Dr. Yasir Noorani

Court Drive Dental Practice

Inspection report

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Date of inspection visit: 1 December 2023
Date of publication: 16/01/2024

Overall summary

We carried out this unannounced comprehensive inspection on 1 December 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:

- Appropriate medicines and life-saving equipment were available.
- Patients were treated with dignity and respect. Staff took care to protect patients' privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system worked efficiently to respond to patients' needs, and 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, supported and worked as a team.

Summary of findings

- Patients were asked for feedback about the services provided.
- Complaints were dealt with positively and efficiently.
- The practice had information governance arrangements.
- The dental clinic appeared clean and well-maintained, however, the practice infection control procedures did not fully reflect published guidance.
- Improvements were needed to the systems of managing risks for patients and staff. This included risks associated with premises, use of equipment, and the delivery of care using conscious sedation. All staff involved in the delivery of treatment under conscious sedation had not completed Immediate Life Support training (or basic life support training with airway management).
- There were ineffective processes in place to identify and report abuse of vulnerable adults and children.
- The practice did not have suitable recruitment procedures to comply with current legislation.
- There was ineffective leadership, and systems in place to support continuous improvement were not effective.

Background

Court Drive Dental Practice is in Uxbridge, 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. Car parking spaces are available near the practice. The practice has made reasonable adjustments to support patients with access requirements.

The dental team includes the principal dentist, 5 associate dentists, 1 dentist specialising in endodontics, periodontics, prosthodontics and restorative dentistry, 1 oral and maxillo-facial surgeon, 3 dental nurses, 1 dental hygienist and 2 receptionists. They are supported by a consultant practice manager. The practice has 4 treatment rooms.

During the inspection we spoke with the consultant practice manager, 1 associate dentist, 1 dental nurse and 1 receptionist. We looked at practice policies, procedures and other records to assess how the service is managed.

The practice is open:

Monday to Thursday from 8.30am to 5pm

Friday from 8.30am to 4pm

Saturday from 8.30am to 2pm.

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

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

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

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

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

The practice did not have effective safeguarding processes to identify and report abuse. Internal safeguarding arrangements were not communicated effectively. One of the staff members we spoke with was unaware of the safeguarding arrangements within the practice. Furthermore, on the day of inspection there was no evidence to demonstrate that 7 out of 14 members of staff had completed safeguarding training at a level appropriate to their role. The safeguarding policy was a brief document and did not set out a clear process for raising safeguarding concerns within the practice. Following the inspection, the provider submitted a document titled 'Flowchart for Safeguarding Action'. We noted that this did not include the contact numbers for the local authority child protection and adult protection referrals. Staff told us that they recently had a safeguarding incident that prompted the practice to make safeguarding enquires however the practice could not demonstrate that the incident and subsequent actions taken by the practice had been suitably recorded.

The practice infection control procedures did not fully 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 dental instruments were not immersed in the solution while scrubbing and they were rinsed under running water. This increased the risk of producing aerosol contamination during the decontamination process. Water temperature was not monitored throughout the cleaning process to ensure it was 45C or lower. Staff we spoke with were not aware if there were protocols in place to ensure that laboratory work returned to the practice was disinfected before fitting. After the inspection, the provider submitted photographic evidence that a poster had been displayed in the practice, reminding staff that all laboratory work must be disinfected upon delivery to the practice.

The Infection Prevention and Control Policy dated was a generic document and did not include a practice specific infection control procedure staff could refer to.

Quarterly automatic control tests, validation and calibration records were not available for the ultrasonic cleaner. Following the inspection, the provider submitted photographic evidence of the packaging of a new ultrasonic cleaner they had purchased.

The procedures to reduce the risk of Legionella or other bacteria developing in water systems were ineffective. A Legionella risk assessment dated November 2022 was made available for review. This recommended that 'as the first floor has been refurbished and incorporated into the dental practice', the upstairs sinks should be part of the monthly hot and cold-water temperature checks. We were not shown records of the upstairs outlets testing. Following the inspection, the provider submitted email evidence that they had contacted the assessor to seek further clarification about their recommendation for testing outlets on the first floor.

Though the risk assessment stated that the practice used a specific product to disinfect the Dental Unit Waterlines (DUWLs), staff we spoke with told us that they did not use that product. We were not assured that the risk assessment was

reflective of the arrangements within the practice, or that it was suitable to identify risks associated with Legionella. Staff also told us that the DUWLs were only flushed once a week. This is not in line with the recommendations set out in HTM01-05 which states that DUWLs should be flushed for at least two minutes at the beginning and end of the day and for at least 20-30 seconds between patients.

In addition, we noted that some hot water outlet measurements were under 50C. The practice could not demonstrate that they had looked into this and identified remedial action to ensure that the hot water temperatures were in the range of the recommendations included in the Legionella risk assessment, namely that hot water temperature should be above 50C as bacteria, including Legionella are able to proliferate at water temperatures between 25-45C.

