Provident Practices Ltd

Preston House Dental Practice

Inspection report

29 High Street
Sandwich
CT13 9EB
Tel: 01304621621
www.prestonhousedental.co.uk

Date of inspection visit: 11 July 2023
Date of publication: 18/08/2023

Overall summary

We carried out this announced comprehensive inspection on 11 July 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:

- The dental clinic appeared clean and maintained.
- The practice had infection control procedures which did not reflect published guidance.
- Some staff knew how to deal with medical emergencies, although not all staff had completed training. Not all the minimum appropriate medicines and life-saving equipment were available.
- The practice did not have efficient systems to manage risks for patients, staff, equipment, and the premises.

Summary of findings

- Safeguarding processes were in place, this could be improved. Staff knew their responsibilities for safeguarding vulnerable adults and children. However, not all staff had completed training to the correct level. The safeguarding policies did not contain up to date information.
- The practice had staff recruitment procedures which did not wholly reflect current legislation.
- Clinical staff provided patients' care and treatment in line with current guidelines.
- 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.
- 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.
- Some of the staff did not always feel involved and supported. We saw they worked as a team.
- Staff and patients were asked for feedback about the services provided.
- Complaints were dealt with positively and efficiently.
- The practice did not have information governance arrangements.

Background

Preston House Dental Practice is in Sandwich, Kent and provides private dental care and treatment for adults and children.

There are steps leading into the practice, people who use wheelchairs and those with pushchairs would have difficulty entering the building. Car parking spaces, including dedicated parking for disabled people, are available near the practice. The practice had not made or considered reasonable adjustments to support patients with access requirements.

The dental team includes 2 dentists, a qualified dental nurse, a trainee dental nurse, a dental hygienist, a practice manager and 2 receptionists. The practice has 3 treatment rooms. One of the treatment rooms is not currently in use.

During the inspection we spoke with a dentist, the trainee dental nurse, the dental hygienist, both receptionists and the practice manager. We looked at practice policies, procedures, and other records to assess how the service is managed.

The practice is open:

- Monday to Thursday 8.30am to 4.30pm
- The practice is closed for lunch between 12.30pm and 1.30pm

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

- Ensure care and treatment is provided in a safe way for service users.
- Improve the practice's protocols and procedures for the use of X-ray equipment in compliance with The Ionising Radiations Regulations 2017 and Ionising Radiation (Medical Exposure) Regulations 2017 and taking into account the guidance for Dental Practitioners on the Safe Use of X-ray Equipment.
- Improve the practice's infection control procedures and protocols taking into account the guidelines issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices and having regard to The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.

Summary of findings

- Improve the practice's systems for checking and monitoring equipment taking into account relevant guidance and ensure that all equipment is well maintained. (In particular, servicing of the equipment in a timely manner and in line with the manufactures, and current legislation for the servicing and maintenance of equipment.
- Improve the practice's risk management systems for monitoring and mitigating the various risks arising from the undertaking of the regulated activities.
- Improve the practice's arrangements for ensuring good governance and leadership are sustained in the longer term.
- Improve the practice's recruitment policy and procedures to ensure accurate, complete, and detailed records are maintained for all staff.
- Take action to ensure that all clinical staff have adequate immunity for vaccine preventable infectious diseases.
- Develop systems to ensure an effective process is established for the on-going assessment, supervision, and appraisal of all staff. Including the training, learning and development needs of individual staff members at appropriate intervals.
- The proper and safe management of medicines could be improved. In particular: We saw all the required information was not documented on medicines dispensed by the practice, such as the practice name and address.

Full details of the regulation/s the provider is not meeting are at the end of this report.

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

- Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the Faculty of General Dental Practice.
- Implement an effective system of checks of medical emergency equipment and medicines taking into account the guidelines issued by the Resuscitation Council (UK) and the General Dental Council.

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?	**No action**
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.

We are considering enforcement action in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

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 had safeguarding processes which needed improvements and some staff knew their responsibilities for safeguarding vulnerable adults and children.

