Dr. Norman Bloom

N Bloom & Associates - Bridlington Road

Inspection Report

38 Bridlington Road
Watford
Hertfordshire
WD19 7AE
Tel: 0208 8428 6712
Website: www.bloomdental.com

Date of inspection visit: 24 June 2015
Date of publication: 01/10/2015

Overall summary

We carried out an announced comprehensive inspection on 24 June 2015. At this inspection we identified a number of breaches of the regulations. Some of the concerns affected patient safety and there were some procedural issues. As a result of these findings we asked the provider to assure us that patient safety issues had been dealt with immediately and that they were working towards making improvements in the other areas of concern.

We then visited the practice again on 22 July 2015 after being advised that the safety issues had been actioned. We attended to check that these had taken place and that patients were safe. We also looked at what other progress was being made in relation to the concerns we found at our first visit.

We ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

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 not 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 practice has a lead dentist who employs two other dentists that work full time. The dentists are supported by three dental nurses a practice manager and reception staff that work a variety of hours. The practice has three surgeries, a decontamination room and an X-ray suite.

Summary of findings

The practice provides primary dental services to mainly NHS patients but also provides private care. The practice is open Monday to Thursday between the hours of 8.30am and 5.30pm and Fridays between the hours of 8.30am and 2pm. They are closed at weekends.

We were unable to speak with patients on the day of the inspection but did review CQC comment cards left for patients to complete prior to the inspection. There were 11 completed cards. The comments left by patients indicated that the majority of those patients were happy with the services provided by the dentists and the reception staff, including the way they supported nervous patients. We received one negative comment about the quality of the dentistry.

The lead dentist is the responsible individual. A responsible individual a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Our key findings at the first inspection at the practice were:

- Staff felt supported and were encouraged to develop themselves through training.
- Patients were treated with dignity and respect and they said staff were kind and supportive.
- Dental staff followed published dental guidance when undertaking consultations and explained care and treatment options to patients and involved them in decisions.
- There were sufficient numbers of staff working at the practice.
- Significant events were not being identified, recorded and analysed effectively or learning identified and cascaded to staff.
- Where mistakes had been made patients were not given appropriate explanations about the outcome of any investigation and there was a lack of clinical input and oversight by the provider.
- Some staff had not received safeguarding and whistleblowing training and were not aware of the processes to follow to raise any concerns.
- A health and safety and legionella risk assessment had not taken place as required by legislation.
- Feedback from staff about poor performance of colleagues was not acted upon in an effective manner and records were not kept.
- Dental nurses had received training in relation to infection control but were not supervised adequately and were not following published guidance.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available but not sufficiently accessible. Staff were unaware how to use the emergency oxygen.
- There was no infection control policy or identified lead for infection control. Infection control procedures were not robust and the practice staff were not following published guidance.
- Infection control audits were not taking place in line with guidance and did not identify where systems were failing.
- Instruments designed for single use only were being sterilised and re-used.
- Procedures and guidelines for the safe taking of X-rays were not being followed. Unqualified staff were taking X-rays. The quality of X-rays was not being audited. The provider was not aware of the identity of the radiation protection advisor or supervisor. There was no radiation protection documentation available at the practice.
- There was a lack of evidence to demonstrate that a system was in place to review patients' medical histories.
- National patient safety and medicines alerts were not being acted upon or cascaded to other dentists. There was no system in place to receive updates about best practice and legislation changes guidelines in dentistry.
- Patients received clear explanations about their proposed treatment, costs, benefits and risks and were involved in making decisions about it.
- Patients were treated with dignity and respect and confidentiality was maintained.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- There was no system in place that identified the type of staff training that was required and the frequency of it. Staff training and completion of it was not being monitored.

Summary of findings

- The complaint system was ineffective. Patients' complaints were not being handled with a duty of candour and not dealt with to the satisfaction of patients. Learning was not being identified and cascaded to staff at the practice.
- There was no recruitment policy for staff to follow. Recruitment procedures were not effective.
- There was no appraisal system in place, staff were not receiving appraisals and their competency was not being assessed.
- There was a lack of visible leadership from the provider.
- The provider had a lack of knowledge about the Health and Social Care Act Regulations and how they affected their dentistry role.
- There were no regular staff meetings taking place. Those that did take place were not minuted. There was no other system in place to reflect that governance issues were being discussed and the learning from significant events, complaints, safety issues or areas for improvement that had been identified.
- There was no system in place to assess and monitor the quality of the services they provided. There was no evidence that clinical and non-clinical audits were taking place.
- Governance systems were ineffective. There was an absence of key policies to support staff in the workplace and to set standards of performance.
- The practice did not seek feedback from staff and patients about the services they provided.
- The new practice manager had not received a job description, support or guidance for their new role.
- Staff were unclear about their responsibilities or who the leads were for governance at the practice.
- The absence of historical documentation to support compliance with the regulations reflected a lack of leadership and poor quality of care.