The practice had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance.

The practice appeared clean and there was an effective schedule in place to ensure it was kept clean.

The practice recruitment procedure to help them employ suitable staff did not reflect the relevant legislation. We looked at 15 staff records and identified some shortcomings in the recruitment process. On the day of inspection 6 members of staff did not have the relevant Disclosure and Barring (DBS) check on file. Evidence of conduct in previous employment (references) had not been obtained for 14 members of staff. We noted that the practice Recruitment and Selection Policy stated that 'All employment offers are conditional upon receipt of two professional references which are satisfactory'. We were not assured that the practice followed their recruitment policy.

In addition, the provider could not demonstrate that a full employment history had been obtained for 8 members of staff. Three members of clinical staff did not have evidence of their response to the Hepatitis B vaccination they received.

The provider could not demonstrate that they had the required recruitment documents for all visiting sedationists.

Overall, 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. In response to our inspection feedback the compliance manager told us that they would be 'making changes in the way they employ going forward'.

Clinical staff were qualified, registered with the General Dental Council and had professional indemnity cover.

The practice had systems in place to ensure equipment was safe to use, maintained and serviced according to manufacturers' instructions. We saw evidence that the autoclave, and compressor had been serviced and there were systems in place to ensure portable appliances were safe to use.

On the day of the inspection the provider could not demonstrate that the Electrical Installation Condition Rest (EICR) had been carried out in line with the relevant regulations. In addition, the practice did not have a current gas safety certificate to demonstrate that the boiler and gas installations had been checked for safety or maintained regularly. Following the inspection, the provider submitted evidence that the EICR and the gas safety tests had been undertaken on 5 December 2023 and were satisfactory. Improvements were needed to ensure that the necessary checks to demonstrate that the premises were safe were being carried out in a timely manner.

The practice had some systems in place for the management of risks associated with fire. We saw evidence that the fire extinguishers had been serviced on 11 November 2023. We were shown records of the periodic in-house checks of the fire safety equipment and the emergency fire evacuation drills. A fire risk assessment dated 16 September 2023 stated that the overall risk rating at the premises was medium, meaning that there was a significant risk to life in the event of fire. The risk assessment made a number of recommendations, including installing fire doors with self-closing devices on the first floor, fitting all doors with self-closing devices, reinstating the intruder alarm, removing waste from the loft, and upgrading fire detection and emergency lighting systems to cover the whole building and upgrading the fire alarm to cover all areas and providing call points and relevant signage. The provider could not demonstrate that all these recommendations had

been acted upon or that there was a clear plan for their completion in a timely manner. In response to our inspection feedback the compliance manager told us that they had spoken with the fire risk assessor who has 'agreed three months for the completion of the fire doors and closures'. We noted that the originally recommended completion date for the fitting of fire doors was October 2023.

The arrangements in place to ensure the safety of the X-ray equipment were not effective. The provider could not demonstrate that the 3-yearly performance survey reports and annual electro-mechanical servicing on the intraoral units were being carried out. The most recent records available for review were dated 24 March 2015. The provider told us that they recently had the radiation equipment serviced but they were unable to access the online portal where relevant documents were stored. We were shown the servicing certificate for the Cone-beam computed Tomography (CBCT) machine dated 15/06/2022 which stated that the next servicing was due on 15 June 2023. The provider could not demonstrate that this recommendation for the annual servicing had been acted upon.

Risks to patients

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

On the day of the inspection the provider could not demonstrate that a sharps risk assessment which considered risks relating to all forms of sharps used in the practice had been undertaken. The practice did not have safer sharps systems to prevent the need for re-capping or needle guards to reduce the risk of sharps injury. In addition, 3 members of clinical staff did not have evidence of a blood test to show their response to the Hepatitis B vaccination they had received and there was no evidence that the provider had assessed the risks associated with this. 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 are in place. Following the inspection, the provider submitted a sharps risk assessment dated 5 December 2023. This stated that 'safer sharps needles are to be used' and 'specific training is given on the use of this system before implementation'. We noted that the risk assessment had not identified control measures to reduce the risk of sharps injury while the new system is being implemented.

The practice did not have a lone worker risk assessment on the day of the inspection; however this has now been submitted in response to our inspection feedback.

On the day of inspection not all emergency equipment and medicines were available in accordance with national guidance. The practice did not have adult and child self-inflating bags with reservoir, dispersible aspirin, bodily spillage fluid kit or mercury spillage kit. In addition, the adult pad and battery for the Automated External Defibrillator (AED) expired in January 2021. After the inspection, the provider submitted photographic evidence to show that they took immediate action and purchased the missing medical emergency and medicines items.