We saw there was no safeguarding training for one member of staff. The lead for safeguarding had not refreshed their training which had expired in 2018. We noted there was no reference to modern day slavery in the safeguarding policy which had last been reviewed in 2017. We noted the whistleblowing policy did not have the contact details of the escalation organisations.

- The practice had infection control procedures which did not wholly reflect published guidance. We witnessed the contaminated instruments being scrubbed above the enzymatic detergent instead of being submerged. This poses a risk of aerosol contamination around the sink. The sink was not cleaned following this process.
- We noted there was no long handled brush available for the scrubbing of instruments; this poses a risk of inoculation injury.
- The scrubbed instruments were not rinsed before loading in the autoclave; this poses a risk of contaminants remaining on the instruments.
- Instruments that had been through a cycle in the autoclave were left to cool and dry partly removed from the autoclave. We saw the instruments were not covered during the cooling and drying process; his poses a risk of recontamination as decontamination processes were conducted in the treatment room.
- We saw the re-processed instruments being carried by hand after packaging. There was no lockable transportation box for the re-processed instruments; this poses a risk of injury if a slip, trip, or fall occurs.
- No infection prevention and control audit had been conducted.
- Time, steam, and temperature test strips were performed with a load of instruments. This was not in line with the manufacturers guidance. We would expect to see this test performed at the start of the day with the autoclave empty.
- Impression preparation before sending to the laboratory was incomplete. The packed impressions were not labelled as disinfected and the person responsible for disinfecting the impressions had not signed the package.

The practice had some procedures to reduce the risk of Legionella, or other bacteria, developing in water systems, but these were ineffective.

- We were unable to review the Legionella risk assessment conducted in 2016 as this, when requested, was not available.
- We saw that the last documented water temperature testing records were dated January 2023 but should have been done on a monthly basis. Staff, when questioned, confirmed that was the last time the water temperatures had been tested.
- There were several unused outlets in the building which were not flushed on a regular basis. We could not be assured sufficient measures were in place to detect, monitor and prevent Legionella in the practice.

Are services safe?

- Maintenance of the dental unit water lines was efficient.

The practice had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. However, we noted the policy for clinical waste had not been reviewed or updated since 2016.

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

The practice had a recruitment policy and procedure to help them employ suitable staff, including for agency or locum staff. These did not wholly reflect the relevant legislation.

- We saw that references were not obtained for some members of staff. Therefore, their conduct in previous employment was unknown.
- One member of staff did not have an enhanced Disclosure and Barring Service Check (DBS) as required. A standard DBS certificate was on file for this individual.
- One member of clinical staff could not demonstrate they were sufficiently vaccinated against Hepatitis B. There were only two initial doses of the required course of three documented. This was confirmed by the member of staff.

Clinical staff were qualified, registered with the General Dental Council and some had professional indemnity cover. However, we saw there was no up-to-date indemnity information for two members of the clinical team.

The practice ensured some equipment was safe to use, maintained and serviced according to manufacturers' instructions, such as the autoclaves.

- We saw the compressor had not been serviced annually and the documentation available referred to the installation of the compressor as having been completed in November 2020. The practice ensured the other facilities were maintained in accordance with regulations.

A fire safety risk assessment was carried out in line with the legal requirements. The management of fire safety was ineffective.

- A fire risk assessment had been carried out in October 2022 by staff. The risk assessment had failed to identify potential risks should a fire occur on the upper two floors.
- The air horn, used to alert all to a fire was stored downstairs in treatment room one. When asked staff told us the alert to a fire on the upper floors would be to shout. This had not been tested and was not part of the fire risk assessment.
- A ladder was identified as the means of escape from the second and third floors. This had not been risk assessed sufficiently or tested.
- The risk assessment referred to heat producing laboratory equipment on the ground floor. Staff told us these had not been used for years.
- We were informed an external company was booked for 18 June 2023 to conduct a full fire risk assessment.
- No fire safety, awareness or marshal training had been completed.
- The last fire drill was conducted on 03 January 2018.
- In the absence of emergency lighting, we were informed there was a torch to be used to help escape the building. The torch was not tested regularly.
- There was no electrical fixed wiring certificate.

