Peartree Dental Care Partnership

Peartree Dental Care

Inspection report

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Overall summary

We carried out this unannounced comprehensive inspection on 19 October 2022 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 second CQC inspector and a specialist dental adviser.

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?
- Is it well-led?

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

Our findings were:

• Appropriate medicines and life-saving equipment were available**.**

- The practice was not clean and not well-maintained.
- The provider's infection control procedures were not operated effectively.
- The provider did not operate effective systems to help them manage risk to patients and staff.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider's staff recruitment procedures were not operated effectively.

Summary of findings

- The clinicians provided patients' care and treatment in line with current guidelines.
- Staff provided preventive care and supported patients to ensure better oral health.
- Staff training was not monitored effectively.
- The provider did not have effective leadership and a culture of continuous improvement.
- Staff did not feel involved and supported by the provider.

Background

Peartree Dental Care is in Southampton and provides NHS and private dental care and treatment for adults and children.

There is step free access to the practice for wheelchair users and those with pushchairs.

On street car parking spaces are available near the practice.

The dental team includes 2 dentists, 2 qualified dental nurses (one of which is also the practice manager), 3 trainee dental nurses, 1 dental hygienist and a receptionist.

The practice has 4 treatment rooms of which 3 are in use.

During the inspection we spoke with 2 dentists, 2 trainee dental nurses, 1 qualified dental nurse, a receptionist and the practice manager. The provider or their management team were not present during our visit.

We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday to Friday between 8.30am and 5pm.
The practice closes for lunch each day.

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

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate training necessary to enable them to carry out their duties.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed and specific information is available regarding each person employed.

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

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

- Implement protocols regarding the prescribing and recording of antibiotic medicines taking into account guidance provided by the Faculty of General Dental Practice in respect of antimicrobial prescribing.
- Improve the practice protocols regarding auditing patient dental care records to check that necessary information is recorded.

Summary of findings

The practice manager accepted the clinical and non-clinical issues raised and started to take action to address these.

Where evidence is sent that shows the relevant issues have been acted on, we have stated this in our report but we cannot say that the practice is compliant for that key question as this would not be an accurate reflection of what was found on the day of our inspection.

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**
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 Requirement Notices/ 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 had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.

We saw evidence which confirmed that 5 of the 9 staff had received the appropriate level of safeguarding training.

The provider had a system to highlight vulnerable patients and patients who required other support such as with communication, within dental care records.

The practice did not have infection control procedures which reflected current published guidance. We found:

- Out of date dental materials in all 4 treatment rooms.
- Out of date local anaesthetic ampules in treatment rooms 1 and 4.
- Undated sterilised pouched instruments in all treatment rooms.
- Out of date pouched instruments in treatment rooms 1, 2 and 3.
- Clinical staff outdoor clothes and clinical uniforms were stored together in staff room lockers presenting a possible cross-infection risk.
- Clinical cotton rolls were stored in open boxes in treatment rooms 1,2 and 4.
- The windowsill in the decontamination room was rotten in places which prevented appropriate cleaning.
- The clinical bin was not foot operated in treatment room 4.
- An open box of paper handtowels in the patient toilet was stored on the floor next to the toilet.
- Floor to skirting seals were incomplete in places in the decontamination room.
- Handwashing soap was not available in the staff toilet.
- A wastepaper bin was overflowing in the staff toilet.

Staff did not follow guidance in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care. We found:

- Instruments that were manually cleaned were not immersed in water during the process which created an aerosol risk.
- A manual cleaning scrubbing brush and glove replacement schedule was not available.
- Handwashing protocols were not followed by staff during the decontamination process.
- Handwashing soap and paper towels were not available in the decontamination room.
- Visors were not used by staff performing decontamination duties.
- The decontamination room window was closed throughout our visit and no fan was available, impacting airflow from clean to dirty areas
- Historical unused pre-dated instrument pouches, stamped with start and end dates, were seen in treatment rooms and the decontamination room.

The staff carried out manual cleaning of dental instruments prior to them being sterilised. We advised the provider that manual cleaning is the least effective recognised cleaning method as it is the hardest to validate and carries an increased risk of an injury from a sharp instrument.

Are services safe?

The practice had procedures to reduce the risk of Legionella or other bacteria developing in water systems, in line with a risk assessment. A legionella risk assessment review in 2017 recommended a new risk assessment should be carried out. This action remained outstanding at the time of our visit.

