Mr Tariq Aziz Kanjoo

# The Dental Surgery

## Inspection Report

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Barrow in Furness
Cumbria
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## Overall summary

We carried out this announced inspection on 2 July 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 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**

The Dental Surgery is in Barrow in Furness and provides both NHS funded treatment and private treatment to adults and children.

There is assisted access for people who use wheelchairs and those with pushchairs. On street car parking spaces are available near the practice.

The dental team includes one dentist and two trainee dental nurses. The practice has one treatment room.

# 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 collected 35 CQC comment cards filled in by patients.

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

The practice is open:

Monday 9.15am – 6.00pm

Thursday 9.15am – 5.30pm

Friday 9.15am – 4.30pm

**Our key findings were:**

- The décor in the practice needed some updating. We could not be assured that the practice was well maintained.
- The practice had infection control procedures which did not fully reflect published guidance.
- The principal dentist knew how to respond to medical emergencies. Appropriate medicines and life-saving equipment were not available.
- The practice did not have appropriate systems in place to help them manage risk.
- The practice did not have suitable safeguarding processes and staff were unsure of their responsibilities for safeguarding adults and children.
- Patient care and treatment was inconsistent and not in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The practice was providing preventive care and supporting patients to ensure better oral health but this was not recorded in the patient's dental care records.
- The appointment system met patients' needs.
- There was no effective leadership and culture of continuous improvement in the practice.
- The practice has limited systems in place for staff and patients to feedback about the services they provided.
- The practice had a complaints process.

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.

**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 processes and systems for seeking and learning from patient feedback with a view to monitoring and improving the quality of the service.
- Review the practice's waste handling protocols to ensure waste is segregated and disposed of in compliance with the relevant regulations, and considering the guidance issued in the Health Technical Memorandum 07-01.
- Review the practice's policy for the control of substances hazardous to health and the storage of products identified by the relevant legislation to ensure a risk assessment is undertaken and up to date data sheets are obtained.
- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued by the Medicines and Healthcare Products Regulatory Agency, the Central Alerting System and other relevant bodies, such as Public Health England.
- Review the practice's information leaflet to ensure information is recorded and correct to assist a patient who wished to make a complaint.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Are services safe?**

**Requirements notice** 

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

The practice did not have systems and processes to provide safe care and treatment. There were no processes in place to learn from incidents and complaints to help them improve.

Staff had a limited understanding on how to recognise the signs of abuse and how to report concerns.

The principal dentist was qualified for their role. They were supported by two trainee dental nurses both of which were in the first year of their training. The principal dentist supported the trainee dental nurses.

Premises appeared cluttered and we could not assure ourselves that they were adequately cleaned or maintained.

The practice had limited arrangements for dealing with medical and other emergencies.

Infection prevention and control systems were not in line the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health.

**Are services effective?**

**Requirements notice** 

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

We found and were told the dentist did not always assess patients' needs and provided care and treatment in line with recognised guidance. The dental care records we reviewed did not provide adequate documentation to support treatment and discussions had with patients'.

Patients described the treatment they received as great, excellent and efficient. Patients commented that the dentist discussed treatment with them so they could give informed consent. There was no evidence to support this recorded in the dental care records we reviewed.

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

# 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 35 people. Patients were positive about all aspects of the service the practice provided. They told us staff were friendly, helpful and supportive.

They said that they were given helpful and honest explanations about dental treatment, 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. This included providing facilities for disabled patients and families with children. The practice had access to telephone interpreter services and had limited arrangements to help patients with sight or hearing loss.

The principal dentist told us they took patients views seriously. They valued compliments from patients. The practice had not received any formal complaints. Information about other organisations a patient could contact was either incorrect or absent.

**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 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

The principal dentist did not demonstrate they had the capacity and skills to deliver high-quality, sustainable care or had the experience, capacity and skills to deliver the practice strategy and address risks to it.

The provider did not have an effective system of clinical governance in place.

The practice had arrangements to ensure the smooth running of the service. These did not include systems for the practice team to discuss the quality and safety of the care and treatment provided.

The principal dentist did not keep complete patient dental care records. These were not clearly written and did not include all the required documentation. Records were stored securely.

