East Finchley Smiles Limited

East Finchley Smiles

Inspection report

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Overall summary

We carried out this unannounced comprehensive inspection on 14 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:

- 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.
- Complaints were dealt with positively and efficiently.
- The dental clinic did not appear clean or well-maintained.

Summary of findings

- The practice infection control procedures did not reflect published guidance.
- Staff did not know how to deal with medical emergencies. Appropriate medicines and life-saving equipment were not available.
- The practice did not have systems to manage risks for patients, staff, equipment and the premises.
- Safeguarding processes were not in place and staff did not know their responsibilities for safeguarding vulnerable adults and children.
- The practice did not have suitable recruitment procedures to comply with current legislation.
- There was ineffective leadership and a lack of oversight of the day-to-day management of the service.
- There were ineffective systems to support continuous improvement.
- Patients were not asked for feedback about the services provided.
- The practice had information governance arrangements. Improvements were needed to the protocols for the use of closed-circuit television cameras.

Background

East Finchley Smiles is in the London Borough of Barnet 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, 3 associate dentists, 2 qualified dental nurses, 1 trainee dental nurse, 1 dental hygienist, 1 practice manager and 2 receptionists. The practice has 2 treatment rooms.

During the inspection we spoke with principal dentist, the practice manager, 1 qualified 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 Friday 9am to 5pm.

We identified regulations the provider was/is 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.

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?	**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.

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

The practice did not have effective safeguarding processes in place to prevent abuse of vulnerable adults and children. Internal safeguarding arrangements were not communicated effectively. One member of staff we spoke with was unaware of the safeguarding arrangements within the practice.

Information about current safeguarding procedures and guidance about raising concerns about abuse, were not accessible to people who used the service or to staff. The safeguarding flowchart was a blank template and did not include the contact details of the Local Authority`s safeguarding board.

On the day of the inspection there was no evidence that all members of staff completed safeguarding training at a level appropriate to their role and safeguarding training for 2 members of staff were out of date.

Following the inspection, the provider told us that updated safeguarding information had now been displayed in the decontamination room and the surgeries. In addition, staff were in the process of completing or retaking safeguarding training at a level appropriate to their role.

The practice infection control procedures did not reflect published guidance.

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

We observed that staff did not wear appropriate Personal Protective Equipment (PPE), including mask, domestic gloves and a disposable plastic apron while cleaning used dental instruments. The enzymatic solution used to disinfect instruments was not measured to ensure correct concentration of the solution was achieved as recommended by the manufacturer. Instruments were not fully immersed during the cleaning process to ensure aerosol risk was minimised. The long-handled brush used to scrub contaminated dental instruments was kept in a rusty and dirty box with other items, including sponges and wired brushes. There were no systems and processes to monitor the use of long-handled brushes. The temperature of the water for cleaning used dental instruments, was not monitored to ensure the temperature was 45C or lower. The staff member demonstrating the decontamination process told us that they only used the illuminated magnifying glass to check for residual contamination when they 'thought it was needed'. In addition, staff did not wash their hands before and after undertaking decontamination of used instruments.

There were no systems and processes in place to ensure the safe separation of instrument reprocessing from other activities by physical or temporal means. We observed a in the dirty zone in Surgery 2. In addition, we saw a food fridge and a microwave oven in the decontamination room, adjacent to the designated clean zone. We were not assured that staff had identified the risks arising from the preparation of food and drinks in areas otherwise used to clean dental instruments or dedicated as a dirty zone. We bought this to the provider`s attention and following the inspection they submitted photographic evidence that the kettle, food fridge and microwave oven had been removed.

Systems and processes to control the storage time of sterilised instruments were ineffective. We found a large number of undated sterilisation pouches, containing mouth mirrors, tweezers, pluggers and scissors. In addition, we found an open sterilisation pouch with exposed dental instruments, unwrapped high speed and slow handpieces, and unwrapped X-Ray film holders in the drawers in Surgery 2.

We noted that local anaesthetic cartridges were not stored in blister packs.

Are services safe?

The practice could not demonstrate that periodic safety checks, such as daily automatic control tests and weekly air leakage tests were carried out on the autoclave in line with the relevant guidance. The last test strip in the autoclave logbook was dated 12 June 2023. The practice manager told us that that they had implemented the use of a data logger however the printer and the USB stick did not work, and they were unable to access the data. We were not assured that there were systems in place to ensure periodic tests were carried out to demonstrate the equipment reached the required temperature and pressure parameters.

