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Provident Dental Surgery

Inspection Report

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Overall summary

We carried out this announced inspection on 8 June under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

We told Healthwatch that we were inspecting the practice. They did not provide any information.

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

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

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

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Provident Dental Surgery is located in Worthing and provides private treatment to patients of all ages.

The practice is located on first floor premises. Car parking spaces are available near the practice.

The dental team includes one principal dentist and two trainee dental nurses who perform dual roles as receptionists. The practice has two treatment rooms, one of which is used to decontaminate dental instruments.

Summary of findings

The practice is owned by an individual who is the principal dentist there. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

On the day of inspection we received feedback from three patients. This information gave us a positive view of the practice.

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

The practice is open: Monday to Friday from 9am to 5.30pm and Saturday from 9am to 1pm.

Our key findings were:

- The practice was clean and most equipment was maintained in line with manufacturer's recommendations and guidance.
- The practice had infection control procedures which were reflective of published guidance. However these were not adhered to or followed by staff.
- Staff lacked knowledge in how to deal with emergencies. Appropriate medicines and life-saving equipment were available with the exception that an automated external defibrillator (AED) was not available.
- Risks related to undertaking of the regulated activities had not been suitably identified and mitigated.
- Dental care and treatment was being provided using conscious sedation without taking into account current national guidelines.
- Staff lacked knowledge of their responsibilities for safeguarding adults and children. Improvements were required to the practice's safeguarding processes.
- The practice lacked thorough staff recruitment procedures.
- Consent was not suitably obtained and documented.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The appointment system met patients' needs.
- Effective systems were not in place to suitably assess, monitor and improve the quality of the service.

We identified regulations the provider was not meeting. 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 sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.
- Ensure specified information is available regarding each person employed.

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

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

- Review the practice's policy and the storage of products identified under Control of Substances Hazardous to Health (COSHH) 2002 Regulations to ensure a risk assessment is undertaken and the products are stored securely.
- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies, such as Public Health England (PHE).
- Review the practice's sharps procedures and ensure the practice is working in compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Review the practice's protocols for the use of rubber dam for root canal treatment taking into account guidelines issued by the British Endodontic Society.
- Review the practices' Legionella risk assessment and implement the required actions taking into account guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in

Summary of findings

primary care dental practices and have regard to The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.'

- Review the protocols and procedures for use of X-ray equipment taking into account Guidance Notes for Dental Practitioners on the Safe Use of X-ray Equipment.
- Review the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking the X-ray and quality of the X-ray ensuring compliance with the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000.
- Review the systems in place to ensure that care and treatment of patients is only provided with the consent of the relevant person.
- Review the systems and processes in place to ensure that these are established and operated effectively to safeguard service users.

The principal dentist was made aware of our findings on the day of the inspection and they were formally notified of our concerns immediately after the inspection. They were given an opportunity to put forward an urgent action plan with remedial timeframes, as to how the risks could be mitigated.

The provider responded appropriately within the required time frame to inform us of the urgent actions they had undertaken to mitigate the risks. These included voluntary cessation of the provision of dental care using conscious sedation at the practice and in a domiciliary setting with immediate effect.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

Requirements Notice and Enforcement Action section at the end of this report).

The practice had inadequate systems and processes to provide safe care and treatment.

Risk assessments related to Control of Substances Hazardous to Health, sharps and lone working were absent.

Serious shortfalls were identified in the provision of dental care delivery using conscious sedation. Dental care procedures were being undertaken in domiciliary settings using conscious sedation without regard to suitability of the environment and availability of equipment to manage a medical emergency.

The practice told us on the day and following the inspection that dental care delivery using conscious sedation would no longer be undertaken at the practice or in a domiciliary setting.

Staff lacked training in safeguarding and did not know how to recognise the signs of abuse and how to report concerns.

The practice had not completed essential recruitment checks and not all staff were suitably qualified and trained to undertake the tasks required of them.

Premises and equipment were clean although X-ray equipment was not maintained as per current guidance. The practice did not follow national guidance for cleaning, sterilising and storing dental instruments.

The practice had arrangements for dealing with medical and other emergencies although shortfalls were identified in these.

Enforcement action

Are services effective?

We found that this practice was not providing effective care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the

Requirements Notice and Enforcement Action section at the end of this report).

The dentist discussed treatment with patients so they could give informed consent although this was inconsistently recorded. Dental care records were not maintained in line with current guidance.