# Summary of findings

There was no monitoring of clinical and non-clinical areas of their work to help them improve and learn. They did not actively request for, and listening to, the views of patients and staff.

# Are services safe?

## Our findings

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

The practice did not have clear systems to keep patients safe.

Staff did not understand 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 did not know how to report concerns, including notification to the CQC. There were no contact details for the Cumbria County Council available.

We did not see evidence of a whistleblowing policy. Staff told us they felt confident they could raise concerns without fear of recrimination.

The dentist did not use rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment. A risk assessment had not been completed and no alternative safety measures were available.

The practice had a staff recruitment policy and procedure to help them employ suitable staff. These reflected the relevant legislation. The principal dentist was unable to provide any recruitment documentation with regards to the two trainee dental nurses. The principal dentist told us the trainee dental nurses were recruited via their training college.

The principal dentist was qualified and registered with the General Dental Council (GDC) and had professional indemnity cover.

We did not see any evidence to show that the practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions, including the fixed electrical wiring and gas boiler.

We saw evidence to show that the fire extinguishers had been serviced. We found fire extinguishers were stored under the desk in the upstairs office and were difficult to access. There were no ongoing checks for fire safety such as regular checks on the smoke alarms, firefighting equipment or emergency exits in the building.

Due to these concerns and the clutter identified within the practice we have shared this information with Cumbria Fire and Rescue Service.

The practice had a radiation protection file and arrangements to ensure the safety of the X-ray equipment. This had not been updated. We noted that the practice had not registered their practice's use of dental x-ray equipment with the Health and Safety Executive in line with the new Ionising Radiation Regulations 2017 (IRR17). Local rules for the use of x-ray equipment were displayed in the surgery, these were dated 2009 and had not been reviewed. There was no evidence that new staff had received induction in the safe use of x-rays.

We saw little evidence that the dentist justified, graded and reported on the radiographs they took. The practice did not carry out radiography audits every year following current guidance and legislation.

There was no evidence to show that the principal dentist had completed continuing professional development (CPD) in respect of dental radiography.

**Risks to patients**

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

The practice's health and safety policies, procedures and risk assessments were not up to date and not reviewed regularly to help manage potential risk. The health and safety poster displayed in the reception area was incorrect in being the 2009 version.

The practice had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. Safer sharps systems were in use and the practice followed relevant safety laws when using needles and other sharp dental items. This practice was not underpinned by a sharps risk assessment.

Staff confirmed that only the dentist was permitted to assemble and dispose of needles where necessary to minimise the risk of inoculation injuries to staff. Protocols were not in place to ensure staff accessed appropriate care and advice in the event of a sharps injury and staff were

unaware of the importance of reporting inoculation injuries. Both trainee dental nurses were unaware of who to contact or where to attend in the event of a sharps injury. Contact numbers were displayed in the surgery but the trainee dental nurses were unaware of them. The sharps policy was not practice specific and had not been reviewed to ensure it reflected process within the practice.

There was no evidence the trainee dental nurses had received vaccinations to protect them against Hepatitis B or the effectiveness checked. There was no risk assessment in place to mitigate the risks associated with staff working without the effectiveness of vaccination being known.

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

The principal dentist had limited risk assessments to minimise the risk that can be caused from substances that are hazardous to health (COSHH). Risk assessments and manufacturers data sheets had not been updated. The principal dentist told us that this information was available through an outside agency and would be sought by telephone.

The trainee dental nurses did not know how to respond to a medical emergency and they had not completed training in emergency resuscitation and basic life support (BLS). Guidelines for resuscitation from the GDC state that there should be two members of staff who have up to date CPR training. We saw that CPR training was booked for 11 July 2018 for the trainee dental nurses

Emergency equipment and medicines did not fully reflect nationally recognised guidance.

The practice did not have a defibrillator and there was no risk assessment to mitigate its absence. The principal dentist explained that they could access a machine from the local health centre which was four minutes away or would rely on NHS emergency ambulance support. These arrangements were not supported with a service level agreement.