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

The practice was not visibly clean and there was not an effective cleaning schedule to ensure the practice was kept clean. We observed:

- Cleaning equipment storage arrangements did not follow national guidance.
- Cobwebs on window frames throughout the practice.
- The 'patient toilet cleaning and safety checklist' did not reflect the poor state of cleanliness.
- Visible dust on the patient treatment chair light in treatment room 2.
- Visibly dirty drawer fronts and tops in treatment room 1.
- Clinical debris in the cupboards behind 2 clinical waste bins in treatment room 1.
- The clinical waste bin was not emptied the previous day in treatment room 4.
- The floor and skirting paintwork was visibly dirty in the patient and staff toilet.
- The handwashing sink area in the decontamination room was visibly dirty.

Recruitment procedures were not operated effectively to ensure only fit and proper persons were employed and specified information was available regarding each person employed.

We looked at 9 staff recruitment records. Evidence presented to us confirmed that:

- Six out of 9 had photographic identification.
- Five out of 8 had Hepatitis B immunity.
- Two out of 9 had eligibility to work in UK.
- No one had a health assessment.
- Three out of 9 had a full employment history.
- One out of 9 had a 12-month employment history gap with no written explanation of why.
- No one had received a formal induction.
- One out of 9 had two references (in line their own internal recruitment policy).
- Four out of 9 had one reference.
- Four out of 9 had no references.
- Four out of 9 had a Peartree DBS carried out (in line with their own internal recruitment policy
- Three out of 9 had a historical DBS from a previous employer.

Clinical staff were qualified, registered with the General Dental Council and had professional indemnity cover.

Staff did not ensure facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. We observed:

- A cracked patient treatment chair base cover in treatment room 4.
- The autoclave annual service was overdue by 8 months (last service 02/2021) We were told a service had been booked for later in October 2022.
- Emergency lights were not serviced.
- Black bin bags and a number of boxes of water damaged new personal protective equipment (PPE) were seen on the grass in the back garden. We were told these were awaiting disposal when the council rubbish bin was next emptied. We were told staff had taken a number of bags of new PPE to a local council recycling centre.
- Servicing records for the air conditioning units were unavailable.
- Rusty pitted drawer handles in treatment room 1.

Are services safe?

- Bramble coming through an open window in treatment room 2.
- A radiator was rusted in the patient toilet.
- A ripped patient treatment chair headrest covering in treatment room 2 .
- A ripped clinician stool covering in treatment room 1.
- The toilet seat was broken in the staff toilet.
- Two discarded pots of paint, cleaning mops and a mop bucket was seen on the path to back garden.
- The ground and walled area behind the gate to the back garden was littered with used cigarette butts. We were told this was the smoking area for staff.

The management of fire safety at the practice was not effective. In particular:

- Fire alarm tests were not carried out at appropriate intervals (weekly).
- Emergency lights were not tested.
- All three emergency lights failed a power outage test.
- Fire escape direction signage pointed to the ceiling in the ground floor corridor.
- There was no fire escape direction sign present above the only exit in the building (front door).
- Annual fire drills were not carried out.
- A fire risk assessment was carried out by a staff member who could not demonstrate fire safety management competence.
- A current five yearly electrical fixed wiring check evidence was unavailable.
- Portable Appliance Test (PAT) evidence was unavailable.
- Waste bins at the front of the building were not protected from unauthorised interference and potential arson.

The practice did not have arrangements to ensure the safe use of the X-ray equipment.
In particular:

- Rectangular collimators were not available for X-ray machines in treatment room 1 and 2.
- Critical examination packs were not available for X-ray machines in in treatment room 1, 2 and 3.
- Local rules were not available in full (a partial extract was seen on wall).

Risks to patients

Systems to assess, monitor and manage risks to patient safety were not effective.

Sharps risk management was not effective:

- Sharps bins were not labelled appropriately in treatment rooms 2 and 3.
- Sharps bins in treatment rooms 1 and 4 had not been changed after three months.

The provider did not operate an effective system to ensure clinical staff were vaccinated against the Hepatitis B virus. The effectiveness of the vaccination was not checked for 5 of the 8 clinical staff working at the practice.

Records available confirmed that 3 out of 9 staff had completed training in emergency resuscitation and basic life support in the previous 12 months.

Emergency equipment and medicines were available as described in recognised guidance. We found staff kept records of their checks of these to make sure they were available, within their expiry date, and in working order.

The practice automatic external defibrillator (AED) was attached to a wall outside the practice. We were told this was available for the community to use in an emergency. The frequency of checks did not reflect this arrangement as staff only checked the AED weekly and were not informed should the AED be used.