We did not see evidence that 3 clinical staff members had completed training in emergency resuscitation and basic life support training in the previous year. In addition, there was no evidence that members of the dental team involved in the provision of treatment to patients under conscious sedation had completed Immediate Life Support training (or basic life support training with airway management). Medical emergency scenarios were not discussed in practice meetings.

The practice had risk assessments to minimise the risk that could be caused from substances that are hazardous to health. Improvements could be made to ensure the cabinet used to store hazardous cleaning materials was lockable.

Information to deliver safe care and treatment

Patient care records were complete, legible, kept securely and complied with General Data Protection Regulation requirements.

The practice had systems for referring patients with suspected oral cancer under the national 2-week wait arrangements.

Safe and appropriate use of medicines

Are services safe?

The practice had systems for appropriate and safe handling of medicines.

We were shown a document titled 'Prescription audit' which we noted was a quantitative summary of antibiotics prescribed and not an audit suitable to drive improvement or to identify where prescribing practice diverts from the relevant guidance. We noted from the prescription log that Co-Amoxiclav was prescribed on a number of occasions, Amoxicillin 500mg was prescribed for 7 days and a combination of Metronidazole and Erythromycin were prescribed on some occasions. These prescribing practices were not in line with the relevant guidance and this was not reflected in the audit. Improvements were needed to ensure audits of antimicrobial prescribing were undertaken at regular intervals with documented learning points.

Track record on safety, and lessons learned and improvements

The practice had some systems to review and investigate incidents and accidents. Staff told us that they recently had an incident, however, on the day of the inspection we were not shown evidence that this had been suitably recorded. Following the inspection, the practice submitted the relevant incident report.

The practice had a system for receiving and acting on safety alerts.

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 systems to keep dental professionals up to date with current evidence-based practice.

The practice offered conscious sedation for patients. The sedation records maintained by the external sedationist included the consent form for sedation, pre-operative advice, sedation equipment checklist, peri operative monitoring records and discharge records. However, there was no evidence that members of the dental team involved in the provision of treatment to patients under conscious sedation had completed Immediate Life Support training (or basic life support training with airway management) as recommended in "Standards for Conscious Sedation in the Provision of Dental Care" published by the Intercollegiate Advisory Committee for Sedation in Dentistry. Following the inspection, the provider told us that they had booked Immediate Life Support training for 27 January 2024 and they confirmed that until that date no treatment under conscious sedation would be carried out in the practice.

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 obtained patients' consent to care and treatment in line with legislation and guidance. They understood their responsibilities under the Mental Capacity Act 2005.

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

Monitoring care and treatment

The practice kept detailed patient care records in line with recognised guidance.

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.

We saw evidence the dentists justified and reported on the radiographs they took. The practice radiography audit was generated by their X-Ray software. We noted that it stated that 66% of radiographs taken were not graded. The audit was not suitable to drive improvement as the generated results were based on less than 50% of the radiographs taken. In addition, the audit did not include learning points or reflect on the inconsistent practice of grading within the service.

Effective staffing

The practice could not demonstrate that there were systems in place to ensure newly appointed staff received structured induction to prepare them for their new role. Eleven members of staff did not have record of the induction they received.

There were ineffective systems in place to ensure training, learning and development needs of individual staff members were met and reviewed at regular intervals. One member of clinical staff providing chairside support on the day of inspection had no evidence of training on their file. We were not shown evidence that three other clinical staff and the support staff completed safeguarding training at a level appropriate to their role. Safeguarding training for one clinical

Are services effective?

(for example, treatment is effective)

staff was out of date. Not all members of staff completed training on interacting with people with a learning disability and autistic people as required by the Health and Care Act 2022, Mental Capacity Act (2005) and fire awareness training. In addition, we did not see evidence that 3 clinical staff members had completed training in emergency resuscitation and basic life support training in the previous year.

Improvements were needed to ensure that clinicians involved in referring, justifying, performing and interpreting dental CBCT examinations undertook CBCT core and further training at a level appropriate to their role.

Overall, we found that the provider did not have effective systems in place to monitor staff training to ensure appropriate action was taken quickly when training requirements were not being met.

Co-ordinating care and treatment

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

The dentist confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide.

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.

Staff were compassionate and understanding when they were in pain, distress or discomfort.

Privacy and dignity

Staff were aware of the importance of privacy and confidentiality.

The practice had installed closed-circuit television (CCTV) to improve security for patients and staff. The practice had a CCTV policy, however this was not reflective of the arrangements within the service. The document stated that "This policy is applicable to all employees of the Trust, third parties operating Trust CCTV systems and applies also to other persons who may, from time to time, and for whatever purpose, be present on Trust premises". We noted that the service was a dental practice and was not part of a Trust. In addition, improvements could be made to ensure the practice conducted data protection impact assessments for their surveillance cameras.