There were no records of checks of the emergency medicines and equipment to ensure these were available and within their expiry date. When we looked at the emergency medicines we found medicines which had expired in 2014. The provider was unaware of this.

The principal dentist had the injectable form of Midazolam available in the emergency drug box. This is not in line with guidance from the British National Formulary (BNF). The BNF states that the buccal form of midazolam is available for emergency use. This had not been risk assessed by the principal dentist.

The self-inflating bag with a reservoir was only available in an adult sized mask with no child provision. The medical oxygen cylinder was in date. The trainee dental nurses told us they did not know how to use it. The portable suction and self-inflating bag were not stored with the other resuscitation equipment but in a locked filing cabinet.

The practice had infection prevention and control policy and procedures. These did not follow guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health. We found the system disorganised and cluttered. There was no specific area or allocated zones for decontamination process. There was no evidence available to show staff had completed infection prevention and control training.

The practice had arrangements for cleaning, checking, sterilising and storing instruments, these were not in line with guidance in HTM01-05. The practice did not have a separate decontamination room on the premises and there was no plan in place to move towards installing a separate decontamination facility.

The records showed equipment used by staff for sterilising instruments were not always validated, maintained and used in line with the manufacturers' guidance, for example there was no daily testing which verified the steriliser was effective. Instrument trays were stored unwrapped in cupboards in the clinical areas. There was no evidence to show that these instruments were reprocessed in the correct timescale if they were not used.

A foaming detergent was being used for the manual washing of instruments. This was not in line with HTM 01 – 05 guidance. There was inadequate personal protective equipment for staff namely disposable aprons were not provided. There was no illuminated magnification for examining instruments. There was no clear zoned area for the unloading of clean instruments from the autoclave and the available area was cluttered. Ventilation was achieved

by opening the outside door in the surgery. The hand wash solution was in refillable containers and did not contain their original product. This had not been identified and adequate COSHH precautions and signs were not in place.

We saw completed infection control audits but these were not dated and there were no documented actions on the audit. These audits had not identified the issues we found on the day of inspection.

The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. All recommendations had been actioned and records of water testing and dental unit water line management were in place.

The trainee dental nurses were responsible for the cleaning of the premises. We did not see cleaning schedules for the premises. The practice appeared cluttered when we inspected and the general décor did need updating.

The practice had did not have policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. We found that clinical waste bags were not dated or labelled as originating from the practice (HTM 07-01 – safe management of healthcare waste).

**Information to deliver safe care and treatment**

We could not assure ourselves the principal dentist had the information they needed to deliver safe care and treatment to patients as dental care records were not complete.

We discussed with the principal dentist how information to deliver safe care and treatment was handled and recorded. We reviewed dental care records with the dentist to confirm our findings. Dental care records we saw were not accurate and complete.

Dental care records we saw were kept securely and complied with General Data Protection Regulation (GDPR) requirements (formerly known as the Data Protection Act).

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**

The practice did not have reliable systems for appropriate and safe handling of medicines.

There was not a suitable stock control system of medicines which were held on site. We found emergency medicines which had passed their expiry date. We found boxes of loose antibiotics in the cupboard in the surgery.

The dentist did not follow current guidance with regards to prescribing antibiotics.

**Lessons learned and improvements**

In the previous three years there had been no recorded accidents, safety incidents or significant events. Risk assessments were not in place to support safety issues.

The staff were unaware of the process for reporting significant events, incidents or accidents. We did not see and staff could not tell us if there were adequate systems for reviewing and investigating when things went wrong.

The principal dentist was unable to demonstrate a system for receiving and acting on safety alerts.

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment, care and treatment**

The dental care records we reviewed had no medical history forms signed by patients. The dentist noted any relevant medical history on the outside of the paper record. These updates were not dated. There was no explanation of any presenting complaint in any examination. None of the dental record cards we reviewed had a basic periodontal examination (BPE) recorded in the last five years. A BPE is an examination to check the health of a patients gums. There was no recorded discussion of options, costs and treatment plans on any record card seen. There was no intra or extra oral soft tissue examination recorded. None of the radiographs taken in the dental care records had been justified or reported on. A risk assessment or an X-ray recall interval had not been recorded.

