Revive Dental Care Limited

Revive Dental Care - Manchester city centre

Inspection Report

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Overall summary

We carried out this announced inspection on 17 September 2018 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.

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 providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this practice was 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

Revive Dental Care - Manchester city centre is in Salford and provides NHS and private treatment to adults and children.

Summary of findings

Due to the nature of the premises wheelchair access is not possible. Car parking spaces are available near the practice.

The dental team includes three dentists, three dental nurses (two of whom are trainees), one receptionist and a practice manager. The practice has three treatment rooms.

The practice is owned by a company and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at Revive Dental Care - Manchester city centre had recently left the organisation and the practice manager was in the process of applying to be the registered manager.

On the day of inspection, we collected 24 CQC comment cards filled in by patients.

During the inspection we spoke with two dentists, one dental nurse, the receptionist and the practice manager. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday to Friday from 9:00am to 5:00pm

Our key findings were:

- The practice appeared clean and well maintained.
- The provider had infection control procedures which reflected published guidance.
- Staff knew how to deal with emergencies. Not all equipment to deal with medical emergencies was available.
- The practice had some systems to help them manage risk to patients and staff. A Legionella risk assessment had not been completed and recommendations from maintenance reports of X-ray equipment had not been acted on.
- The practice had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children. Not all staff had completed safeguarding training.
- Staff were qualified for their roles. The recruitment process could be improved.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The provider was providing preventive care and supporting patients to ensure better oral health.
- The appointment system met patients' needs.
- The practice asked patients for feedback about the services they provided.
- The provider dealt with complaints positively and efficiently. Storage of documents relating to patient complaints could be improved.

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

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

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

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

- Review staff training to ensure that all the staff have received training, to an appropriate level, in the safeguarding of children and vulnerable adults.
- Review the security of NHS prescription pads in the practice and ensure there are systems in place to track and monitor their use.

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?

No action

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

The practice had systems and processes to provide safe care and treatment. They used learning from incidents and complaints to help them improve.

The dentists and practice manager had received training in safeguarding. The qualified dental nurse and receptionist had not completed safeguarding training. The trainee dental nurses who had started in the last 12 months had covered safeguarding as part of their induction. Staff knew about the signs and symptoms of abuse and what to do if they had concerns.

Staff were qualified for their roles. Improvements could be made to the process for obtaining Disclosure and Barring Service (DBS) checks.

The practice followed national guidance for cleaning, sterilising and storing dental instruments. We noted some instruments had debris on them.

Staff had completed training in how to deal with medical emergencies. Not all medical emergency equipment was available as described in recognised guidance.

Are services effective?

No action

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

The dentists assessed patients' needs and provided care and treatment in line with recognised guidance. Patients described the treatment they received as professional, brilliant and excellent. The dentists discussed treatment with patients so they could give informed consent and recorded this in their records.

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

The practice supported staff to complete training relevant to their roles and had systems to help them monitor this.

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 24 people. Patients were positive about all aspects of the service the practice provided. They told us staff were friendly, warm and welcoming.

Summary of findings

They said that they were given clear advice about treatments and said their dentist listened to them. 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. Due to the nature of the premises wheelchair access was not possible. The practice had access to interpreter services.

The practice took patients views seriously. They valued compliments from patients and responded to concerns and complaints quickly and constructively.

Are services well-led?

Requirements notice

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 Requirement Notices section at the end of this report).

The practice had some arrangements to ensure the smooth running of the service. Improvements could be made to some of the arrangements. For example, a legionella risk assessment had not been completed, DBS checks were not sought at the point of employment, the medical emergency equipment did not reflect recognised guidance and actions highlighted in the routine test of the X-ray equipment had not been actioned. The process for the storage of records relating to patients' complaints could be improved.

The practice team kept complete patient dental care records which were typed and stored securely.

The practice monitored clinical and non-clinical areas of their work to help them improve and learn. Improvements could be made to the process for carrying out the radiography audit.

The provider had a process to ask for and listen to the views of patients.

Are services safe?

Our findings

Safety systems and processes, including staff recruitment, Equipment & premises and Radiography (X-rays)

The practice had some systems to keep patients safe.

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The practice had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC. We noted that only the dentists and practice manager had completed safeguarding training. The receptionist and qualified dental nurse had not completed safeguarding training. The two trainee dental nurses had covered safeguarding as part of their induction.

There was a system to highlight vulnerable patients on records e.g. children with child protection plans, adults where there were safeguarding concerns, people with a learning disability or a mental health condition, or who require other support such as with mobility or communication.

The practice had a whistleblowing policy. Staff felt confident they could raise concerns without fear of recrimination.