There was no evidence that periodic safety checks, including visual checks, protein residue tests, automatic control and cleaning efficacy tests, and annual validation were carried out on the ultrasonic bath in line with the manufacturer`s guidance or in the absence of this, in line with HTM01-05.

In addition, we observed a free-standing fan in Surgery 1 and Surgery 2. This was not in line with the guidelines set out in HTM01-05, which state that 'the use of free-standing or ceiling mounted fan units' was not recommended.

The provider could not demonstrate that all clinical staff, including those involved in the decontamination process undertook regular infection prevention and control training.

Following the inspection, the provider submitted evidence that they had arranged a practice meeting for 18 July 2023 to discuss the feedback from the inspection and reinforce staff understanding of the current infection prevention and control guidelines. In addition, relevant members of staff had been given until 24 July 2023 to complete infection prevention and control training.

The provider further informed us that all unwrapped dental instruments had been sterilised and wrapped and dated, and those contained in undated sterilisation pouches had been reprocessed and dated.

The practice reassured us that autoclave test strips had been ordered and moving forward, periodic safety checks such as daily automatic control tests and weekly air leakage tests would be carried out on the autoclave in line with the relevant guidance. The ultrasonic bath had been taken out of use and decommissioned.

The practice did not have effective systems to reduce the risk of Legionella and other bacteria developing in the water system.

A legionella risk assessment dated 29 April 2021 was made available for review. This made a number of recommendations, including – 'the implementation of the policy and scheme for precautions provided, the nomination of the duty holder or responsible person in writing, the implementation of record keeping (including results of control measures, system diagrams), training in Legionella for all staff involved in Legionella management, ensuring that the dead leg pipework is cut back and the descaling of scaled fittings'. The provider could not demonstrate that the recommendations made in the Legionella risk assessment had been acted upon or that the risk assessment had been reviewed at all or on a regular basis.

We observed heavy scale deposits on the taps in the decontamination room and in Surgery 2.

Staff we spoke with were not aware of the current guidance in relation to the management of Dental Unit Water Lines (DUWLs). When asked about the management of DUWLs in the practice, a member of staff said they would use 'biofilm to flush 15 minutes at the start of the day and biofilm at the end of the day'. This was not in line with HTM01-05 which states that DUWLs should be disinfected periodically in accordance with the manufacturer`s instructions to remove biofilm and flushed for at least two minutes at the beginning and the end of the day and for at least 20-30 seconds between patients.

Following the inspection, the provider told us that they had nominated a Legionella duty holder who would undertake Legionella training by 24 July 2023. In addition, they had implemented systems to ensure the temperature of hot and cold water outlets were monitored.

Are services safe?

The practice did not ensure that clinical waste was managed in line with the current guidance. One of the outside clinical waste bins was not secure and not locked. This was stored in an area that was accessible to the public, including private tenants occupying the first floor of the building. Yellow sharps bins were not labelled or dated. The practice did not have an amalgam separator connected to the suction unit in Surgery 2. This meant amalgam particles were not removed from the wastewater which would reduce the amount of amalgam entering the sewage system.

Following the inspection, the provider told us that sharps boxes had now been dated and labelled.

We observed that the premises were visibly dirty with high level of dust and soiled work surfaces in the decontamination room. In addition, we saw cobwebs on the ventilation fan and the light sockets and dead insects on the emergency lights. We noted that the upholstery on the dental chair in Surgery 2 was ripped. The practice did not have colour coded buckets and mops to reduce cross contamination between the clinical area, toilets and waiting area. There were no cleaning schedules in place to ensure the effectiveness of cleaning.

Following the inspection, the provider told us that they had arranged an induction for the cleaner to reinforce their understanding of the guidelines about environmental cleaning, and a deep clean of the premises had been booked for 18 July 2023.

The practice recruitment policy and procedure to help them employ suitable staff did not reflect the relevant legislation. We looked at 11 staff recruitment records. We noted that 3 members of staff did not have the required Disclosure and Barring Service (DBS) check on record. There was no evidence that the provider had undertaken checks of satisfactory conduct in previous employment for 6 members of staff. One member of staff did not have evidence of antibody blood tests to indicate their immunity to Hepatitis B. We noted that the required recruitment information was available for the 2 most recently appointed members of staff. This reflected the improved recruitment processes the practice manager was in the process of implementing.