Where a recent root canal treatment had been recorded there were no pre- or post-operative X-rays. We also found recent antibiotic provision for pain or facial swelling, the dental record card did not record a reason for antibiotic provision or why active treatment had not been attempted.

**Helping patients to live healthier lives**

The principal dentist described how they provided preventive care and supported patients to ensure better oral health. This information was not recorded on the dental care records.

The dentist told us they prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them.

The dentist told us that where applicable they discussed smoking, alcohol consumption and diet with patients during appointments. This information was not recorded in the dental care records we reviewed.

The practice had a selection of dental products for sale and provided health promotion leaflets to help patients with their oral health.

We could not assure ourselves that the principal dentist was aware of national oral health campaigns and local schemes available in supporting patients to live healthier lives.

**Consent to care and treatment**

When talking to the dentist and within the dental care records we reviewed there was no evidence to show the practice recorded consent to care and treatment in line with legislation and guidance.

The dentist told us they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions. This was not recorded in the dental care records we reviewed.

The principal dentist described how they involved patients' relatives or carers when appropriate. In the CQC comment cards patients confirmed the dentist listened to them and gave them clear information about their treatment.

**Monitoring care and treatment**

The practice did not keep detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. The principal dentist told us that they assessed patients' treatment needs in line with recognised guidance but did not record the information.

**Effective staffing**

The principal dentist was registered with the General Dental Council (GDC). There was no evidence available to show the principal dentist had completed the continuing professional development required for their registration with the GDC.

The trainee dental nurses were undertaking a recognised dental qualification. One of these nurses had just completed the first year of their training whilst the other was due to commence formal training in September 2018.

There was no evidence to show that staff new to the practice had a period of induction. The trainee dental nurses were unaware of the basic procedures in health and safety.

The trainee dental nurses confirmed the principal dentist did show and discuss procedures with them. The principal dentist confirmed they signed off their practical work.

**Co-ordinating care and treatment**

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

# Are services effective?

## (for example, treatment is effective)

We did not see systems and processes to identify, manage, follow up and where required refer patients for specialist care when presenting with bacterial infections.

The practice had systems and processes 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.

We did not see that 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, helpful and supportive. We saw that staff treated patients. respectfully, appropriately and kindly and were friendly towards patients at the reception desk and over the telephone.

Patients said staff were compassionate and understanding. Patients told us staff were kind and helpful when they were in pain, distress or discomfort.

**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 privacy when reception staff were dealing with patients. Staff did not leave patients' personal information where other patients might see it.

All records were kept in paper format. These were stored securely.

**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 (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.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped them ask questions about their care and treatment.

The practice gave patients clear information to help them make informed choices. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. The dentist described the conversations they had with patients to satisfy themselves they understood their treatment options. These conversations were not recorded on the patient's treatment record.

The practice's information leaflet provided patients with information about the range of treatments available at the practice. This patient information did not accurately reflect the current members or the correct complaints procedure. It stated that there were dental hygienists and practice manager available when there was not. The complaints procedure stated that all complaints should be taken to the practice manager. There was no mention of external organisations and the details for NHS patient complaints was outdated.

# 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.

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

Staff told us that they were not aware of any patients for whom they needed to adjust enable them to receive treatment but this would be recorded in the dental care records.

The practice had made some adjustments for patients with disabilities. This included the provision of a portable ramp. An accessible toilet was not available. The patient's toilet was in the bathroom on the first floor. Patients who needed assisted facilities were signposted to another practice which could meet their needs.

A disability access audit had not been completed.

**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 practice information leaflet.

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.

They took part in an emergency on-call arrangement with the NHS 111 out of hour's service. The practice information leaflet 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 principal dentist advised us that the practice took complaints and concerns seriously and would respond to them appropriately to improve the quality of care. There had been no complaints recorded in the last 12 months so we were unable to confirm this. 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. Limited information was available about organisations patients could contact if not satisfied with the way the practice dealt with their concerns. The information for NHS Morecambe Bay CCG was incorrect. There was no mention external organisation for patients to contact if the need arose.