As a result of our second visit to the practice, we checked the progress that had been made and established that the provider had made some improvements and work was in progress on others. However the provider must**:**

- Ensure staff are following guidance in relation to the wearing of personal protective equipment when cleaning used instruments and that cleaning solutions are measured correctly and at the correct temperatures. Undertake a health and safety and legionella risk assessment as required by health and safety legislation.
- Ensure a robust recruitment process is in place and followed, including record keeping in relation to the documentation as highlighted in Schedule 3 of the Health and Social Care Act regulations. This includes ensuring that staff currently employed are appropriately qualified, experienced and skilled to carry out their roles.
- Implement a system so that staff working at the practice receive support, training, professional development, supervision and appraisal to enable them to carry out their duties. This includes safeguarding, infection control, whistle blowing training, supporting staff to undertake their continuous professional development and providing evidence of registration with their professional association. Implement a procedure for managing disciplinary and under performance issues.
- Ensure that there is a system in place to assess, monitor and improve the quality of services provided, including clinical and non-clinical audit cycles, the risks to patients and staff, infection control, maintaining accurate records for each patient to reflect the care and treatment received. Maintain staff records in relation to their employment, qualifications, training and management of the regulated activities.
- Implement a system to obtain feedback from staff and patients about the services provided at the practice.
- Ensure staff are aware of consent issues relating to children and young persons including the requirement for dentists to carry out mental capacity assessments where required.

You can see full details of the regulations not being met at the end of this report.

There were areas where the provider could make improvements and should:

- Ensure radiation protection documentation is kept up to date and that staff are aware of the correct procedures to follow.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report). The practice had some systems and processes in place that kept patients safe. This included recording, investigating and analysing them safety incidents and cascading them to staff. Staff were encouraged to raise concerns with the practice manager and/or dentists. A system was in place to manage national patient safety and medicines alerts. Staff had not received safeguarding training and were unaware of the different signs of abuse and the action to take. The system for updating the medical history of patients was satisfactory. Infection control procedures were not robust. Instruments were being cleaned and sterilised effectively but staff were not routinely wearing personal protective equipment or preparing solutions in line with recommended guidance. Infection control audits were not being carried out at the intervals recommended in published guidance. Radiation protection documentation in relation to X-ray equipment was not being completed satisfactorily. Emergency medicines and equipment were available and in date. Cleaning schedules for the premises and surgeries were in place. Neither a health and safety nor legionella risk assessment had taken place. Recruitment processes were not robust and record keeping was poor.

Are services effective?

We found that this practice was not providing effective care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report). Dentists carried out consultations in line with recommended guidance. Patients were supplied with a written treatment plan. Patients were recalled in line with recommended intervals and dependant on their needs. Health and prevention advice was given to patients to support them in maintaining healthy teeth. Staff were not receiving effective supervision and appraisal. Systems for managing under-performance were ineffective. Training records were unclear and not being effectively monitored. Staff were encouraged to undertake their continuous professional development but this was not being monitored. Checks were not being made to ensure that some clinical staff were registered with their professional body and fit to practice. Some staff had insufficient knowledge about consent and Mental Capacity Act guidelines.

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations. Patients were treated with dignity and respect and their confidentiality maintained. Patients reported that they were treated with kindness and that staff at the practice were polite and courteous.Decisions about care and treatment were discussed with patients in a way they understood.

Are services responsive to people's needs?

We found that this practice was not providing responsive 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 at the end of this report). The practice had information available to enable patients to understand the services they offered and it met their needs. The practice offered both NHS and private treatments. The practice did not obtain feedback from patients about the services provided. There was access for the disabled or those with limited mobility and they were supported by staff working at the practice. The appointment system met the needs of patients including access to emergency dental care. An appropriate complaint system was in place.

Summary of findings

Are services well-led?