Are services safe?

An emergency medicines and equipment bag and oxygen was stored in an under-stair cupboard along with cleaning equipment and the vacuum cleaner. The cupboard was cluttered which may hinder the removal of the emergency kit in an emergency.

We were unable to confirm that the temperature of the fridge containing the Glucagon was monitored as logs could not be located.

The practice did not have risk assessments to minimise the risk that can be caused from substances that are hazardous to health. Safety data sheets available did not reflect all the COSHH identified products we reviewed.
Control of Substances Hazardous to Health (COSHH) identified products were stored around the practice, this included the patient toilet. None of the COSHH identified products were stored securely or labelled appropriately.

Window blind adjustment looped cords were not tethered to window frames and may pose a risk of choking to young children in the waiting area.

Information to deliver safe care and treatment

Dental care records we saw were complete, legible, were 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 dentists were aware of current guidance with regards to prescribing medicines.

The practice did not have a system for appropriate and safe handling of prescriptions. Specifically, new prescription pads were neither stored securely nor logged.

Antimicrobial prescribing audits were not carried out.

Track record on safety, and lessons learned and improvements

There were no records available to confirm that systems were in place to investigate, document and discuss safety incidents and significant events.

We observed that the accident book was not compliant with General Data Protection Regulations (GDPR).

The practice did not have a system for receiving and acting on safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

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

The dentists obtained consent to care and treatment but did not have a thorough understanding of the Mental Capacity Act 2005.

The dentists understood the importance of obtaining and recording patients' consent to treatment. They were aware of the need to obtain proof of legal guardianship or Power of Attorney for patients who lacked capacity or for children who are looked after.

Monitoring care and treatment

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

The practice did not have effective assurance processes to encourage learning and continuous improvement. Patient dental care record audits were not fully completed to include analysis, outcomes or plans.

We saw evidence the dentists justified, graded and reported on the radiographs they took. The practice carried out radiography audits six-monthly but did not follow current guidance and legislation.

Effective staffing

Staff did not have the skills, knowledge and experience to carry out their roles:

Appraisals were not carried out.

Training was not monitored.

Evidence was not available to confirm that newly appointed staff had a structured induction and clinical staff completed continuing professional development required for their registration with the General Dental Council.

We looked at 9 staff training records. Evidence presented to us confirmed that:

- 3 out of 8 had completed Infection Control training.
- 3 out of 9 had completed Basic Life Support training.
- No staff had completed Fire Safety training.
- 4 out of 8 had completed Safeguarding Children Level 2 training.
- 4 out of 8 had completed Safeguarding Adults Level 2 training.
- 0 out of 1 had completed Safeguarding Children Level 1 training.
- 0 out of 1 had completed Safeguarding Adults Level 1 training.

Are services effective?

(for example, treatment is effective)

- 0 out of 2 had completed 5 hours of IR(ME)R training in previous 5 years.
- 2 out of 6 had completed Radiography training.

Co-ordinating care and treatment

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

The dentists confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide.

Are services caring?

Our findings

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

Kindness, respect and compassion

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

On the day of inspection, we obtained the views of 14 patients.
All of the patients we asked told us the clinicians were compassionate and understanding.

Privacy and dignity

Staff were aware of the importance of privacy and confidentiality.

Staff password protected patients' electronic care records and backed these up to secure storage. However, storage was not effective. The practice immediately addressed this shortfall during our visit.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care.

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

Are services responsive to people's needs?

Our findings

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

Responding to and meeting people's needs

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

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

Staff had partially carried out a disability access audit.
An action plan to continually improve access for patients was not produced.

We observed:

- A hearing loop was not available.
- Vision aids (magnifier or reading glasses) were not available
- The notepad, known as a clinipad, which allows patients to electronically complete and sign forms at the practice could not be increased to large print text size.

Timely access to services

Patients reported that they could not 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 but lacked the staff available to meet these requirements.

Listening and learning from concerns and complaints

The practice responded to concerns and complaints appropriately and discussed outcomes with staff 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.

At the time of inspection there was no registered manager in post as required as a condition of registration. A registered manager is legally responsible for the management of services for which the practice is registered.

Leadership capacity and capability

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

The practice was part of a corporate group which had a management team to support the effective running of the business, but their management oversight of the practice was not effective.

The information and evidence presented during the inspection process was unclear and poorly documented.