The dentists used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment.

The provider had a business continuity plan describing how they would deal with events that could disrupt the normal running of the practice.

The practice had a recruitment procedure which consisted of a checklist that was completed for each newly recruited member of staff. This checklist included photo identification, references, qualification certificate, registration with the GDC, medical indemnity and a DBS check. We looked at five staff recruitment records. We noted the DBS checks for the dentists and the qualified dental nurse were more than three months old at the point of employment. In addition, they were awaiting DBS checks for the trainee nurses. There was no risk assessment in place to mitigate the risks of staff working without a DBS check, or whether an updated check was needed.

We noted that clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover.

The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions, including electrical and gas appliances.

Records showed that fire detection equipment, such as smoke detectors and emergency lighting, were regularly tested and firefighting equipment, such as fire extinguishers, were regularly serviced.

The practice had some arrangements to ensure the safety of the X-ray equipment. The practice held a radiation protection file which contained details of the service history of the X-ray machines. We saw the routine tests of the X-ray machines. The most recent routine tests for all three X-ray machines had identified the dose was too high and should be adjusted. We asked if they were aware of the recommendations or whether the dose had been adjusted. Staff were unable to demonstrate that the dose had been adjusted or whether any advice had been sought in relation to this.

We saw evidence that the dentists justified, graded and reported on the radiographs they took. The practice carried out radiography audits every year following current guidance and legislation. We noted these audits were not practitioner specific. Therefore, any issues with individual practitioners would not be picked up.

Clinical staff completed continuing professional development (CPD) in respect of dental radiography.

Risks to patients

There were some systems to assess, monitor and manage risks to patient safety.

The practice's health and safety policies, procedures and risk assessments were up to date and reviewed regularly to help manage potential risk. The practice had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. A sharps risk assessment had been

Are services safe?

undertaken and was updated annually. This stated that needles should not be re-sheathed and in the event a needle needs to be re-sheathed a safety device should be used. We asked to see any re-sheathing devices. Staff confirmed that there were none within the practice. In addition, the risk assessment did not cover the risks associated with the dismantling of matrix bands.

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus. We noted there was no evidence of the effectiveness of the vaccination for one dentist and the two trainee dental nurses had yet to finish their courses of vaccinations. There was no risk assessment in place for the dentist whose immunity was unknown.

Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support (BLS) every year.

We noted that not all emergency resuscitation equipment was available as described in recognised guidance. There was no adult or child sized self-inflating bags, portable suction device or size 0 and 4 oropharyngeal airways. In addition, the reservoir and tubing for the adult and child oxygen masks was out of date. We looked at the emergency medicines available. We saw three adrenaline autoinjectors. There was one for an adult, one for a child and one for an infant. There were no supplemental doses of adrenaline. This had not been risk assessed. We were later told that additional doses of adrenaline had been ordered.

A dental nurse worked with the dentists when they treated patients in line with GDC Standards for the Dental Team.

The provider had suitable risk assessments to minimise the risk that can be caused from substances that are hazardous to health.

The practice had an infection prevention and control policy and procedures. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health and Social Care. Staff completed infection prevention and control training and received updates as required.

The practice had suitable arrangements for cleaning, sterilising and storing instruments in line with HTM01-05.

The records showed equipment used by staff for cleaning and sterilising instruments were validated, maintained and used in line with the manufacturers' guidance. We asked if boxes were used to transport clean instruments back to the surgeries. They did not have any clean boxes. During the inspection we noted two mixing spatulas and another dental instrument had visible debris on them. In addition, the mixing spatulas were not bagged as per guidance in HTM01-05. This issue was brought to the attention of the practice manager who advised us that action would be taken to address this.

In one surgery we saw some root canal files. These were being stored for when the patient retuned for a second visit. These root canal files are single use and guidance in HTM01-05 states that they should not be reprocessed to be used at another visit even on the same patient. The practice manager told us that they had spoken to the dentist in question about this previously.

In two surgeries we noted they used spittoon funnels for patients to spit out in after treatment. These were autoclavable. We asked staff if these were sterilised after each patient. We were told they were not but were wiped with disinfectant wipes.

The practice had in place systems and protocols to ensure that any dental laboratory work was disinfected prior to being sent to a dental laboratory and before the dental laboratory work was fitted in a patient's mouth.

A Legionella risk assessment had not been completed. We were told one was due to be done the week prior to the inspection. On the day of inspection, a Legionella risk assessment was carried out. Staff carried out processes to reduce the likelihood of Legionella developing in the water lines such as the use of a water conditioning agent and regular flushing of the dental water lines.