# Are services well-led?

## Our findings

**Leadership capacity and capability**

We did not see evidence that the principal dentist had the capacity and skills to deliver high-quality, sustainable care or had the experience, capacity and skills to deliver the practice strategy and address risks to it.

Staff told us the principal dentist was visible and approachable. They worked closely with staff to make sure they prioritised compassionate care.

**Culture**

Staff stated they felt respected, supported and valued. They told us the practice focused on the needs of patients.

As there had been no recorded incidents and complaints. Staff were not aware of what constituted a significant event, incident or how to report a sharps injury effectively. The principal dentist was aware of compliance with the requirements of the Duty of Candour.

Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.

**Governance and management**

The principal dentist had overall responsibility for the management and clinical leadership of the practice and for the day to day running of the service. They were also responsible for the systems of accountability to support good governance. Staff knew the management arrangements but seemed unaware of their roles and responsibilities.

The provider did not have an effective system of clinical governance in place. All required policies and procedures were not available in the practice. Policies that were in place were not dated so we could not see that policies and procedures were reviewed on a regular basis.

**Appropriate and accurate information**

There were no quality and operational systems in place to ensure and improve performance of staff and the practice. There were no mechanisms for performance information to be combined with the views of patients.

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

The practice did not involve patients, the public, staff and external partners to support high-quality sustainable services.

The practice did not have systems to obtain staff and patients' views about the service

Patients were not 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. Results from this practice were very limited.

The practice gathered feedback from staff through informal discussions. Although staff were encouraged to offer suggestions for improvements to the service they had little experience which enabled them to do so.

**Continuous improvement and innovation**

The practice did not have a quality assurance processes to encourage learning and continuous improvement. There was no evidence of audits of radiography. We saw completed infection prevention and control audits, these were not dated and there were no documented action plans or learning outcomes in place. In addition, the infection prevention and control audits had not identified issues we found on the day of inspection.

Both the trainee dental nurses were undertaking a recognised dental qualification. They told us that they discussed learning needs, general wellbeing and aims for future professional development with the principal dentist. We did not see evidence of these discussions or their outcome.

We were not shown information to demonstrate the principal dentist had completed 'highly recommended' training as per General Dental Council professional standards. This included undertaking medical emergencies and basic life support training. There was no evidence that the trainee nurses had received medical emergency training. Guidance from the resuscitation council states that all new members of staff should have resuscitation training as part of their induction programme. A course had been arranged for them in July 2018.

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<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**Regulation 12: Safe care and treatment. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**<br>The registered person did not assess the risks to the health and safety of service users when receiving care and treatment and had limited systems in place to mitigate this risk.<br>• Risk assessments relating to the health, safety and welfare of people using the service were not completed or reviewed.<br>• The registered person's process for checking the effectiveness of the Hepatitis B vaccination in staff was not operating effectively.<br>• The registered person had a system in place to check that medical emergency equipment was available as recommended in the Resuscitation UK guidance but it was not operating effectively as some items were not available at the practice.<br>• The registered person had not taken all reasonably practicable measures to reduce the risks in relation to the use of sharps.<br>There were limited systems for assessing the risk of, and preventing, detecting and controlling of the spread of, infections, including those that are health care associated.<br>• The practices infection control procedures did not meet the Department of health's code of practice or guidance in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05)<br>Regulation 12 (2) |

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<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**Regulation 17: Good Governance.**<br>**Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**<br>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. Records relating to the management of the regulated activities means anything relevant to the planning and deliver of care and treatment. This includes governance arrangements such as policies and procedures, service and maintenance records, audits and reviews, and records of any reported risk or incident. In particular:<br>· The provider did not have systems and processes to ensure regular audits of radiation and infection prevention and control were in place.<br>· The provider did not maintain accurate, complete and contemporaneous records in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. In particular: results of examinations, treatment plans and an accurate record of the treatment undertaken.<br>The provider did not maintain records in relation to the persons employed in the carrying on of the regulated activity. In particular: |

This section is primarily information for the provider

# Enforcement actions

· The provider did not hold any recruitment information for staff. Recruitment information was retained by the training course establishment they were recruited to. There were no risk assessments in place to mitigate the risk.