We saw the practice did not have effective processes to support staff with additional roles and responsibilities. For example, the lead nurse was supporting the receptionist and did not have time to oversee the work of the trainee dental nurses' decontamination tasks.

Culture

The practice did not have a culture of high-quality sustainable care.

Staff stated they did not feel respected, supported or valued.
Staff did not have annual appraisals or one to one meetings.

Governance and management

Staff did not have clear responsibilities, roles and systems of accountability to support good governance and management. There was no:

- Legionella lead.
- Fire safety lead.
- Safeguarding lead.
- Clinical lead.

The provider had a system of clinical governance in place which included policies, protocols and procedures but systems were not followed.

The management of radiography, fire safety, health and safety, recruitment, COSHH, infection control, training, equipment and premises required immediate improvement.

Appropriate and accurate information

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 told us they used patient surveys to obtain patients' views about the service.

Are services well-led?

Staff told us their concerns were not listened to or addressed.
Examples of concerns raised included:

- Consumables were only authorised to be ordered twice a month which caused stock shortages for example, patient bibs.
- Low numbers of instruments were available which placed extra pressure on staff to reprocess instruments, for example, scaler tips.

Continuous improvement and innovation

The provider had quality assurance processes to encourage learning and continuous improvement, but these were not operated effectively.

Audits were partially carried out for radiography and patient records.

Antimicrobial prescribing audits were not carried out.

Training was not monitored effectively. Evidence was not available to confirm that relevant staff had completed the 'highly recommended' training as per General Dental Council professional standards.

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 CQC (Registration) Regulations 2009 Statement of purpose Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 **Regulation 12** **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: **Assessments of the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated were not carried out:** • Out of date dental materials in all 4 treatment rooms. • Out of date local anaesthetic ampules in treatment rooms 1 and 4. • Undated sterilised pouched instruments in all treatment rooms. • Out of date pouched instruments in treatment rooms 1, 2 and 3. • Clinical staff's outdoor clothes and clinical uniforms were stored together in staff room lockers presenting a possible cross-infection risk. • Clinical cotton rolls were stored in open boxes in treatment rooms 1,2 and 4. • The windowsill in the decontamination room was rotten in places. • The clinical bin was not foot operated in treatment room 4. • An open box of paper handtowels in the patient toilet was stored on the floor next to the toilet. • Floor to skirting seals were incomplete in places in the decontamination room. • Handwashing soap was not available in the staff toilet. • A wastepaper bin was overflowing in the staff toilet.

This section is primarily information for the provider

Requirement notices

- Instruments that were manually cleaned were not immersed in water during the process which created an aerosol risk.
- A manual cleaning scrubbing brush and glove replacement schedule was not available.
- Handwashing protocols were not followed by staff during the decontamination process.
- Handwashing soap and paper towels were not available in the decontamination room.
- Visors were not used by staff performing decontamination duties.
- The decontamination room window was closed throughout our visit and no fan was available, impacting airflow from clean to dirty areas
- Historical unused pre-dated instrument pouches, stamped with start and end dates, were seen in treatment rooms and the decontamination room.

Legionella

- A legionella risk assessment review in 2017 recommended a new risk assessment should be carried out. This action remained outstanding at the time of our visit.

Cleaning

- Cleaning equipment storage arrangements did not follow national guidance.
- There were cobwebs on window frames throughout the practice.
- The 'patient toilet cleaning and safety checklist' did not reflect the poor state of cleanliness.
- Visible dust on the patient treatment chair light in treatment room 2.
- Visibly dirty drawer fronts and tops in treatment room 1.
- Clinical debris in cupboards behind 2 clinical waste bins in treatment room 1.
- The clinical waste bin was not emptied the previous day in treatment room 4.
- The floor and skirting paintwork was visibly dirty in the patient and staff toilet.
- The handwashing sink area in the decontamination room was visibly dirty.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

The registered person did not ensure that the premises and equipment used by the service were clean, secure, properly used and maintained.
In particular:

- A cracked patient treatment chair base cover in treatment room 4.
- The autoclave annual service was overdue by 8 months (last service 02/2021) We were told a service had been booked for later in October 2022.
- Emergency lights were not serviced.
- Servicing records for the air conditioning units were unavailable.
- Rusty pitted drawer handles in treatment room 1.
- Bramble coming through an open window in treatment room 2.
- A radiator was rusted in the patient toilet.
- A ripped patient treatment chair headrest covering in treatment room 2 .
- A ripped clinician stool covering in treatment room 1.
- The toilet seat was broken in the staff toilet.
- Window blind adjustment looped cords were not tethered to window frames and may pose a risk of choking to young children in the waiting area.