We saw cleaning schedules for the premises. The practice was clean when we inspected and patients confirmed that this was usual.

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

The practice carried out infection prevention and control audits twice a year. The latest audit showed the practice was meeting the required standards.

Information to deliver safe care and treatment

Are services safe?

Staff had the information they needed to deliver safe care and treatment to patients.

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at a sample of dental care records to confirm our findings and noted that individual records were written and managed in a way that kept patients safe. Dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation (GDPR) requirements.

Patient referrals to other service providers contained specific information which allowed appropriate and timely referrals in line with practice protocols and current guidance.

Safe and appropriate use of medicines

There was a suitable stock control system of medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required.

The practice did not store NHS prescription pads securely. These were not locked away at night. We discussed this with the practice manager who advised us that they would be securely locked away when not in use. There was no system in place to monitor the use of prescriptions within the practice.

The dentists were aware of current guidance with regards to prescribing medicines.

Track record on safety

The practice had a good safety record.

There were comprehensive risk assessments in relation to safety issues. The practice monitored and reviewed incidents. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements. In the previous 12 months there had been no safety incidents.

Lessons learned and improvements

The practice learned and made improvements when things went wrong.

The staff were aware of the process for reporting significant events and recorded, responded to and discussed all incidents to reduce risk and support future learning in line with the framework.

There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons identified themes and took action to improve safety in the practice. Learning from incidents and accidents were shared with other practices in the organisation.

There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The practice had systems to keep dental practitioners up to date with current evidence-based practice. We saw that clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

Helping patients to live healthier lives

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

The dentists prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for children based on an assessment of the risk of tooth decay.

The dentists where applicable, discussed smoking, alcohol consumption and diet with patients during appointments. The dentists directed patients to their GP for further advice about smoking cessation if they wished. The practice had a selection of dental products for sale and provided health promotion leaflets to help patients with their oral health.

The dentists described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition

Patients with more severe gum disease were recalled at more frequent intervals to review their compliance and to reinforce home care preventative advice.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentists 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.

The practice did not have a formal consent policy. The dentists understood their responsibilities under the Mental Capacity Act 2005 when treating adults who may not be able to make informed decisions. They also understood the principals of Gillick competence, by which a child under the age of 16 years of age can give consent for themselves.

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 dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dentists assessed patients' treatment needs in line with recognised guidance.

We saw the practice audited patients' dental care records to check that the dentists recorded the necessary information.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

Staff new to the practice had a period of induction based on a structured programme.

Staff discussed their training needs at appraisals. We saw evidence of completed appraisals and how the practice addressed the training requirements of staff.

Co-ordinating care and treatment

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

Dentists confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide.

The practice had systems to identify, manage, follow up and where required refer patients for specialist care when presenting with bacterial infections.

The practice also had systems for 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 all referrals to make sure they were dealt with promptly.

Are services caring?

Our findings

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

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

Patients commented positively that staff were friendly, warm and welcoming. We saw that staff treated patients with dignity and respect and were friendly towards patients at the reception desk and over the telephone.

Patients said staff were compassionate and understanding and they told us they could choose whether they saw a male or female dentist.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting areas provided some privacy when reception staff were dealing with patients. If a patient asked for more privacy they would take them into another room. The reception computer screens were not visible to patients and staff did not leave patients' personal information where other patients might see it.

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 be involved in decisions about their care and were aware of the

Accessible Information Standards and the requirements under the Equality Act. The Accessible Information Standard is a requirement to make sure that patients and their carers can access and understand the information they are given. Interpretation services were available for patients who did not have English as a first language.

The practice gave patients clear information to help them make informed choices about their treatment. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. The dentists 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.

The dentists described to us the methods they used to help patients understand treatment options discussed. These included for example X-ray images and models.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

Staff were clear on the importance of emotional support needed by patients when delivering care.

For example, staff told us about a patient who had a phobia of a certain colour of glove. As a result, they used different coloured gloves for this patient.

Patients described high levels of satisfaction with the responsive service provided by the practice.

Due to the nature of the practice wheelchair access would not be possible. We were told that any patients who could not access the practice would be signposted to a fully accessible practice.

The practice sent text message reminders to patient two days prior to their appointment. In addition, they received an e-mail when their appointment was booked.

Timely access to services

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

The practice displayed its opening hours in the premises, and included it in their information leaflet and on their website.

The practice had an efficient appointment system to respond to patients' needs. Patients who requested an urgent appointment were seen the same day. Patients 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.

Patients requiring emergency dental treatment outside normal working hours were signposted to the NHS 111 out of hour's service.