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). There was a lack of leadership at the practice from the provider who was the lead dentist. They had not set standards for staff to follow and there was no monitoring of governance taking place. They were unaware of the Health and Social Care Act regulations and how they affected the practice or them as the registered provider. Staff meetings took place regularly and minutes were being recorded. There were no audits being undertaken at the practice. There were no appraisals taking place at the practice. Risks to patients and staff were not being assessed. There was no system in place to obtain the views of staff or patients. Staff working at the practice were not supported and were not being supervised. Staff were unaware of the content of many of the policies in place. There was no system in place to continually assess and monitor the services they provided.

N Bloom & Associates - Bridlington Road

Detailed findings

Background to this inspection

The inspection took place on 24 June 2015 and was conducted by a CQC inspector and a specialist dental advisor. The second inspection on 22 July 2015 was also undertaken by the same personnel.

Prior to the inspection we asked the practice to send us some information which we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, the details of their staff members, their qualifications and proof of registration with their professional bodies.

We also reviewed the information we held about the practice and consulted with other stakeholders, such as NHS England area team / Healthwatch, however we did not receive any information of concern from them.

During the inspection we spoke with three dentists, two dental nurses, the practice manager/receptionist and the finance manager. We reviewed policies, procedures and other documents. We did not speak with patients. We reviewed comment cards that we had left prior to the inspection, for patients to complete, about the services provided at the practice.

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 therefore formed the framework for the areas we looked at during the inspection.

Following the evidence we gathered at this inspection, we required the provider to make immediate changes to some of their procedures, including infection control, the decontamination of instruments and the taking of X-rays. This involved the practice agreeing to suspend certain procedures until we were satisfied that new systems were in place that were safe for patients and staff.

Due to the concerns that we identified, we again visited the practice on 22 July 2015 to assure ourselves that the practice had taken the appropriate action towards complying with the regulations and had dealt with immediate safety issues. Between the two inspections we were regularly updated by the provider in relation to the improvements that had been undertaken. This included the appointment of a consultant by the provider to support them in making the necessary improvements.

On 22 July 2015 when we again visited the practice, we spoke with the provider, a newly appointed practice manager and two dental nurses. We looked at X-ray documentation, infection control procedures, the system used to clean and decontaminate dental instruments and other improvement areas that were being undertaken. We also spoke with the consultant employed by the practice to support them to comply with the regulations.

A further follow-up inspection will take place in the future to ensure that the practice is compliant with the regulations.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

On 24 June 2015 we found that the practice had a significant events policy but had ineffective systems in place to identify and respond to them. We looked at one such event that had occurred in January 2015. This involved a patient that had received treatment at the practice and then had to attend A&E as a result of swallowing an item of dental equipment that had fallen into their mouth. The patient had subsequently complained and was advised that the fee for their treatment had been waived as a gesture of goodwill. The incident was dealt with by the practice manager in post at the time.

This incident was not brought to the attention of the lead dentist (the registered provider) as when asked about it during the inspection, they told us that they were unaware it had taken place. A second dentist we spoke with was also unaware of the incident. The letter from the practice manager to the complainant indicated that an investigation would be undertaken and an explanation provided. Subsequent correspondence did not explain how the incident had happened and what steps had been taken to prevent it from occurring in the future. It did not provide a satisfactory explanation and a duty of candour was not displayed by the practice. We asked the previous practice manager and the provider about the duty of candour regulation and they were unaware of it.

We did not find any details of the investigation into the cause of the incident, no apparent analysis and learning had not been identified. A clinical input had not been sought and there was no satisfactory explanation offered to the complainant that demonstrated the practice was providing a duty of candour. This was a clear safety incident and of sufficient seriousness to be classified as a significant event but it had not been categorised as such or brought to the attention of the provider.

There was no system in place to manage national patient safety or medicines alerts that affected the dental practice. This put patients at risk of receiving unsafe care or treatment.

There was no system in place to ensure that the practice was complying with the control of substances hazardous to health (COSHH). Substances in use at the practice had not been risk assessed and measures put in place to keep staff and patients safe.

We were told that regular staff meetings took place but there was no evidence available that reflected that these had occurred. Minutes of meetings were not being recorded and there was no other system in place to discuss safety issues with staff, seek their ideas for improvement and cascade relevant learning to them.

