore, on the day of inspection there was no evidence that 6 out of the 7 members of staff had completed safeguarding training at a level appropriate to their role. We noted that safeguarding was not covered as part of the induction. Following the inspection, the provider submitted 2 of the missing safeguarding certificates and said they were 'chasing up' others.

Information about current procedures, and guidance about raising concerns about abuse were not accessible to people who use the service and to staff. The safeguarding poster displayed in the office included contact details of the 'NHS Hillingdon CCG'. (Clinical Commissioning Groups (CCG) ceased to exist in 2013). We were not assured that the practice ensured that up to date local safeguarding board contact details were made available to staff.

The practice infection control procedures did not reflect published guidance.

The decontamination process demonstrated by staff was not in accordance with the Department of Health publication 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05).

We observed that staff did not wear appropriate Personal Protective Equipment (PPE), including a visor or face shield during the manual cleaning process. Staff did not remove the plastic apron they wore during the decontamination process after finishing the procedure. Instruments were not kept moist after use and prior to decontamination. Instruments were not fully immersed during the cleaning process to ensure aerosol risk was minimised. There were no systems and processes to monitor the use of long-handled brushes and domestic gloves. Water temperature was not monitored throughout the cleaning process to ensure it was 45C or lower. We observed that staff cross contaminated surfaces by opening the autoclave with dirty gloves.

A dirty to clean flow was not maintained during the decontamination process. Sterilised instruments were transported from the decontamination room to the surgery and set down in the clean zone. Staff then moved the instruments to the dirty zone for pouching. This meant there were no effective processes in place to ensure instruments were not re-contaminated via a surface that had potentially been contaminated.

The tap in the decontamination room was not a sensor-operated or lever-operated mixer tap as recommended in guidance.

The practice did not have effective systems and processes in place to control the storage time of sterilised instruments. We found unwrapped instruments, including burs and rubber dam clamps in the drawers in the surgery. The provider could not demonstrate that unwrapped dental instruments stored in the clinical area were reprocessed at the end of the working day. We further noted that there was an inconsistent use of processing and expiry dates on the pouches of sterilised instruments.

We observed that work surfaces in the decontamination room were not impervious, posters in the surgery and the clinical area were not laminated to ensure they were easily cleansable, and the clinical area was cluttered.

Are services safe?

In addition, the provider could not demonstrate that all clinical members of staff had completed infection prevention and control training.

Following the inspection, the provider told us that they had implemented a system to monitor the water temperature throughout the cleaning process to ensure it was 45C or lower. In addition, they told us staff had now commenced wrapping instruments in the decontamination room to ensure a dirty to clean flow was maintained and implemented a consistent use of the processing date on the sterilisation pouches.

The practice did not have a suitable infection prevention and control policy staff could refer to for guidance about the practice specific infection prevention and control processes. The policy stated that the clean sink should be filled for scrubbing and a second sink for rinsing. We noted that the practice only had 1 sink. The policy further referred to Type B and Type S steriliser and a washer disinfector. We noted that the practice did not have any of these types of equipment.

The procedures to reduce the risk of Legionella or other bacteria developing in water systems were ineffective. A Legionella risk assessment dated 26 May 2023 was made available for review. This made a number of recommendations, including the appointment of a responsible person to deal with daily responsibilities of Legionella management (with considerations given to their training, experience and knowledge), Legionella training for the responsible person, and annual inspection of the boilers by a Gas Safe engineer. The provider could not demonstrate that these recommendations had been acted upon. The risk assessment further stated that monthly checks of the hot water outlets should be undertaken to ensure that all temperature recording was above 55C. We were shown the practice hot water outlet temperature log and noted that the temperature in the decontamination room and of the handwash sink did not reach 55C on a number of occasions between November 2022 and September 2023. The practice could not demonstrate that they took any action to address this issue. We further noted that temperatures of the hot water outlets were recorded sporadically (only 5 times in the last 10 months) and not monthly.

The practice had procedures in place to ensure clinical waste was segregated in line with guidance. However, clinical waste was not stored securely. Clinical waste awaiting collection (including contaminated sharps) was stored in an unlocked cabinet, accessible to the public, including those visiting the osteopath clinic occupying a room on the first floor of the building.