Following the inspection, the provider submitted the missing Hepatitis B antibody test result and evidence of checks of satisfactory conduct in previous employment (references) for 1 member of staff.

Clinical staff were qualified, registered with the General Dental Council. On the day of inspection 3 indemnity certificates on record were out of date.

The practice ensured the autoclave was safe to use, maintained and serviced according to manufacturers' instructions. Improvements were needed to ensure the compressor was inspected in accordance with the relevant regulations. Records indicated that the last compressor servicing took place on 2 October 2020 and the servicing document stated that compressor should not be used without further testing. However, the compressor had continued to be used and was still in use. In addition, the practice did not have systems in place to ensure portable appliances were safe to use. The last portable appliance testing had been undertaken on 28 September 2020; however, the provider could not demonstrate that all portable appliances currently in use had been tested at that time.

Following the inspection, the provider submitted evidence that the compressor had been serviced on 18 July 2023 and informed us that in line with the recommendations of the servicing report, they were in the process of having a new compressor installed.

The provider did not have systems in place to ensure the premises were safe. Electrical installation condition tests had not been carried out.

The management of fire safety was ineffective. A fire risk assessment dated 25 September 2020 was made available for review. This made a number of recommendations, including ceiling tiles to be replaced within 2-6 months of the assessment. There was no evidence that this recommendation had been actioned within the given timeframe. In

addition, the fire risk assessment recommended that new fire extinguishers were required within 8 weeks of the assessment. The practice manager was unsure if this referred to fire extinguishers in addition to the existing ones in the practice or the replacement of them. Further, the provider could not demonstrate that the fire risk assessment had been reviewed at all or on a regular basis by a competent person.

We further noted that the fire risk assessment was not reflective of the arrangements in the practice. For example, it stated that staff were given periodic refresher training annually, fire drills were carried out, weekly testing and periodic servicing of the fire detection systems were undertaken, and monthly and annual testing of the emergency lighting were carried out. None of these statements were substantiated by our findings on the day of the inspection. There were no records of fire drills, no evidence that the fire alarm system or the emergency lighting had been serviced or that periodic in-house checks of the fire safety equipment were carried out. This meant that the fire risk assessment dated 25 September 2020 was no longer suitable to identify the level of risk at the practice.

Following the inspection, the provider told us that they had arranged for a fire risk assessment and servicing of the fire detection system on 17 July 2023 and portable appliance testing for 19 July 2023.

The arrangements to ensure the safety of the X-ray equipment were ineffective and the required radiation protection information was not available. The practice had 2 intraoral X-Ray units. On the day of the inspection, only one equipment performance report was available for review, however the serial number on the document did not match the serial numbers on either of the intraoral units in the practice. Following the inspection, the provider contacted the company that undertook the test and they received confirmation that both intraoral units had received performance testing on 5 October 2020 and the discrepancy in the serial numbers was due to human error.

There was no evidence that a Radiation Protection Advisor had been appointed and consulted regarding the layout of the dental radiography facilities, including required structural protection, safety and warning devices and the required control measures in line with a risk assessment.

There was no evidence that a radiation risk assessment identifying the procedural controls required to restrict exposure had been undertaken. The practice did not have adequate and up-to-date local rules communicating the main working instructions intended to restrict any exposures arising from being in the controlled area. The local rules displayed in Surgery 1 and 2 referred to operators who no longer worked at the practice and they did not consider location specific arrangements. For example, the local rules displayed in Surgery 2 did not consider that those working in the decontamination room might be within the controlled zone or in close proximity of the intraoral unit located in Surgery 2.

In addition, the provider could not demonstrate that they had registered their work with a radiation generator with the Health and Safety Executive.

Risks to patients

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

The practice could not demonstrate that they had taken reasonable steps to reduce the risk of sharps injuries in line with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The practice had not substituted traditional medical sharps with a 'safer sharp' system, which includes incorporating mechanisms to minimise the risk of accidental injury.