On 22 July 2015 we visited the practice again to assess whether sufficient progress had been made in relation to the evidence we found on 24 June 2015.

We found that the practice had made sufficient progress in relation to the way they handled significant events. A process for managing them was in place and they had started staff meetings where safety was a fixed agenda item. Meetings had been scheduled monthly and minutes were being recorded.

They had reviewed their COSHH procedures and were now following published guidance. A system was in place to manage national patient safety and medicine alerts.

We found that the areas identified at our first inspection had been dealt with satisfactorily.

Reliable safety systems and processes (including safeguarding)

On 24 June 2015 we found that the was no identifiable lead in place who took responsibility for safeguarding issues. Some staff at the practice had not received safeguarding training for children and vulnerable adults. Training records were inconsistent and it was unclear who had received this training. Some staff members told us they had received this training; however staff could not describe the types of abuse that could take place or the system for reporting them to a nominated individual internally or externally if required. Contact numbers of external agencies to whom safeguarding concerns should be reported were not available to support staff.

The dentists we spoke with on the day all used rubber dam for endodontic procedures. Rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to

isolate the operative site from the rest of the mouth. This prevents inhalation of small instruments during treatment. It was practice policy not to re-use rubber dams and dentists spoken with were aware of this requirement.

We were told that patients attending for their consultation had their medical history reviewed on each occasion by one of the dentists to ensure that any health conditions or medicines being taken could be considered before receiving care or treatment. We looked at a sample of ten patient records and found that the medical history was not being checked each time they attended. We compared the appointment date with the latest entry on the medical history form and found that seven of them did not match. This indicated that this was not routinely taking place and put patients at risk. When asked about this the provider was unaware that records were not accurate.

On 22 July 2015 we visited the practice again to assess whether sufficient progress had been made in relation to the evidence we found on 24 June 2015.

We found that all staff had been booked on safeguarding training for the end of July 2015 and a lead for safeguarding had been appointed. The system for recording the medical history of patients had been revised and was now robust and we were shown the system in place.

Medical emergencies

On 24 June 2015 we found that the practice held emergency medicines, a first aid kit and oxygen but these were not readily accessible to staff in the event of a medical emergency.

The range of emergency medicines and equipment available in the practice were in line with the 'Resuscitation Council UK' and 'British National Formulary' guidelines. We checked the emergency medicines and found that they were of the recommended type. However one of the recommended emergency medicines, glucagon (used if diabetic patients experience a medical emergency caused by low blood/sugar levels), was not in the emergency medicine supplies. There was no checking process in place to ensure stocks did not run low or that medicines had expired.

We were told that sufficient numbers of staff had been trained in basic life support, including the use of emergency oxygen but when trained staff were asked to demonstrate its use they were unable to operate the oxygen. The oxygen was also due to be serviced in August 2014 but this had not taken place. The practice had chosen not to have a defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm).

All emergency medicines we viewed were in date but there was no system in place to check the expiry dates and stock levels and this included the completion of records to reflect that they were being checked routinely. The location of the medicines and their accessibility was not suitable to afford easy access for staff needing to use them in an emergency. We asked staff to unlock the case containing the medicines but they were unable to do so. Different medicines were stored in different locations; this was not satisfactory and likely to delay the treatment of a patient suffering with a medical emergency. It was apparent from our findings that the staff at the practice were not able to respond to a medical emergency and procedures must be reviewed.

On 22 July 2015 we visited the practice again to assess whether sufficient progress had been made in relation to the evidence we found on 24 June 2015.

We found that appropriate emergency medicines and equipment were now in place and readily accessible to staff. They had received training in how to use the equipment and the oxygen had been replaced. There was a system in place to monitor expiry dates and the correct medicines were being stocked and were in date. Weekly checks were being made and these had been recorded. There were no outstanding matters form our first inspection.

We found that the areas identified at our first inspection had been dealt with satisfactorily.

Staff recruitment

On 24 June 2015 we found that the practice did not have a recruitment policy for staff to follow. We looked at three staff files on the day of our inspection to establish whether there were robust recruitment processes in place, including supporting documentation that reflected that staff new to the practice were suitably qualified and experienced to carry out their role.

One staff file was that of a newly employed dental nurse who had been employed in January 2015. There was a disclosure and barring service check (a check to identify

whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable) in place that was dated June 2012. This was three years old at the time of their employment and a recent check had not been undertaken. No references had been taken for this member of staff.