The practice did not have a cleaning schedule to ensure the effectiveness of environmental cleaning. In addition, the available buckets and mops were not stored in line with the relevant guidance. We observed that the cabinet used to store cleaning materials was not lockable and was potentially accessible to service users and the public, including those visiting the osteopath clinic.

We were not assured that the provider had systems in place to satisfy themselves that the persons employed for the purposes of carrying on a regulated activities were of good character and had the competence, skills and experience which were necessary for the work to be performed by them. The practice recruitment policy and procedure to help them employ suitable staff did not reflect the relevant legislation. On the day of inspection, we noted that as part of their recruitment process the practice had not obtained a proof of identity including a recent photograph for any of the members of staff. In addition, there was no evidence that enhanced criminal checks had been undertaken for 4 members of staff, and satisfactory evidence of conduct in previous employment had not been obtained for 6 members of staff. In addition, the provider could not demonstrate that a full employment history had been obtained from new members of staff at the point of employment. Following the inspection, the provider submitted 2 of the missing Disclosure and Barring Service (DBS) certificates.

Clinical staff were qualified and registered with the General Dental Council (GDC). The provider did not have on file evidence of indemnity cover for all members of clinical staff registered with the GDC).

Are services safe?

The practice had some systems in place to ensure equipment was safe to use, maintained and serviced according to manufacturers' instructions. We saw evidence that the autoclave, ultrasonic bath and compressor had been serviced. However, the provider could not demonstrate that they had systems in place to ensure portable appliances were safe to use.

The provider did not have systems in place to ensure the premises were safe. Electrical installation condition tests had not been carried out in line with the relevant regulations. The practice did not have a gas safety certificate to demonstrate that the appliance had been checked for safety or maintained regularly. Following the inspection, the provider told us that they had arranged the electrical installation condition checks and portable appliance testing.

The management of fire safety was ineffective.

An undated fire risk assessment was made available for review. We noted that this had not been completed by a person with the qualifications, skills, competence and experience to do so. The risk assessment stated that fixed installation was periodically inspected, portable appliance testing was carried out and that there was a policy in place regarding the use of personal electrical appliances. None of these statements were substantiated by our findings. We were not assured that the fire risk assessment was suitable to identify and mitigate risks of fire at the practice.

The practice did not have emergency lights installed and they could not demonstrate that fire evacuation drills were carried out. There were no records of periodic in-house checks of the fire safety equipment and there was no fire exit signage in the surgery, in the upstairs area or in the surgery. Staff had not completed fire safety training.

After the inspection the provider told us that they had booked a fire risk assessment with an external company.

The practice had some arrangements to ensure the safety of the X-ray equipment, however the overall management of radiation safety was ineffective. The provider had not undertaken a radiation risk assessment identifying the procedural controls required to restrict exposure. Local rules communicating the main working instructions intended to restrict any exposures arising from work in the controlled area were not up-to-date. A 3-yearly performance survey report dated 6 December 2022 was made available for review. This had made a number of recommendations including the installation of a rectangular collimator. The provider could not demonstrate that they acted upon this. The report further stated that the measured patient entrance dose for both adult and child mandibular molar were found to be greater than National Diagnostic Reference levels – both should be reduced to acceptable level and the practice should consult their Medical Physics Expert (MPE). The practice could not demonstrate that they had consulted their MPE to discuss how the relevant dosage levels could be reduced.

On the day of inspection, the provider could not demonstrate that they had registered their work with a radiation generator with the Health and Safety Executive. Following the inspection, they told us that the registration had now been completed.

Risks to patients

Systems and processes to assess, monitor and manage risks to patients and staff were ineffective.

A sharps risk assessment that considered risks relating to all forms of sharps used in the practice had not been undertaken. We were not assured that the provider was complying with the requirements of Health and Safety (Sharps Instruments in Healthcare) Regulation 2013 which states that employers are required to ensure that risks from sharps injuries are adequately assessed, and appropriate control measures were in place. Three members of clinical staff did not have evidence of a blood test to show their response to the hepatitis B vaccination they received and there was no evidence that the provider had assessed the risks associated with this. Following the inspection, the principal dentist told us that they would undertake a sharps risk assessment.

Sepsis prompts for staff, and information posters were not available within the practice. We discussed the advantages of staff undertaking sepsis awareness training to ensure they were able to triage patients with sepsis symptoms correctly.