The practice had clear arrangements when patients needed to be referred to other dental or health care professionals.

The practice had no systems to monitor staff training, learning and development.

Requirements notice

Summary of findings

Are services caring?

No action

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

We received feedback about the practice from three people. Patients were positive about the service the practice provided. They told us staff were kind. They said that they were given explanations about dental treatment. Patients commented that they made them feel at ease, especially when they were anxious about visiting the dentist.

We saw that staff protected patients' privacy and were aware of the importance of confidentiality. Patients said staff treated them with dignity and respect.

Are services responsive to people's needs?

No action

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

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

Staff considered patients' different needs and provided domiciliary visits where required.

Are services well-led?

Enforcement action 

We found that this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the

Enforcement Action section at the end of this report).

The practice did not have robust arrangements to ensure the smooth running of the service. There was a lack of leadership and oversight to support staff and ensure that they understood and followed relevant legislation and guidance in relation to their roles and responsibilities for the safe running of the practice.

Risks arising from undertaking of regulated activities had not been suitably identified and mitigated.

The practice did not have effective systems for monitoring clinical and non-clinical areas of their

work to help them improve and learn.

The practice sought patient feedback and responded appropriately.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had policies and procedures to report, investigate, respond and learn from accidents, incidents and significant events but staff lacked knowledge and understanding of their roles in the process. Additionally, procedures referred to were out of date.

There was a system in place for the practice to record accidents but we found that these were not always recorded, responded to or acted on appropriately to reduce risk and support future learning.

The practice had not received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA).

The provider was not aware of any of the recently issued alerts which related to medicines and medical devices used in a dental practice; and was not registered with the website to receive alerts.

Following the inspection the provider told us that staff would be trained in accidents, incidents and significant events. We were sent evidence that the practice had signed up to receive MHRA alerts.

Reliable safety systems and processes (including safeguarding)

The practice had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse although this did not contain the contact details of local safeguarding teams. Not all staff had received training in safeguarding nor knew how to report concerns. The provider told us that staff would be provided with appropriate training following the inspection. The practice did not have a whistleblowing policy but staff felt confident they could raise concerns without fear of recrimination.

The practice had a policy for the prevention and management of blood-borne virus exposure. This had not been reviewed since 2013. Staff had not received training in how to work with sharps safely and were not aware of the correct procedures to follow should they sustain a needle stick injury.

The principal dentist told us that they resheathed needles in an appropriate manner and that needles were disposed of suitably. Improvements could be made to ensure a sharp's risk assessment was undertaken and move to the use of safer sharps in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013

Improvements were also required to ensure sharps boxes were dated and signed.

The principal dentist told us rubber dams were not being used when providing root canal treatment but the practice would begin to work towards this following the inspection. In patients' dental care records we found that the provider had not documented how patients' safety was maintained throughout the procedure in the absence of a rubber dam.

Medical emergencies

There were significant shortfalls in the arrangements the practice had to deal with medical emergencies. Not all staff knew the procedures to follow in a medical emergency or had completed training in emergency resuscitation and basic life support.

Following the inspection the provider told us that all staff would be required to attend appropriate training in medical emergencies and basic life support.

The practice did not have an automated external defibrillator (AED). The location of the nearest AED was unknown to the provider and there was no risk assessment detailing how an AED would be accessed in a timely manner.

Following the inspection we were sent evidence to demonstrate that an AED had been purchased.

Most of the emergency equipment and medicines were available as described in recognised guidance, though we noted that glucagon was not stored suitably in a fridge and there were syringes that were past their use by date. Improvements were required to the systems in place to make sure that these were available, within their expiry date, and in working order.

Staff recruitment

The practice did not have a staff recruitment policy to help them employ suitable staff and all the staff records we viewed demonstrated that the practice recruitment procedures did not reflect relevant legislation.

Both the dental nurses were trainees and were not yet registered with the General Dental Council (GDC). One of

them was completing training towards qualification and registration with the GDC. The other trainee was not completing training towards qualification and there were no plans for this to happen.

The dentist had professional indemnity cover.

The practice had not carried out the relevant recruitment checks on staff. For example, references were not sought, Disclosure and Barring Service (DBS) checks had not been carried out on clinical staff, neither was the immunisation status of all staff known.

Monitoring health & safety and responding to risks

The practice had some health and safety policies and these covered general workplace and specific dental topics. We noted that these were not followed routinely by all staff and risks to patients and staff were not assessed or managed in a number of areas.