The practice manager in post at the time told us that they had referenced this member of staff verbally, having worked with them in the past. This had not been recorded in the staff file or that other references were not required. There was no evidence of documentation verifying their identity. There was no evidence that the dental nurse was appropriately skilled or qualified. There was a letter stating that the dental nurse was currently registered with their professional body. The practice manager told us that this had not been confirmed for this member of staff or any other member of staff. They were unaware that this registration could be checked via the internet to eliminate the risk of identity fraud or forged documentation. There were no systems in place to monitor registration annually.

A second staff file we looked at contained insufficient detail to assure us that the staff member had been through a robust recruitment process. This member of staff had commenced employment in May 2013. There was a lack of documentation to support that they were suitably qualified and experienced, there were no references or proof of identity, no criminal record check (this was relevant at the time of their employment as the DBS was not in use then) and no evidence that they had been through an interview process. A letter was present that reflected that they were a member of their professional body but this expired in July 2014. There was no evidence to reflect that they were currently registered and therefore qualified to practice as a dental nurse.

We looked at the file of a member of staff that was regularly used as a temporary employee when staff shortages occurred. We asked what the system was for checking that temporary staff were suitably skilled and qualified. We were told that the agency was responsible for those checks. We asked to view the documentation in relation to the agency to identify whose responsibility it was to check on competence. This was not available for us to view. Some agencies stipulate that it is the responsibility of the provider and not the agency to check competence. The previous practice manager we spoke with, now working at the practice in a different role, said they did not check the qualifications of temporary workers.

We found that recruitment processes were not robust and this put patients at risk of receiving unsafe care and treatment. There was also no oversight of these processes by the provider to ensure that safe recruitment systems were being followed.

There were sufficient numbers of staff working at the practice. A system was in place to ensure that where absences occurred, part-time staff were contacted to attend the practice and cover for their colleagues. Where this was not possible agency staff, or qualified temporary workers were used. Locum dentists were rarely used. However there was an ineffective system in place to check and monitor the qualifications and competence of staff working at the practice.

On 22 July 2015 we visited the practice again to assess whether sufficient progress had been made in relation to the evidence we found on 24 June 2015.

We found that the practice had made progress in relation to their recruitment process and a new practice manager had been appointed to oversee this area of concern. We accepted this was work in progress. The new practice manager was planning to review all of their recent staff members to ensure appropriate documentation was in place to reflect that staff were suitable qualified and experienced to carry out their roles, including renewing disclosure and barring service checks where relevant. When we next visit the practice we will look at whether they have robust recruitment processes.

Monitoring health & safety and responding to risks

On 24 June 2015 we found that he practice had a health and safety policy but had not undertaken a health and safety risk assessment as required by health and safety legislation, so risks to patients and staff who attended the practice were not being mitigated.

The practice had a business continuity plan that outlined the procedures to follow in the event that services were disrupted. This identified the steps to take so that the practice could maintain a level of service for the patients.

Accidents had been recorded in the records of complaints but there was an inadequate response to them. The

analysis and investigation from the accidents did not give us assurance that learning had been identified and acted upon as the lead dentist was unaware of some of the issues. There was no evidence that learning had been cascaded to staff at team meetings or other means of communication.

There was no written policy or procedure to follow in the event of a fire or the need to evacuate the premises and there was no evidence that staff had received fire training or that fire drills had taken place.

On 22 July 2015 we visited the practice again to assess whether sufficient progress had been made in relation to the evidence we found on 24 June 2015.

We found that health and safety and legionella risk assessments had been planned for the near future in order to comply with health and safety legislation. A log had been designed to record the action taken to mitigate the risks of legionella. A satisfactory system was in place to record, analyse and identify improvements if accidents occurred.

Infection control

On 24 June 2015 we found that the practice was visibly clean, tidy and uncluttered. An infection control policy was not in place and a lead had not been identified. There was no information to support staff in the event that a needle stick injury occurred and no policies or procedures in relation to inoculations against Hepatitis B and the handling of clinical waste.

There was no policy in place that described how cleaning was to be undertaken at the premises, including the general areas and the surgeries. Checklists were not available to support staff carrying out these duties and there was no information available about the protocols used by the cleaning company. There was no colour coding of cleaning equipment and the mop heads we looked at were visibly dirty. There were no records held to reflect that the quality of the cleaning was being monitored.