Are services safe?

The principal dentist told us that some members of staff occasionally worked alone when they carried out cleaning duties outside surgery hours. The practice did not have arrangements in place to identify and mitigate the risks arising from staff working alone at the premises.

Medical emergency drugs and equipment were not available in line with the guidance issued by the British National Formulary and the Resuscitation Council (UK). The practice did not have Glucagon (an emergency drug to treat low blood sugar), child self-inflating bag with reservoir, clear face masks sizes 0, 1, 2, 3 or 4 and oropharyngeal airways sizes 0, 1, 2 or 4. The practice had 2 oxygen cylinders; both were smaller than the 460L size recommended by the guidance. In addition, one of the cylinders was empty and out of date. The second cylinder had a use-by date of 23 September 2023. Following the inspection, the principal dentist told us that they had purchased a new oxygen cylinder and the missing medical emergency drugs and equipment had been ordered.

The practice staff did not check the medical emergency drugs and equipment at least weekly as set out in the relevant guidance published by the Resuscitation Council (UK).

The practice did not have a bodily fluid spillage kit and the Automated External Defibrillator (AED) pads were out of date.

The provider could not demonstrate that all clinical staff completed regular training in the management of medical emergencies. Medical emergency scenarios were not discussed in practice meetings.

The practice did not carry out risk assessments for all hazardous materials used within the practice as per Control of Substances Hazardous to Health Regulations 2002 (COSHH). In addition, staff did not have access to the relevant safety data sheets of hazardous materials used in the service.

Information to deliver safe care and treatment

Patient care records were not complete and legible. In addition, dental care records were not kept securely, and the practice did not comply with General Data Protection Regulation requirements. We observed a large number of patient care records piled up in open boxes in the office. We noted that the office door was open. This meant that persons entering the premises, including those using the services of the osteopath clinic, had potential access to confidential information, including medical records.

The practice did not have systems for tracking and monitoring referrals for patients with suspected oral cancer under the national two-week wait arrangements.

Safe and appropriate use of medicines

The practice did not have effective processes for the appropriate and safe handling of medicines. The practice did not have systems in place to monitor prescription pads to ensure missing prescriptions can be identified. In addition, they did not have a log of medicines kept on site and prescription only medication was not stored securely.

Antimicrobial prescribing audits were not carried out.

Track record on safety, and lessons learned and improvements

The provider told us that in the previous 12 months there had been no safety incidents. The provider could not demonstrate that they had systems and processes in place for reporting on accidents and incidents internally to ensure information about these were shared with staff to promote learning.

Staff were not aware of the most recent recalls and rapid response reports relevant to the service issued by the Medicines and Healthcare products Regulatory Agency (MHRA).

Are services effective?

(for example, treatment is effective)

Our findings

We found 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). We will be following up on our concerns to ensure they have been put right by the provider.

Effective needs assessment, care and treatment

The practice had some systems to keep dental professionals up to date with current evidence-based practice. Improvements were needed to ensure clinicians read and implemented relevant nationally recognised guidance, including Patient Group Directions, the most recent guidelines around antimicrobial prescribing and the restrictions of using amalgam on deciduous teeth, breastfeeding women and children under 15.

Helping patients to live healthier lives

The practice provided preventive care and supported patients to ensure better oral health.

Consent to care and treatment

Staff told us they obtained patients' consent to care and treatment in line with legislation and guidance. Improvements were needed to ensure details around consent taken were recorded in the patient care records. In addition, the dentist also needed to improve their knowledge and awareness of Gillick competency, by which a child under the age of 16 years of age may give consent for themselves in certain circumstances.

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

The practice did not keep detailed patient care records in line with recognised guidance. We looked at 9 patient care records and found that the information in relation to care was not always recorded in accordance with the relevant guidance. Missing details included medical history, intraoral and extraoral examination, Basic Periodontal Examination (BPE), risk assessment of periodontal disease, caries and oral cancer, oral health instructions, recall intervals according to risk and treatment options.

Staff conveyed an understanding of supporting more vulnerable members of society such as patients living with dementia or adults and children with a learning disability.

The dentists did not justify, grade and report on all the radiograph they took. The practice did not carry out six-monthly radiography audits.

Effective staffing

Staff did not have the skills, knowledge and experience to carry out their roles. We identified gaps in staff members' understanding of infection prevention and control and safeguarding.