We looked at the practice's arrangements for safe dental care and treatment. These included risk assessments. The practice had not carried out a risk assessment around the safe use, handling and Control of Substances Hazardous to Health, 2002 regulations (COSHH). There was a potential risk to staff who were not aware of the need to manage substances differently depending on their risk. We brought this to the attention of the provider.

The practice had current employer's liability insurance.

The practice had carried out a fire risk assessment but actions had not been completed. Following the inspection the provider told us that the practice had purchased new fire extinguishers.

The principal dentist was not always supported at the chairside by a dental nurse and there were no risk assessments in place to mitigate these risks. The principal dentist was not supported by a GDC registered or appropriately trained dental care professional when completing domiciliary visits.

The practice also provided dental care and treatment for patients using conscious sedation. This included patients in both the practice and domiciliary setting. During the inspection we identified that the practice did not have systems in place to help them do this safely.

The provider had not taken into account national guidelines in ensuring the appropriateness of the physical environment, supporting facilities or the equipment for the delivery of dental care under sedation.

Dental care records we checked demonstrated that neither a detailed medical history nor an assessment of physical status using the recommended American Society of Anaesthesiologists (ASA) classification system was undertaken.

Not all recommended emergency equipment, such as for example, an AED was present. Not all members of the care team had the relevant knowledge, capability and skills for the technique being used. The principal dentist was not supported by a suitably trained nurse. Only one member of staff had undertaken training in immediate life support.

There was lack of written contemporaneous records of the peri-operative monitoring of the patients and all members of the clinical team did not have an understanding of the requirements of monitoring and recording the condition of the patient.

The team had not undertaken any scenario-based team training in the management of potential complications associated with conscious sedation nor completed any audits to assess the suitability of the procedures.

The provider had not undertaken a suitable risk assessment while providing dental care treatment under conscious sedation to elderly patients in domiciliary setting.

The processes for gaining consent from patients as set out in the guidance were not adhered to.

The provider responded appropriately within the required time frame to inform us that with immediate effect the practice had ceased the provision of conscious sedation.

Infection control

The practice had an infection prevention and control policy to keep patients safe. However, suitable infection prevention and control procedures were not being adhered to and staff had a limited understanding of the correct processes for cleaning dental instruments. The practice was not always following guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health.

Are services safe?

Staff had not completed infection prevention and control training.

We noted that recommended guidelines were not being following during the cleaning of dental instruments. Instruments were being cleaned in a liquid detergent not suitable for dental instruments. Instruments were not rinsed as per the guidelines nor were they being bagged and stored in accordance with the guidelines set out in HTM 01-05.

We found that tests required to check that the ultrasonic cleaner was working effectively were not being carried out.

There were shortfalls in the systems used to reduce the possibility of Legionella and other bacteria developing in the water systems. The testing of water and flushing of dental unit water lines was not being carried out. Cleaning of the waterlines was carried out on an infrequent basis.

We saw that environmental cleaning of the practice was appropriate. Clinical waste was stored in line with relevant guidelines.

The practice had recently carried out an infection prevention and control audit. The latest audit identified several shortfalls including the aforementioned issue of sharps bins, rinsing of dental instruments and management of the dental until waterlines; but there was no action plan in place to rectify these issues. We also noted that the audit prior to the most recent one had been carried out in 2013. It is recommended that these audits are carried out twice a year to test the effectiveness of infection prevention and control procedures.

Following the inspection we were told that staff will be required to complete training in infection prevention and control.

Equipment and medicines

We saw servicing documents for some of the equipment used; for example, the autoclave was last serviced in June 2017; no previous servicing and maintenance documents were available.

The servicing document of the compressor was not available on the day.

The practice stored medicines and private prescriptions as described in current guidance although we noted that the labelling of medicines did not include the practice name and address as required.

Radiography (X-rays)

The practice did not have suitable arrangements in line with current radiation regulations to ensure the safety of the X-ray equipment. Annual maintenance of the X-ray equipment was not being carried out.

The patients' dental care records we examined identified that X-rays were not being justified, graded and reported on. No X-ray audits had been completed since 2012 which did not follow current guidance and legislation. We brought this to the attention of the provider who told us that improvements will be made and audits will be undertaken.