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

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care and gave patients clear information to help them make informed choices about their treatment.

The practice's website 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 photographs, X-ray images and an intra-oral camera.

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.

The practice had made reasonable adjustments, including a portable ramp, for patients with access requirements. Staff had carried out a disability access audit and had formulated an action plan to continually improve access for patients.

Timely access to services

The practice displayed its opening hours and provided information on their website.

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. The frequency of appointments was agreed between the dentist and the patient, giving due regard to NICE guidelines. Patients had enough time during their appointment and did not feel rushed.

The practice's website and 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 practice responded to concerns and complaints appropriately. Staff discussed outcomes to share learning and improve 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 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.

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 did not have sufficient oversight of the day to day activities of the practice. They employed a practice manager who spent approximately 1 day a week in the practice and we were not assured that this was sufficient for ongoing oversight or to identify emerging issues and concerns.

We found that the dentist and the other staff member who we spoke with, 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.

We noted that there were no arrangements for staff new to the practice to have a structured induction programme.

Culture

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

There were no records to demonstrate that individual training needs or clinical supervision had been discussed during 1 to 1 meetings.

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.

Governance and management

The practice did not have effective governance and management arrangements. The provider could not demonstrate that policies and procedures were up to date and regularly reviewed. This meant that staff did not act on accurate information. The Safeguarding Policy did not include a clear process to raise concerns within the practice. The infection prevention and control policy did not contain a practice specific decontamination process staff could refer to. The CCTV Policy referred to Trust employees, although the practice was not part of a Trust. The Whistleblowing Policy signposted staff to Public Concerns at Work, which ceased to exist in 2018. The Recruitment Policy did not reflect the actual recruitment processes of the practice, in particular, references had not been obtained prior to employment.

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, fire safety infection prevention and control and Legionella.

Appropriate and accurate information

The practice had information governance arrangements and staff were aware of the importance of protecting patients' personal information.

Engagement with patients, the public, staff and external partners

Are services well-led?

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 had some systems and processes for learning, quality assurance and continuous improvement. These included audits of disability access.

The findings of the infection prevention and control audit undertaken on 18 October 2023 was not reflective of the arrangements within the practice. It stated that all staff had Hepatitis B vaccination, disposable instruments trays, nail brushes were used and there were soft toys in the waiting area. These statements were not substantiated during our inspection.

The radiography audit generated by the practice X-Ray software was not suitable to drive improvement as the generated results were based on less than 50% of the radiographs taken. In addition, the audit did include learning points or reflect on the inconsistent practice of grading within the service.

The antimicrobial audit was a quantitative summary of medication prescribed and did not include meaningful learning points or reflect on when prescribing diverted from the published guidance.

The record card audit included the review of 1 patient care record and did not contain a sufficient sample of records to identify trends or areas in need of improvement.

Overall, improvements were needed to ensure audits were suitable to drive improvement and included a documented analysis and recommendations for 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 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 practice did not have a suitable infection prevention and control policy staff could refer to for guidance. • Quarterly automatic control tests, validation and calibration records were not available for the ultrasonic cleaner. • Flushing of Dental Unit Water Lines (DUWLs) was not in line with the published guidance. • The procedures to reduce the risk of fire were ineffective. The practice could not demonstrate that they had a clear plan to act upon the recommendations made in their most recent fire risk assessment. • 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

Requirement notices

- Members of the dental team involved in the provision of treatment to patients under conscious sedation had not completed Immediate Life Support training (or basic life support training with airway management).
- Systems and processes to ensure the safe use of radiography equipment were not effective.

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: • The practice did not monitor and mitigate the risks arising from the use of sharps. • Not all members of staff had evidence of a blood test to show their immune response to the Hepatitis B vaccination they had received and there was no evidence that the provider had assessed the risks associated with this. • The procedures to reduce the risk of Legionella or other bacteria developing in water systems were ineffective. The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • The 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

Requirement notices

- The radiography audit did not include a suitable sample of radiographs and did not identify actions or learning points.
- The provider could not demonstrate that policies and procedures were up to date and regularly reviewed.

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.

Regulation 17 (1)

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: • Information about current procedures, and guidance for raising concerns about abuse were not made available to staff • The provider could not demonstrate that staff received safeguarding training that was relevant, and at a suitable level for their role. • 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. • There were no systems in place to ensure staff completed training required to carry out their roles.

This section is primarily information for the provider

Requirement notices

- There was no evidence that all members of staff received an induction at the point of employment to prepare them for their new role.
- Not all members of staff received regular appraisals of their performance to ensure learning and development needs were identified.

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 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 checks, evidence of conduct in previous employment and employment histories had not been obtained for newly appointed staff at the point of employment. Regulation19(3)