The sharps risk assessment dated 16 March 2023 was not reflective of the arrangements within the service. For example, it stated that 'Needle blocks are provided to remove and hold the needle cap and allow safe one-handed recapping'. We noted that the practice did not have needle blocks. In addition, the sharps risk assessment stated that 'Safer sharp needles are to be used and disposed of only by the administering clinician'. However, we noted that the practice did not

use safer sharp needles, there was no sharps box in Surgery 2 and the practice manager told us that dental nurses disposed of contaminated needles in the sharps box located in the decontamination room. A sharps injury policy including the process in case of an accidental sharps injury and the contact details of the local Accident and Emergency department was not made available to staff.

Following the inspection, the provider told us that they had ordered needle guards and displayed an updated sharps flowchart with the relevant contact details in the surgeries and the decontamination room.

The practice manager told us that the cleaner and the dental hygienist worked alone. The practice did not have arrangements in place to identify and mitigate the risks arising from staff working alone.

Medical emergency drugs and equipment were not available in line with the guidance issued by the British National Formulary and the Resuscitation Council (UK). The medical emergency kit did not include a spacer device for inhaled bronchodilators, oral glucose, suitable Buccolam (a medicine used to treat epileptic seizures), an adult self-inflating bag with reservoir or portable suction. Glucagon (the emergency medicine used to treat severe low blood sugar) was stored in the fridge, but the fridge thermometer did not work and there were no systems in place to monitor the fridge temperature. Therefore, we did not have assurance that the glucagon had been stored correctly. There was no evidence that the oxygen cylinder received servicing.

Following the inspection, the provider submitted evidence that they had purchased Buccolam suitable for use on adults. The provider further informed us that they had placed an order for the spacer device and oral glucose.

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

Following the inspection, the provider submitted evidence that a medical emergency checklist had been implemented.

Staff did not know how to respond to a medical emergency and there was no evidence that all members of staff had completed training in emergency resuscitation and basic life support every year. When asked, staff were not comfortable using the oxygen cylinder and were unable to select the correct mask to connect to the oxygen cylinder.

Following the inspection the provider told us that staff had been given a deadline of 24 July 2023 to complete outstanding and out of date emergency resuscitation and basic life support training.

The provider could not demonstrate that they carried out risk assessments for all hazardous materials used within the practice as per Control of Substances Hazardous to Health Regulations 2002 (COSHH). Some of the risk assessment available for review were not reflective of the service as they referred to materials, including nitrous oxide and X-ray developer, which the practice did not use. In addition, staff did not have access to the relevant safety data sheets of all hazardous materials used in the service.

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 did not have systems for the appropriate and safe handling of medicines. We found expired dental materials in Surgery 2. This included fast acting cement which expired in December 2022 and April 2021 and alveolar dressing which expired in May 2023.

Are services safe?

NHS prescription pads were not stored securely, and the practice did not have systems in place to monitor prescription pads to ensure missing prescriptions can be identified. Antimicrobial prescribing audits were not carried out.

Following the inspection the provider told us that the NHS prescription pad had now been locked away and they had updated the prescription log to assist with identifying missing prescriptions.

Track record on safety, and lessons learned and improvements

The practice did not have effective systems to review and investigate incidents and accidents.

The practice manager told us that a member of staff suffered a needle stick injury while handling contaminated sharps in March 2022 and subsequently they had been referred for blood tests to a local hospital. There were no records of this accident in the accident book, and we were not provided evidence that information about this sharps injury had been shared with staff to promote learning and to reduce the risk of the same accident happening again.

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

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

The practice had systems to keep dental professionals up to date with current evidence-based 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. Improvements were needed to ensure all clinical staff completed training in 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, graded and reported on the radiographs they took. Improvements were needed to ensure the practice carried out radiography audits on a six-monthly basis following current guidance.

Effective staffing

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

Newly appointed staff did not have a structured induction and some members of staff were not up to date with their medical emergency, infection control and safeguarding training.

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.

Privacy and dignity

Staff were aware of the importance of privacy and confidentiality.

The practice had installed closed-circuit television to improve security for patients and staff. Improvements were needed to ensure the relevant policies and protocols were in place. The practice did not have CCTV signage to inform people about the presence of CCTV cameras.

The CCTV Policy was a blank template and did not reflect the arrangements within the service. For example, it referred to external and internal signage and a practice leaflet. We noted that the practice did not have CCTV signage and a member of staff told us that the practice did not have a patient leaflet. In addition, the policy stated that *'the system has / has not an automatic back up'.* Based on the policy it was not clear if they had an automatic back up.