The provider could not demonstrate that newly appointed staff received induction at the point of employment. We saw the induction records for the two trainee nurses; however these records were not available to review for the rest of the dental team. Not all members of staff were up to date with their medical emergency, infection control, safeguarding and autism and learning disability training. On the day of inspection, the provider had very few training certificates on record and some members of staff had no evidence of any of the continuous professional training they received. Following the inspection, the provider submitted some training certificates but a number of training certificates we asked to see had not been provided.

Are services effective?

(for example, treatment is effective)

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

The dentist told us that they would refer patients to a range of specialists in primary and secondary care for treatment the practice did not provide. Improvements could be made to ensure there were systems in place to track and monitor routine referrals made externally.

Are services caring?

Our findings

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

Kindness, respect and compassion

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

On the day of inspection, we spoke with 1 patient, who told us that they were satisfied with the care they received.

The patient said staff were compassionate and understanding when they were in pain, distress or discomfort.

Privacy and dignity

Staff were not aware of the importance of privacy and confidentiality. Patient care records were not stored securely.

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

Involving people in decisions about care and treatment

The dentist told us that staff helped patients to be involved in decisions about their care and gave patients clear information to help them make informed choices about their treatment.

The practice did not have a website or information leaflet that provided patients with information about the range of treatments available at the practice.

The dentist explained the methods they used to help patients understand their treatment options. These included for example study models and X-ray images.

Are services responsive to people's needs?

Our findings

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

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs and preferences.

Staff were clear about the importance of providing emotional support to patients when delivering care.

Staff had not carried out a disability access audit and they had not formulated an action plan to continually improve access for patients. A document titled 'Written Access Statement' was made available for review. The document referred to designated disabled parking, a hearing loop at the reception and a designated disabled toilet being available. We noted that the practice did not have designated disabled parking, disabled toilet facilities and an induction hearing loop (or a reception).

Timely access to services

The practice displayed its opening hours at the entrance.

Patients could access care and treatment from the practice within an acceptable timescale for their needs. The practice had an appointment system to respond to patients' needs. Patients had enough time during their appointment and did not feel rushed.

The practice's answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open.

Patients who needed an urgent appointment were offered one in a timely manner. Patients with the most urgent needs had their care and treatment prioritised.

Listening and learning from concerns and complaints

The principal dentist told us that they had not received any complaints about the service in the past but if they had one, they would respond in a timely manner. The principal dentist told us, they did not have a written complaints policy setting out the systems and processes for dealing with complaints. Further, we noted that information and guidance about how to complaint was not available and accessible to those who used the service.

Are services well-led?

Our findings

We found this practice was not providing well-led care in accordance with the relevant regulations.

We have told the provider to take action (see full details of this action in the Enforcement Actions section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

Leadership capacity and capability

We found that there was ineffective leadership which impacted on the practice`s ability to deliver safe, high-quality care. The principal dentist could not assure us that they understood risks pertaining to the ineffective management of the service and the delivery of care.

We found that staff worked well together. However, improvements were needed to ensure information about systems and processes were communicated effectively to staff.

The information and evidence presented during the inspection process was not always well documented. Improvements were needed to ensure that records in relation to the management of regulated activities were readily available and easily accessible to all members of staff and those who would need to review them.

The practice did not have systems in place to support staff in their development. For example, we could not be assured staff had an adequate understanding of safeguarding and infection prevention and control. In addition, supervising arrangements of the support staff were ineffective in that those supervising trainee dental nurses did not identify gaps in their knowledge.

Culture

Staff stated they felt respected, supported and valued. They enjoyed working in the practice.

We saw evidence that the two trainee nurses discussed their training needs during annual appraisal. We noted that annual appraisal or 1 to 1 meeting records were not available for other members of the dental team. Improvements were needed to ensure all members of staff had the opportunity to discuss learning needs, general wellbeing and aims for future professional development.

There were no systems in place to monitor staff training to ensure continuing professional development. Additionally, there was no system or process in place to ensure other training requirements relevant to staff in carrying out their role were up-to-date and reviewed at the required intervals. The system in place was therefore not effective to identify if a staff member was or was not up to date with their required training. We noted that not all members of staff had completed training in the Mental Capacity Act 2005, management of a medical emergency, infection control, safeguarding and autism and learning disability training. The practice was unaware of this.