The practice had insufficient arrangements to ensure the safety of the X-ray equipment. Not all the required radiation protection information was available. This included cone-beam computed tomography (CBCT). The X-ray units had not been serviced since 2016 for the unit in treatment room 3 and 2018 for treatment room one. We noted the CBCT unit had recently been subject to a mechanical service but no performance information such as output was checked.

Risks to patients

The practice had not implemented sufficient systems to assess, monitor and manage risks to patient and staff safety.

Are services safe?

- We witnessed trainee staff handling sharps.
- Staff were not aware of what to do in the event of a sharps injury and were not aware of who to contact outside of the practice.
- Staff did not know if there was an accident book and if there was, where it was kept.
- We did not see any information for staff to refer to regarding sepsis. No sepsis training had been completed.
- There was no risk assessment for the hygienist who worked without chairside support.
- We saw sharps boxes in use were not dated, signed or had the location of use recorded on them.

Some emergency equipment and medicines were available. However, these were checked monthly and not weekly as stated in national guidance.

- The log did not include some of the equipment held, including the oxygen, so this was not checked.
- We found the practice did not hold all the minimum required equipment. There were no needles for the syringes to draw up medicines.
- There was no size 0 oropharyngeal airway.
- No child self-inflating bag with reservoir.
- Clear face masks sizes 0, 1, 2 and 3 were not available.
- The oxygen face masks with tubing had expired with no replacements available.
- The practice did not have an eye wash kit and items in the first aid kit were expired. The expiry date was crossed out and marked unsterile.

We were not assured staff knew how to respond to a medical emergency, or that they had completed training in emergency resuscitation and basic life support every year. We did see that some had completed online training, and one member of staff had not completed any training.

The practice had some risk assessments to minimise the risk that could be caused from substances that are hazardous to health. However, these had not been reviewed since 2017 so not all the dental materials and cleaning products had been risk assessed.

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 two-week wait arrangements.

Safe and appropriate use of medicines

The practice had systems for appropriate and safe handling of medicines which could be improved.

- We saw all the required information was not documented on medicines dispensed by the practice, such as the practice name and address.
- Antimicrobial prescribing audits were not carried out.

Track record on safety, and lessons learned and improvements.

We could not be assured the practice had systems to review and investigate incidents and accidents.

- Staff when questioned told us they did not know what to do in the event of a significant event, incident, or accident. We did not see a process for the recording, audit and learning from significant events at the practice.

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 providing effective care in accordance with the relevant regulations.

Effective needs assessment, care, and treatment

The practice did not have sufficient systems to keep dental professionals up to date with current evidence-based practice.

- Staff had not completed training in several areas, such as sepsis and the Mental Capacity Act. The practice did not have information for staff to refer to regarding Gillick principles or mental capacity.

Helping patients to live healthier lives.

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

Staff were aware of and involved with national oral health campaigns and local schemes which supported patients to live healthier lives.

Consent to care and treatment

Staff obtained patients' consent to care and treatment in line with legislation and guidance. We were not assured staff understood their responsibilities under the Mental Capacity Act 2005. The practice policy for consent did not contain up to date information.

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, graded, and reported on the radiographs they took. The practice had not carried out radiography audits six-monthly following current guidance. We were shown data collection of x-rays taken, however, there was no report, analysis or learning points documented.

Effective staffing

We were not assured all staff had the skills, knowledge, and experience to carry out their roles.

- One member of staff was unsupported during their training. They told us they relied upon self-directed learning online and were doing what they could without direction.
- One member of staff was not on a recognised course for a dental nursing qualification. They had been in post for eight months at the practice and a trainee at another practice previously.

Newly appointed staff did not have a structured induction and clinical staff had completed some continuing professional development required for their registration with the General Dental Council.