The registered person did not have adequate systems to minimise the risk that can be caused from substances that are hazardous to health. In particular:

- A clinical waste bin in treatment room 4 was not foot operated.
- Safety data sheets available did not reflect the COSHH identified products we reviewed.
- None of the COSHH identified products at the practice were secure or labelled appropriately.
- Sharps bins were not labelled appropriately in treatment rooms 2 and 3.
- Sharps bins in treatment rooms 1 and 4 had not been changed after three months.

Reasonable adjustments were not made when providing equipment to meet the needs of disabled people in line with requirements of the Equality Act 2010.

- A hearing loop was not available.

This section is primarily information for the provider

Requirement notices

- Vision aids (magnifying glass/reading glasses) were not available.
- A Disability Access audit was partially carried out.
- The notepad, known as a clinipad, which allows patients to electronically complete and sign forms, could not be increased to large print text size.

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 18 HSCA (RA) Regulations 2014 Staffing The registered person did not ensure persons employed in the provision of the regulated activity received the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties. In particular: • Training was not monitored. • 5 out of 8 staff had not completed Infection Control training. • 6 out of 9 staff had not completed Basic Life Support training. • 9 out of 9 staff had not completed Fire Safety training. • 4 out of 8 staff had not completed Safeguarding Children Level 2 training. • 4 out of 8 staff had not completed Safeguarding Adults Level 2 training. • 1 out of 1 staff had not completed Safeguarding Children Level 1 training. • 1 out of 1 staff had not completed Safeguarding Adults Level 1 training. • 2 out of 2 staff had not completed 5 hours of IR(ME)R training in prev.5 years • 4 out of 6 staff had not completed Radiography training. • Appraisals were not carried out. • Evidence was not available to confirm that newly appointed staff received a structured induction

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

This section is primarily information for the provider

Enforcement actions

The registered person did not ensure that recruitment procedures were operated effectively to ensure only fit and proper persons are employed and specified information is available regarding each person employed.

In particular:

Recruitment checks were not monitored to ensure they were completed or stored appropriately.

We looked at 9 staff recruitment records. Evidence presented to us confirmed that:

- 3 out of 9 staff did not have photographic identification.
- 3 out of 8 staff did not have Hep B immunity.
- 7 out of 9 staff did not have eligibility to work in UK.
- 9 out of 9 staff did not have a health assessment.
- 6 out of 9 staff did not have a full employment history
- 1 out of 9 staff had a 12-month employment history gap with no written explanation of why.
- 8 out of 8 staff did not have two references
- 4 out of 8 staff did not have any references.
- 5 out of 9 staff did not have a Peartree Dental Care Disclosure and Baring Service (DBS) check carried out

Regulated activity

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Surgical procedures

Regulation

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.

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:

Fire Safety

- Fire alarm tests were not carried out at appropriate intervals (weekly).
- Emergency lights were not tested.

This section is primarily information for the provider

Enforcement actions

- All three emergency lights failed a power outage test.
- Fire escape direction signage pointed to the ceiling in the ground floor corridor.
- There was no fire escape direction sign present above the only exit in the building (front door).
- Annual fire drills were not carried out.
- A fire risk assessment was carried out by a staff member who could not demonstrate fire safety management competence.
- A current five yearly electrical fixed wiring check evidence was unavailable.
- Portable Appliance Test (PAT) evidence was unavailable.
- Waste bins at the front of the building were not protected from unauthorised interference and potential arson.

Radiography

- Rectangular collimators were not available for X-ray machines in treatment room 1 and 2.
- Critical examination packs were not available for X-ray machines in in treatment room 1, 2 and 3.
- Local rules were not available in full (a partial extract was seen on wall).

Hepatitis B

- The effectiveness of the vaccination was not checked for 5 of the 8 clinical staff working at the practice.

Emergency Medicines and Equipment

- The temperature log of the fridge containing the Glucagon was not available.

Audits

Audits were partially carried out for radiograph and disability access.

NHS Prescriptions

- NHS prescriptions were not stored as described in current guidance.
- No tracking system was in place for prescriptions.

Track record on safety, and lessons learned and improvements

- Systems were not followed to investigate, document and discuss safety incidents and significant events.

This section is primarily information for the provider

Enforcement actions

- We observed that the accident book was not compliant with General Data Protection Regulations (GDPR).
- The practice did not have a system for receiving and acting on safety alerts.