Governance and management

The practice did not have effective governance and management arrangements.

We noted that a health and safety risk assessment had not been carried out. We further noted that the Health and Safety Policy dated 1 January 2023 was a generic document and not reflective of arrangements with the service. For example, it referred to dental lasers, which the service did not have. In addition, it stated that a gas safety engineer serviced the system annually, electrical installations were checked to ensure there was no damage. We were not assured that the practice followed their Health and Safety Policy.

Are services well-led?

The processes for managing risks were ineffective. The practice did not have adequate systems in place for identifying, assessing and mitigating risks in areas such as recruitment of staff, sharps, COSHH, lone working, fire safety, Legionella, radiation safety and general health and safety.

Appropriate and accurate information

Staff did not act on appropriate and accurate information. We noted that the infection prevention and control policy and the disability access statement were not reflective of the arrangements within the service. The safeguarding contact details displayed in the office were out of date.

The practice had ineffective information governance arrangements and staff were not aware of the importance of protecting patients' personal information. We observed that patient care records containing personal information had not been stored securely.

Engagement with patients, the public, staff and external partners

Staff gathered feedback from patients and demonstrated a commitment to acting on feedback.

Feedback from staff was obtained through informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on where appropriate.

Continuous improvement and innovation

The practice did not have systems and processes in place for learning, quality assurance, or continuous improvement.

We were not shown evidence that a disability access audit, radiography audits, record card audits and antimicrobial prescription audits had been carried out in line with the relevant national guidance.

The practice could not demonstrate that infection prevention and control audits had been carried out bi-annually, in line with the relevant guidance. One infection prevention and control audit, dated 2 August 2023, was made available for review. We noted that the answers in the audit were not reflective of our findings. For example, it stated the practice had a policy in place covering all aspects of the decontamination process, the clinical team received training on decontamination processes, all wrapped instruments were stamped with the use by date, instruments that were not decontaminated immediately were kept moist, and 2 bowls were used (one for washing and one for rinsing). None of these statements were substantiated by our findings. We were not assured that the audit was suitable to identify issues and to drive improvement.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act (Regulated Activities) Regulations 2014 was available for each person employed. In particular: • The provider did not have robust recruitment processes in place and they did not make every effort to gather all information to confirm the person is of good character. Enhanced DBS check, evidence of conduct in previous employment and employment history, photographic ID had not been obtained for newly appointed staff at the point of employment. Regulation 19 (3)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person did not have systems and processes in place that operated effectively to prevent abuse of service users. In particular: • Information about current procedures, and guidance about raising concerns about abuse were not accessible to people who use the service and to staff. • The provider could not demonstrate that staff received safeguarding training that was relevant, and at a suitable level for their role. • Staff were not aware of their individual responsibilities to prevent, identify and report abuse when providing care and treatment. Regulation 13 (1)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service provider had failed to ensure that persons employed in the provision of a regulated activity received such 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: • Staff were not supervised effectively in that those supervising trainee dental nurses did not identify gaps in their knowledge. • The provider did not have systems in place to monitor staff training to ensure appropriate action was taken quickly when training requirements were not being met. • The provider could not demonstrate that staff were up to date with their continuous professional development requirements of the General Dental Council (GDC). • There was no evidence that all members received induction at the point of employment to prepare them for their new role. • Not all members of staff received regular appraisal of their performance to ensure learning and development needs were identified. Regulation 18 (2)

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.

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 The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: • The decontamination process demonstrated by staff did not reflect the Department of Health publication 'Health Technical Memorandum 01-05: Decontamination in primary dental practices' (HTM01-05). • The provider did not have effective systems and processes in place to control the storage time of sterilised instruments. • The practice did not have a suitable infection prevention and control policy staff could refer to for guidance. • The practice did not have a cleaning schedule to ensure the effectiveness of environmental cleaning. • Buckets and mops were not stored in line with the relevant guidance. • Cleaning materials were not stored securely. • The provider did not ensure that clinical waste was stored securely. • Electrical installation condition checks had not been carried out in line with the relevant regulations. • The practice did not have systems in place to ensure portable appliances were safe to use.