The relevant clinical staff had completed continuous professional development in respect of dental radiography.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

There were shortfalls in the documentation of patient outcomes at the practice. Whilst the practice had an awareness of recognised guidance with respect to patient outcomes the dental care records we checked showed that guidance was not being followed and risk assessments for patients' oral health were not being documented. Patients' medical histories were not being updated at appropriate intervals nor signed by patients.

Health promotion & prevention

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

The dentist told us that where appropriate they discussed smoking, alcohol consumption and diet with patients during appointments.

Staffing

Staff new to the practice did not have a period of induction. Not all staff had received formal training in core topics such as medical emergencies, infection prevention and control and safeguarding.

Staff told us that the principal dentist was open to staff completing training courses but that these had not yet been undertaken.

Inexperienced staff were required to line manage staff on a day to day basis without formal training themselves in procedures around infection prevention and control. No annual appraisals were held.

We confirmed that the principal dentist undertook the continuous professional development required for their registration with the General Dental Council.

Working with other services

The dentist confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide. This included referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist. The practice monitored urgent referrals to make sure they were dealt with promptly.

Consent to care and treatment

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

There were shortfalls in the processes by which consent was obtained for patients requiring conscious sedation. We noted that there was a consent form for sedation that required a patient's signature. We saw records for a patient who was treated in a domiciliary care setting. The records stated that the patient was confused. There was no mental capacity assessment undertaken and the sedation procedure had been undertaken on the same day.

The practice's consent policy lacked information about the Mental Capacity Act 2005. Although staff understood their responsibilities under the Act when treating adults who may not be able to make informed decisions, dental care records we checked demonstrated that staff did not always follow processes in accordance with the Act.

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

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

Patients commented positively that staff were reassuring. We saw that staff treated patients appropriately and kindly and were friendly towards patients at the reception desk and over the telephone.

Staff were aware of the importance of privacy and confidentiality. The reception computer screens were not visible to patients and staff did not leave personal information where other patients might see it.

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

Involvement in decisions about care and treatment

The practice gave patients clear information to help them make informed choices. Patients confirmed that staff discussed options for treatment with them. A dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

The practice's website provided patients with information about the range of treatments available at the practice. These included general dentistry and treatments for gum disease and more complex treatment such as implants and sedation. The principal dentist told us that sedation would be removed from the practice website.

The principal dentist used different methods to explain treatment options to patients, for example, X-ray images and models.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had an efficient appointment system to respond to patients' needs. Staff told us that patients who requested an urgent appointment were seen the same day. Patients told us they had enough time during their appointment and did not feel rushed. Appointments ran smoothly on the day of the inspection and patients were not kept waiting.

The practice provided domiciliary visits to patients in their own homes and care homes. Improvements were required to ensure that this service was provided in a way which safeguarded patients and was in accordance with published guidance. For example, the principal dentist frequently worked alone when completing domiciliary visits at patients' private residences. This does not follow the standards as set out by the GDC.

Promoting equality

The practice made reasonable adjustments for patients with disabilities but was limited in the extent to which it could make adjustments. A lift was out of order; we were told this was the responsibility of the landlord.

Staff said they had access to interpreter/translation services if required.

Access to the service

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

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

The practice was committed to seeing patients experiencing pain on the same day. The practice answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open. Patients confirmed they could make routine and emergency appointments easily.

Concerns & complaints

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

The principal dentist told us they aimed to settle complaints in-house and invited patients to speak with them in person to discuss these. Information was available about organisations patients could contact if not satisfied with the way the practice dealt with their concerns.

We looked at comments, compliments and complaints the practice received in the previous three years. These showed the practice responded to concerns appropriately.

Are services well-led?

Our findings

Governance arrangements

The principal dentist had overall responsibility for the management and clinical leadership of the practice and was responsible for the day to day running of the service. Staff knew the management arrangements although their roles and responsibilities were not clearly defined or documented. There were ineffective governance systems in place for assessing, monitoring and mitigating risks.

Staff told us that they would alert the principal dentist if there were any concerns and the principal dentist confirmed this. However, we identified instances where there was a lack of consistency in raising concerns for the benefit of improving practice and learning from near misses and a lack of documentation which would support this.

There was a lack of robust systems in place to document procedures being carried out at the practice. For example, there was no sharps risk assessment and no documented procedures for staff to follow with respect to the safe handling of sharps. There were no systems in place to enable staff to carry out required procedures in consistent and uniform ways. Staff told us that this was not required due to the small size of the practice and staff team. We identified areas where procedures around checking sterilisation equipment were not in line with current guidelines. These were identified by the practice but no measures introduced to take action.