The practices' website and 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 and were rarely kept waiting for their appointment.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

The practice had a policy providing guidance to staff on how to handle a complaint. The policy was held behind the reception desk and a patient would have to ask the receptionist for the policy. We discussed the need to display the policy where patients can see it.

The practice manager was responsible for dealing with these. Staff would tell the practice manager about any formal or informal comments or concerns straight away so patients received a quick response.

The practice manager aimed to settle complaints in-house. 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 last 12 months. These showed the practice responded to concerns appropriately and discussed outcomes with staff to share learning and improve the service. Recently they had been advised to keep all records relating to a patient's complaint in their dental care records. This is not in line with the General Dental Council professional standards.

Are services well-led?

Our findings

Leadership capacity and capability

Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.

Culture

The practice had a culture of high-quality sustainable care.

Staff stated they felt respected, supported and valued. They were proud to work in the practice.

The practice focused on the needs of patients.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Staff were aware of and there were systems in place to ensure compliance with the requirements of the Duty of Candour.

Staff were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.

Governance and management

The practice owner had overall responsibility for the management and clinical leadership of the practice. The practice manager was responsible for the day to day running of the service. Staff knew the management arrangements and their roles and responsibilities.

The provider had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff and were reviewed on a regular basis. We noted there were not policies relating to the safe recruitment of staff or consent.

Improvements could be made to some systems and processes to ensure risks were appropriately managed. For example:

- The process for ensuring medical emergency equipment was in line with recognised guidance was not effective. In addition, the risk associated with only having one dose of adrenaline for each age group had not been fully risk assessed.
- The process for ensuring recommendations made in the routine test of the X-ray machines were actioned was not effective. The most recent routine tests for the X-ray machines had identified that the doses were higher than they should be. No action had been taken or further advice sought as a result.
- A Legionella risk assessment had not been completed and staff were not aware of the need to carry out monthly water temperature testing.
- The recruitment process was not wholly effective. A valid DBS check was not sought at the point of employment and no risk assessments were in place for when a staff member had commenced employment and were awaiting the DBS check. In addition, there was no evidence of immunity to the Hepatitis B virus for one dentist and no risk assessment for them.
- Records relating to patient complaints were stored in their dental care records. These records should be separate from the patients' dental care records so that patients are not discouraged from making a complaint.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.

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

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

The practice used patient surveys to obtain patients' views about the service. We saw examples of suggestions from patients the practice had acted on. These included updating the phone line to make it easier for patients to get through on the phone.

Patients were encouraged to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on NHS services they have used. The latest results showed that 100% of patients would recommend the service to friends and family.

Are services well-led?

The practice gathered feedback from staff through meetings and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

The practice had quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, radiographs and infection prevention and control. They had clear records of the results of these audits and the resulting action plans and improvements. We noted the radiography audit was not clinician specific. It was a random, retrospective audit of 20 radiographs taken by all clinicians. Therefore, it would not be possible to identify any individuals whose radiographs were not of sufficient quality.

The principal dentist showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff.

The whole staff team had appraisals. They discussed learning needs, general wellbeing and aims for future professional development. We saw evidence of completed appraisals in the staff folders.

Staff completed 'highly recommended' training as per General Dental Council professional standards. This included undertaking medical emergencies and basic life support training annually.

The General Dental Council also requires clinical staff to complete continuing professional development. The practice provided support and encouragement for them to do so. The principal dentist paid for staff to access an on-line training provider.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 12** Care and treatment must be provided in a safe way for service users **How the regulation was not being met:** The registered persons 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 provider failed to ensure a valid DBS check was sought at the point of employment and no risk assessments were in place for when a staff member had commenced employment and were awaiting the DBS check. In addition, there was no evidence of immunity to the Hepatitis B virus for one dentist and no risk assessment in relation to this. There were insufficient quantities of medicines to ensure the safety of service users and to meet their needs. In particular: • There were no supplementary doses of adrenaline to treat patients in the event of an anaphylactic reaction and no risk assessment to mitigate the risks associated with this. 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: • Single use root canal files were reprocessed and retained for subsequent visits.

This section is primarily information for the provider

Requirement notices

There was additional evidence that safe care and treatment was not being provided. In particular:

- Recommendations made in the routine testing of the X-ray machines had not been actioned.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 17 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 mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • A Legionella risk assessment had not been carried out until the day of inspection. The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • The process for ensuring recommendations made in the routine tests of the X-ray machines was not effective. • The process for ensuring medical emergency equipment and medicines were in line with recognised guidance was not effective. There was additional evidence of poor governance. In particular: • Records relating to patient complaints were stored in their dental care records.

This section is primarily information for the provider

Requirement notices

- The X-ray audit was not practitioner specific.