- Staff had not completed training for sepsis, mental capacity act, general data protection regulations, Legionella awareness or learning disability and autism awareness.

Co-ordinating care and treatment

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

Are services effective?

(for example, treatment is effective)

The dentists 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.

On the day of inspection, we collected feedback from four patients. Patients told us reception staff are always helpful. They also told us the dentists are caring and clear with their explanations of treatment.

Patients said 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.

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

We noted staff had not completed training for data protection and confidentiality.

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 and information leaflet 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, 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.

The practice had not considered reasonable adjustments for patients with access requirements. A disability access audit had not been conducted to continually improve access for patients. We were shown evidence to confirm an external company was booked for 18 July 2023 to conduct a disability access audit.

Timely access to services

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

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 National Institute for health and Care Excellence (NICE) guidelines. Patients had enough time during their appointment and did not feel rushed.

The practice's website, information leaflet and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day. Patients were directed to the local out of hours dental service when the practice was not open.

Patients who needed an urgent appointment were offered one in a timely manner. When the practice was unable to offer an urgent appointment, they worked with local organisations to support urgent access for patients. 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 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.

We are considering enforcement action in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

Leadership capacity and capability

We found improvements were needed to ensure the management and oversight of procedures that supported the delivery of care was effective.

We saw the practice could improve processes to support and develop staff.

Culture

Staff stated they felt respected and valued. They were proud to work in the practice. We noted that some staff felt unsupported but felt welcomed by the team.

Staff discussed their training needs during appraisal. However, this was not always annually. We saw some staff training had lapsed.

The practice did not have sufficient arrangements to ensure staff training was up to date and reviewed at the required intervals.

Governance and management

The practice had a governance system which included policies, protocols and procedures that were accessible to all members of staff. These required improvements. All the documents available were last reviewed in 2016 and 2017; they did not contain the most up to date information for staff to refer to.

The processes for managing risks, issues and performance requires improvement. Risk assessments were ineffective. We were not assured events, accidents and incidents would be recorded appropriately.

Appropriate and accurate information

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

Engagement with patients, the public, staff, and external partners

Staff gathered feedback from patients, the public and external partners and demonstrated a commitment to acting on feedback.

Feedback from staff was obtained through meetings, surveys, and informal discussions.

Continuous improvement and innovation

The practice systems and processes for learning, quality assurance and continuous improvement needed improvements. Audits presented of patient care records, and radiographs which appeared to be collections of data rather than a full audit, with a summary of findings, action plan, learning points and date for re-audit. We did not see any audit activity for infection control, antimicrobial prescribing, and disability access.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation 19. Fit and proper persons employed. The registered person had failed to take such action as is necessary and proportionate to ensure that persons employed continued to have the qualifications, competence, skills, and experience necessary for the work to be performed by them. In particular: • There was insufficient support and supervision for trainee staff. • Staff had not completed training in several areas. There was np raining for fire safety, mental capacity, sepsis, information governance and learning disability, GDPR and autism awareness. The registered person had failed to take such action as is necessary and proportionate to ensure that persons employed remained able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the work for which they are employed. In particular: • One member of clinical staff did not have evidence of sufficient vaccination against Hepatitis B. The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed. In particular: • The practice had not obtained information about conduct in previous employment for five members of staff. • Staff did not have an induction when starting work. • One clinical member of staff had not provided an enhanced disclosure and barring check as required.

This section is primarily information for the provider

Enforcement actions

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12. Safe care and treatment

Care and treatment must be provided in a safe way for service users.

We found infection control and prevention measures were ineffective.