This section is primarily information for the provider

Enforcement actions

- The provider did not have a gas safety certificate to demonstrate that the appliance had been checked for safety or maintained regularly.
- The provider could not demonstrate that a fire risk assessment had been undertaken and regularly reviewed by a person who had the qualification, skills, competence and experience to do so.
- The fire risk assessment was not reflective of the arrangements within the practice and was not suitable to identify and mitigate risks at the practice.
- The practice did not have emergency lights installed.
- Fire evacuation drills were not being carried out.
- There were no records of periodic in-house checks of the fire safety equipment.
- Staff had not completed fire safety training.
- There was no fire exit signage in the surgery, in the upstairs area or in the surgery.
- Medical emergency drugs and equipment were not available as per current national guidance.
- The practice did not check the medical emergency drugs and equipment at least weekly as set out in the relevant guidance published by the Resuscitation Council (UK).
- The Automated External Defibrillator (AED) pads were out of date.
- The practice did not have a bodily fluid spillage kit.
- The mercury spillage kit expired in 2016.
- The provider could not demonstrate that all clinical staff completed regular training in the management of medical emergencies. Medical emergency scenarios were not discussed in practice meetings.

This section is primarily information for the provider

Enforcement actions

- The provider did not have effective systems in place to track and monitor urgent referrals made for patients with suspected oral cancerous lesions.

Regulation 12 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had systems or processes in place that 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: • Systems and processes to ensure the safe use of radiography equipment were not effective. • The practice did not undertake a radiation risk assessment identifying the procedural controls required to restrict exposure. • The provider did not have adequate and up-to-date local rules communicating the main working instructions intended to restrict any exposures arising from work in the controlled area. • Recommendations made in the 3-yearly performance survey report had not been acted upon. • The provider did not monitor and mitigate the risks relating to staff working alone. • The practice did not monitor and mitigate the risks arising from the use of sharps. A sharps risk assessment was not available for review. • The practice did not monitor and mitigate the risks to the health and safety of employees. A health and safety risk assessment had not been carried out. • The Health and Safety Policy was not reflective of arrangements within the service.

This section is primarily information for the provider

Enforcement actions

- The provider did not assess, monitor and mitigate the risk of Legionella and other bacteria developing in the water system.
- The provider could not demonstrate that all recommendations made in the Legionella risk assessment had been acted upon within the given timeframes.
- The practice could not demonstrate that they had carried out risk assessments for all hazardous materials used within the practice as per Control of Substances Hazardous to Health Regulations 2002 (COSHH). Staff did not have access to the relevant safety data sheets of all hazardous materials used in the service.
- Systems in place to ensure the safe use of medicines were not effective. The provider did not have systems in place to monitor prescription pads to ensure missing prescriptions can be identified. In addition, there was no log of medicines kept on site and prescription only medication was not stored securely.
- There were no systems and processes for reporting on accidents and incidents internally to ensure information about these were shared with staff to promote learning.
- Staff were not aware of the most recent recalls and rapid response reports relevant to your service issued by the Medicines and Healthcare products Regulatory Agency (MHRA).

The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

- Radiography audits had not been undertaken.
- Infection prevention and control audits were not carried out bi-annually. The infection control audit available for review was not reflective of the actual arrangements within the practice and it was not suitable to drive continuous improvement.

This section is primarily information for the provider

Enforcement actions

- A disability access audit had not been undertaken. The disability 'Written Access Statement' was not reflective of the arrangements within the service.

- The provider could not demonstrate that clinicians were aware of relevant nationally recognised guidance, including the concept of Gillick competence, guidance about Patient Group Directions, antimicrobial prescribing and the restrictions of using amalgam on certain patient groups.

- The provider did not have a complaints policy setting out the processes in place for dealing with complaints. Information and guidance about how to complain were not made available to service users.

The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular:

- Information in relation to care was not recorded in accordance with the relevant guidance. For example, medical history was not always up to date. Intraoral and extraoral examination , details of periodontal assessment, risk assessment, recall intervals according to risk assessment, justification and reporting on radiographs and oral health advice given were not always recorded.

- Patient care records which contained personal information were not stored securely.

There was additional evidence of poor governance. In particular:

- Governance systems were ineffective as they did not include sufficient oversight, scrutiny and overall responsibility by the registered individual.

- The practice did not have an effective communication system to ensure people working at the service received up to date information about policies, procedures and results of review.