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

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, study models, videos, X-ray images and 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 disabled toilet, 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 Enforcement Actions section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

Leadership capacity and capability

We found that there was ineffective leadership which impacted on the practice`s ability to deliver safe, high-quality care. The principal dentist, who was also the registered manager, did not have sufficient oversight of the day to day activities of the practice.

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.

Following the inspection the provider submitted evidence that the most recently appointed member of staff had now received an induction, covering various topics, including practice rules, confidentiality, safeguarding, training and personal development.

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 during 1 to 1 meetings or clinical supervision had been discussed.

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. Training certificates were stored in multiple places, including emails, hard copies and in a compliance portal. The system in place was therefore not effective to identify if a staff member was or was not up to date with their required training. We noted that not all members of staff had completed training in the Mental Capacity Act 2005, and some members of staff were not up to date with their medical emergency, infection control and safeguarding training. The practice was unaware of this.

The practice manager told us that they were in the process of uploading recruitment documents and training certificates to their compliance portal.

The supervision and monitoring of staff working in the service was not effective, in that the provider did not identify gaps in staff`s knowledge in the areas of the management of medical emergencies, infection prevention and control and safeguarding.

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. We were not assured that the fire and legionella risk assessments had been regularly reviewed by a competent person.

Are services well-led?

A health and safety risk assessment dated 16 March 2022 was made available for review. The document stated that current precautions and infection prevention guidelines were followed, regular training in infection control was provided to staff, the compressor was serviced no later than every 26 months, fire drills were carried out twice a year, an RPA was appointed, and thick household gloves were provided for the decontamination process. None of these statements was substantiated during our inspection. We found that the health and safety risk assessment was not reflective of the arrangement within the service, and it was not suitable to identify hazards and appropriate control measures.

The practice manager told us that they were in the process of updating practice policies and procedures in the compliance portal and moving forward, all members of staff would be given access to the updated policies.

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

Appropriate and accurate information

Staff did not act on appropriate and accurate information. For example, the safeguarding flowchart was a blank template and did not include details of the Local Authority safeguarding board or other location specific information about raising concerns. A practice specific sharps procedure and the relevant contact details in case of an accidental sharps injury had not been made available to staff. Safety data sheets of all hazardous materials and COSHH risk assessments were not accessible to staff. In addition, we were not assured that results of the most recent fire and legionella risk assessments had been shared and reviewed by the practice manager. Further the practice manager told us that the practice currently did not have regular staff meetings and they did not discuss medical emergency scenarios to practise location specific medical emergency procedures.

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

The practice could not demonstrate that they were actively seeking the views of people who used the service about their experience. We asked if the practice had systems in place to gather feedback from patients. The practice manager told us that service users were encouraged to leave Google reviews, however there was no evidence that all service users, including those who did not have access to the internet had an opportunity to provide feedback about their experience.

A staff member we spoke with told us that they were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on where appropriate.

Continuous improvement and innovation

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

There was no evidence that infection prevention and control audits, radiography audits, record card audits or antimicrobial prescription audits had been carried out in line with the relevant national guidance.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: • The decontamination process demonstrated by staff did not reflect the Department of Health publication 'Health Technical Memorandum 01-05: Decontamination in primary dental practices' (HTM01-05). • The provider could not demonstrate that all clinical staff, including those involved in the decontamination process undertook regular infection prevention and control training. • There were no systems and processes in place to ensure the separation of instrument decontamination from other activities by physical or temporal means. • Systems and processes in place to control the storage time of sterilised instruments were ineffective. • The provider could not demonstrate that periodic safety checks, such as daily automatic control tests and weekly air leakage tests were carried out on the autoclave in line with the relevant guidance. • The provider could not demonstrate that periodic safety checks were carried out on the ultrasonic bath in line with the relevant guidance. • Work surfaces in the decontamination room were visibly dirty.