- The manual scrubbing of instruments was not conducted effectively. We witnessed instruments being scrubbed above the enzymatic detergent and not submerged to avoid an aerosol.
- Instruments post scrub were not rinsed before being loaded into the autoclave.
- Once instruments had completed a cycle in the autoclave they were left to cool and dry exposed and partially removed from the autoclave chamber.
- We witnessed staff transporting instruments without using a lockable puncture proof box.
- Time, steam, and temperature test strips were performed with a load of instruments. This was not in line with the manufacturers guidance. We would expect to see this test performed at the start of the day with the autoclave empty.
- Impression preparation before sending to the laboratory was incomplete. The packed impressions were not labelled as disinfected and the person responsible for disinfecting the impressions had not signed the package.
- We saw the sharps boxes in use did not have the location and date indicated.
- We noted that sharps were being handled by staff who were unaware of what to do in the event of an inoculation injury.

We found there were insufficient arrangements to take appropriate action in the event of a medical emergency.

- The practice did not hold the minimum equipment for medical emergencies as required by current guidance. Not all the oropharyngeal airways were available, sizes 0, 1, 2, and 3. Not all the clear face masks sizes were available, sizes, 0, 1, 2 and 3.

This section is primarily information for the provider

Enforcement actions

- The mask and tubing for the oxygen had expired in 2021 and no replacement was available.
- The checks of the medical emergency medicines and equipment was ineffective. Checks were conducted monthly instead of weekly and some of the emergency equipment was not included on the log. The oxygen, self-inflating bags with reservoir, adult and child face masks, the pocket mask and needles had not been checked.
- One member of staff had not completed training for medical emergencies and this training for another member of staff had expired. The practice did not regularly practice medical emergency scenario training. The team had not completed medical emergency training together since 2021.

The arrangements in place for the identification and mitigation of the risks from Legionella were ineffective.

- We could not review the Legionella risk assessment conducted in 2016 as this could not be located.
- We saw the last water temperature monitoring had taken place in January 2023.
- We noted there were several outlets that were not flushed regularly; these were located in the laboratory, the bathroom and treatment room 3.
- There was no training completed with regard to Legionella prevention or management.

We could not be assured staff would know what to do in the event of a fire. Fire safety precautions were inefficient.

- The fire risk assessment conducted in October 2022 had failed to assess several potential risks. The practice had an air horn to alert everyone to a fire. This was stored in treatment room 1 on the ground floor of the practice. Staff told us if a fire occurred on the upper two floors of the building, they would shout to alert people. This had not been tested and was not included in the risk assessment. The risk assessment referred to heat producing lab equipment. We were told these items had not been used for some time.
- The last fire drill was conducted on 03 January 2018
- In the absence of emergency lighting, we were informed there was a torch to be used to help escape the building. The torch was not tested regularly.

This section is primarily information for the provider

Enforcement actions

- The ladder to be used in the evacuation of the second and third floors in the event of a fire had not been tested; no ladder functionality tests were recorded in the fire risk assessment process.

We found there was a lack of oversight of the assessment and mitigation of risk at the practice.

- Risk assessments conducted, had not considered all potential risks, and therefore requires improvement.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15. Premises and equipment. The registered person had failed to ensure that all premises used by the service were properly maintained. In particular: • Radiography equipment had not been maintained and serviced in line with the Ionising Radiation Regulations 2017 (IRR17) the X-ray unit in treatment room one was last serviced on 30 April 2018. • We saw the mechanical service report for the cone-beam computed tomography (CBCT) unit, but this did not have output recorded. • There was no electrical fixed wiring certificate. • There was no servicing information for the compressor since its installation in November 2020.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 - 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 improve the quality and safety of the services being provided. In particular:

This section is primarily information for the provider

Enforcement actions

- Policies, procedures, and protocols had not been reviewed and updated regularly. The majority of policies had last been reviewed in 2016 and did not contain the most up to date information.
- The practice did not have a policy for mental capacity.
- The practice did not have a policy in relation to the General Data Protection Regulations (GDPR).
- Policies for safeguarding, consent and whistleblowing lacked key information.

The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to evaluate and improve their practice in respect of the processing of the information obtained throughout the governance process. In particular:

- They had not conducted an infection prevention and control audit.
- They had not conducted a disability access audit.
- They had collected data with regard to patient records and radiographic image quality. There was no summary of findings, action plan or learning points.