The practice had policies, procedures and risk assessments to support the management of the service and to protect patients and staff. However, these required review to reflect current guidance and practice. Staff we spoke with could not demonstrate that they fully understood or followed these.

There were limited arrangements to monitor the quality of the service and make improvements. Risk assessments were not carried out or were not reviewed regularly to minimise potential risks to patients and staff. There was a lack of oversight of potential risks. Where risks or actions had been identified, there were ineffective systems to monitor and mitigate these and to take remedial action.

Following the inspection the provider told us that policies would be reviewed and necessary risk assessments would be completed.

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

Leadership, openness and transparency

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

Staff told us that the principal dentist was open and transparent with them. They said that they were confident to raise any issues and that the principal was approachable and receptive to feedback.

The practice did not hold staff meetings and there were no systems in place to document or share information and learning; although staff told us that communication amongst staff was open.

Learning and improvement

The practice had limited quality assurance processes to encourage learning and continuous improvement. Audits in relation to monitoring of X-rays and infection prevention and control were absent and carried out infrequently respectively. Audits on conscious sedation procedures had not been undertaken. This was not in line with current guidance. Outstanding actions identified in the infection prevention and control audit were not completed. The practice had completed audits in implants and hand hygiene.

The principal dentist showed a commitment to learning; however this commitment did not extend to the staff team and to implementing systems required to support this.

Staff did not have appraisals although informal discussions around learning needs were held on an infrequent and informal basis.

Not all staff had mandatory training, including in medical emergencies and basic life support. The principal dentist had completed all necessary continuing professional development (CPD).The General Dental Council requires clinical staff to complete continuous professional development.

Are services well-led?

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

The practice had recently completed a patient satisfaction survey and used comment cards to obtain patients' views about the service. The practice had purchased higher chairs for the waiting room as a result of patient feedback.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Requirements in relation to staffing **How the regulation was not being met** The registered person had failed to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed in order to meet the requirements of fundamental standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **In particular:** • The principal dentist was not always supported by a GDC registered or appropriately trained dental care professional. • The service provider had failed to ensure that persons employed in the provision of a regulated activities received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. **In particular:** • Staff new to the practice did not have a period of induction. • Not all staff had received formal training in core topics such as medical emergencies, infection prevention and control and safeguarding. • Infection prevention and control training and associated staff supervision were ineffective as staff were not following national guidance while cleaning used dental instruments. • Inexperienced staff were required to line manage staff on a day to day basis without formal training themselves in procedures around infection prevention and control. • No annual appraisals were held. **Regulation 18 (1) (2)**

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Fit and proper persons employed **How the regulation was not being met** 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:** • Recruitment checks such as evidence of photographic identification, references, DBS checks and immunisation records were not available. **Regulation 19(3)**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users **How the regulation was not being met:** There were insufficient quantities of equipment to ensure the safety of service users and to meet their needs. **In particular:** • The practice did not have immediate access to an AED and no risk assessment was in place detailing how an AED would be accessed in a timely manner. • There was no assessment of the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. **In particular:** • Staff were not following recognised national guidance when disinfecting used dental instruments and handling and storing sterilised instruments. • Tests required to check that the ultrasonic cleaner was working effectively were not being carried out. • Dental unit water lines were not being adequately maintained. • The equipment being used to care for and treat service users was not safe for use. **In particular:** • Annual maintenance of the X-ray equipment was not being carried out. • Limited records were kept to show the periodic examinations of the autoclave.

This section is primarily information for the provider

Enforcement actions

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 Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

How the regulation was not being met

There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided.

In particular:

- Audits in relation to monitoring of X-rays were absent
- Outstanding actions identified in the infection prevention and control audit were not completed.
- The infection control audit had not been conducted in line with recognised national guidance.
- There were no systems or processes that enabled 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:

- Risk assessments such as those related to safe sharps, COSHH, lone working had not been conducted.
- Risks from lack of suitable recruitment processes had not been identified and mitigated.

This section is primarily information for the provider

Enforcement actions

- There were no systems or processes that enabled the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user.

In particular:

- The dental care records we checked showed that guidance was not being followed and risk assessments for patients' oral health were not being documented.
- Patients' medical histories were not being updated at appropriate intervals.

Regulation 17 (1)