On the day of our inspection we asked one of the dental nurses to talk us through the cleaning procedure they used in the surgery before and after a patient attended. We found that the correct processes were being followed including cleaning in between patients and wearing clean personal protective equipment for each patient. However we found that dental nurses did not have cleaning checklists in place in the surgeries to support them in following robust infection control processes.

We were told that dental unit water lines were being flushed through at the end of the day and occasionally between patients for 20 seconds but this was not being recorded. There was no start of day procedure or guidance for dental nurses to follow.

We looked at the procedures in place for the decontamination of used dental instruments. The practice had a decontamination room that was not set out according to the

Department of Health's guidance, Health Technical Memorandum 01-05 (HTM 01-05):

Decontamination in primary care dental practices. The room was also used to take and develop X-rays and used by different staff and patients when X-rays were taken. The room contained a number of stored waste chemicals and one sink. There was a strong smell of chemicals and no ventilation in the room. This increased the risk of cross contamination.

We observed a dental nurse going through the decontamination process for some used dental instruments. We found that instruments were not being cleaned and sterilised in line with published guidance (HTM 01-05). We noted that there was no defined dirty to clean zones as there was a lack of space in the room.

The single sink in use had a small ledge where two plastic containers were being used, one for cleaning and one for rinsing. The sink was visibly dirty and the scrubbing brush used for cleaning and the protective gloves used were lying in the sink. We looked at the gloves and rather than being heavy duty gloves, as recommended, domestic rubber gloves were in use. This increases the risk to staff of an injury from sharp instruments when cleaning them.

During the decontamination process the correct personal protective equipment was not being used. This included an apron and protective glasses. We saw that when the instruments were being cleaned with a scrubbing brush in the first plastic container, they were not held below the surface to prevent splashing. Accordingly the water from the cleaning bowl splashed into the rinsing bowl.

Are services safe?

Once cleaned, the instruments were inspected with a magnifying glass but this was not a thorough check. The instruments were then placed in the rinsing water by the dental nurse wearing the dirty gloves used for the cleaning. The instruments were not dried and placed on a sterilising tray and placed in the autoclave whilst wearing the dirty gloves. The guidance is to dry the instruments before they are put into the steriliser. The dental nurse demonstrating had forgotten to oil the hand pieces as required so took a hand piece from the sterilising tray, dried it and oiled it over the sink where the scrubbing brush had been left.

The instruments were then sterilised in the autoclave and placed into pouches, sealed and dated correctly. Whilst looking at the sterilised instruments in the sterilising tray, after the sterilising cycle, we found a rose head bur which is a single use dental instrument. This was being re-used. When we asked the dental nurse about it they could not provide us with a satisfactory explanation as to the reason why it was present.

We found there were cross contamination risks throughout the decontamination process and there was no hand washing facilities available in the decontamination room. The maintenance records for the autoclave were very sparse and entries were not being made in the maintenance logs for every cycle. There was no evidence to reflect that the start and end of day procedures for the autoclave were being followed. This put patients at risk of a healthcare related infection.

We discussed our findings on the day of the inspection and the provider assured us that immediate action would be taken. We were contacted the next day and told that the correct procedures were being followed.

The practice had undertaken a legionella risk assessment in June 2015 as required by legislation, but there was no evidence of this having been done in recent years. Legionella is a term for particular bacteria which can contaminate water systems in buildings.

Infection control audits not had been carried out at six monthly intervals as required by guidance from the Department of Health. Staff responsible for infection control and the provider were not aware of this requirement or that it had changed from three months to six months over a year ago. Historically, infection control audits at the practice had been taking place irregularly and sometimes in excess of annually. The latest infection control audit was dated seven months prior to the inspection but this had not identified any of the issues that we discovered on the day of the inspection and was therefore ineffective. The person carrying out the audit had not received training in infection control.

We found there were adequate supplies of liquid soaps and hand towels throughout the premises and hand washing techniques were displayed. A clinical waste contract was in place and this was stored securely until collection. Clinical waste bins were being emptied by the contract cleaner and this posed a risk to them. Sharps boxes were in place, were stored correctly and not over filled but they had not been signed or dated.

On 22 July 2015 we visited the practice again to assess whether sufficient progress had been made in relation to the evidence we found on 24 June 2015.