This section is primarily information for the provider

Enforcement actions

- Surfaces in the clinical area were not impervious and not easily cleanable.
- We observed a free-standing fan in Surgery 1 and Surgery 2.
- Systems and processes in place to reduce the risk of Legionella and other bacteria developing in the water system were not effective.
- Clinical waste was not managed in line with the current guidance.
- The practice did not have colour coded buckets and mops to reduce cross contamination between the clinical area, toilets and the waiting area.
- An electrical installation condition report had not been carried out.
- The provider did not have systems in place to ensure portable appliances were safe to use.
- The compressor was last serviced on 2 October 2020 and the servicing certificate stated that the compressor should not be used without further testing after 2 October 2022.
- Systems and processes in place to reduce the risk of fire were not effective.
- Recommendations made in the fire risk assessment dated 25 September 2020 had not been acted upon.
- The provider could not demonstrate that the fire risk assessment had been regularly reviewed by a competent person.
- There was no evidence that fire drills were carried out.
- There was no record of emergency lighting servicing.
- The fire alarm was last serviced in September 2020.
- Periodic in-house checks of the fire safety equipment were not carried out.

This section is primarily information for the provider

Enforcement actions

- Medical emergency drugs and equipment were not available as per current national guidance.
- The practice did not check the medical emergency drugs and equipment at least weekly as set out in the relevant guidance published by the Resuscitation Council (UK).
- Staff failed to demonstrate an understanding of how to manage medical emergencies.
- 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.
- Risks from sharps injuries were not adequately assessed and the provider did not have appropriate control measures in place.
- The provider did not have effective systems in place to ensure that dental materials were not used beyond their expiry date.
- The provider did not have systems in place to monitor prescription pads to ensure missing prescriptions can be identified and NHS prescription pads were not stored securely.
- The provider failed to ensure that incidents and accidents were reported internally and information about these were shared with staff to promote learning.
- Staff were not aware of the most recent recalls and rapid response reports relevant to the service issued by the Medicines and Healthcare products Regulatory Agency (MHRA).

Regulation 12 (1)

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

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

The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:

- Systems and professes to ensure the safe use of radiography were ineffective.
- The practice did not undertake a radiation risk assessment identifying the procedural controls required to restrict exposure.
- The provider could not demonstrate that they had appointed and consulted a Radiation Protection Advisor (RPA) about the location-based arrangements.
- The provider had not notified the Health and Safety Executive (HSE) about the use of ionising radiation at the practice.
- The provider failed to assess, monitor and mitigate the risks relating to staff working alone.
- The health and safety risk assessment was not reflective of the arrangement within the service, and it was not suitable to identify hazards and appropriate control measures.
- The provider could not demonstrate that they carried out risk assessments for all hazardous materials used within the practice as per Control of Substances Hazardous to Health Regulations 2002 (COSHH). Staff did not have access to the relevant safety data sheets of all hazardous materials used in the service.

This section is primarily information for the provider

Enforcement actions

- The practice did not have adequate systems in place for identifying, assessing and mitigating risks in areas such as recruitment of staff, Legionella, fire safety, infection control and medical emergencies.

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

- Radiography audits had not been undertaken.
- Infection prevention and control audits had not been carried out.
- The practice could not demonstrate that they were actively seeking the views of people who used the service about their experience.
- There was no evidence that staff had received an induction at the start of their employment to prepare them for their new role.
- Systems and processes in place to monitor staff training was ineffective.
- The supervision and monitoring of staff working in the service were not effective in that the provider did not identify the gaps in staff`s knowledge.
- The provider did not have effective communication systems to ensure that people working within the service received up to date information about policies, procedures and results of reviews about the quality and safety of the service and any actions required following the review.

The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to maintain securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity or activities. In particular:

- Not all members of staff had the required level of Disclosure and Barring Service (DBS) checks on record.

This section is primarily information for the provider

Enforcement actions

- The provider could not demonstrate that they had undertaken checks of satisfactory conduct in previous employment for new members of staff at the point of employment.
- Some of the clinical staff indemnity certificates and professional registration certificates on file were out of date.

The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to maintain securely such records as are necessary to be kept in relation to the management of the regulated activity or activities. In particular:

- The safeguarding flowchart was a blank template and did not include the details of the Local Authority safeguarding board and other location specific information about raising concerns.
- The practice did not have Closed Circuit Television (CCTV) signage to inform people about the presence of CCTV cameras.
- The CCTV Policy was a blank template and did not reflect the arrangements within the service.
- The practice did not have a sharps injury policy with details of the relevant internal procedures and the contact details of the local Accident and Emergency Department staff could refer to in case of a sharps injury.

Regulation 17 (1)