We found that infection control procedures were now robust and included cleaning checklists for the surgeries and they were being completed. The practice had updated their Control of Substances Hazardous to Health (COSHH) file and colour coded mops were now being used to reduce the risk of cross contamination.

We spoke with two dental nurses and observed the decontamination process for used dental instruments. Staff had received infection control training and most of the recognised decontamination procedures for used instruments were being followed. The cleaning, rinsing and inspection of used instruments was now being undertaken in the dental surgeries and then sterilisation took place in the decontamination room.

We found no evidence that single use dental instruments were being used. There was a needle stick policy in place and dental nurses spoken with understood the process to follow if an accident occurred.

However we found that the detergent used for cleaning used instruments was not being measured to ensure the correct water/detergent ratio and the temperature of the solution was not being checked. Staff were not wearing appropriate personal protective equipment nor washing their hands before and after the cleaning process. The cleaning solution must be below 45 degrees centigrade and staff should wear protective gloves throughout the

process and wash their hands before and after the cleaning process. We pointed this out to the dental nurses and to the provider at the end of our visit. They told us that further improvements would be made.

Equipment and medicines

On 24 June 2015 we found that the records we viewed reflected that some equipment in use at the practice was regularly maintained and serviced in line with manufacturers guidelines. Fire extinguishers were in place throughout the practice and they had been checked and serviced regularly by an external company. Staff had been trained in the use of equipment and evacuation procedures.

X-ray machines were not receiving regular visible checks and records had not been kept. There was no supporting evidence that reflected that X-ray equipment was being serviced in line with recommended intervals.

All equipment used for the cleaning and sterilising of medical instruments had been serviced and maintained regularly. Records reflected that it was in working order at the time of the inspection.

On 22 July 2015 we visited the practice again to assess whether sufficient progress had been made in relation to the evidence we found on 24 June 2015. We found that all X-ray equipment had been serviced at appropriate intervals and a system was in place to periodically undertake visible checks on the X-ray equipment.

Radiography (X-rays)

On 24 June 2015 we found that the practice was unable to produce their radiation protection folder. This documentation provides evidence that the practice uses safe procedures when taking X-rays. Due to the absence of documentation, we could not be assured that before the installation of X-ray equipment, a prior risk assessment had been undertaken by a qualified radiation specialist. This would have approved the installation of such equipment, designated the areas where it should be located and ensured that if required, walls were suitably lead-lined to reduce the risk to patients and staff from radiation exposure.

In addition the documentation would identify those persons qualified to undertake X-rays, the safety measures to be adopted, the local rules for each areas where they would be taken and confirm the levels of radiation emitted from the equipment were safe for patients and staff.

As a result of the lack of appropriate documentation we were not assured that procedures were safe or that the equipment was operating effectively. We therefore asked the provided to voluntarily cease taking X-rays which they agreed to do. On the following day we were then advised that the provider had employed a radiation protection advisor (RPA) to attend the practice and conduct the appropriate safety checks. We were contacted by the RPA within the next two working days and provided with documentation that assured us that the X-ray equipment was safe to use by qualified personnel. The provider then contacted us to confirm so we agreed that they could resume the taking of X-rays.

Regardless of the absence of the documentation, we found that one of the dental nurses was taking X-rays. This included positioning the patient in the correct position and operating the equipment. On speaking with them we established that they were not qualified to do so and had not received the correct training to enable them to carry out the role. The provider agreed to stop this dental nurse taking X-rays in the future.

One of the dentists spoken with was asked about the frequency of X-rays for patients. They told us that each patient would usually receive an X-ray annually rather than justifying and recording the reasons for the X-ray being taken.

We found that there were no X-ray audits taking place to assess the quality of them. Due to medical history records being completed and updated inconsistently, we could not be assured that patients who were or might be pregnant were adequately protected from the risk of radiation or that the risks to them had been assessed before deciding that an X-ray was necessary.

On 22 July 2015 we visited the practice again to assess whether sufficient progress had been made in relation to the evidence we found on 24 June 2015.

We found that an RPA and an RPS had been appointed, qualified staff only were now taking X-rays and radiation documentation was almost completed to a satisfactory standard. There were some minor administration issues

Are services safe?

that required completing such as staff signing local rules for the safe use of X-rays to reflect that they understood the procedures. An audit of X-rays had taken place. We will review this area of concern when we next visit the practice but were satisfied that the taking of X-rays was safe for patients and staff and that administration matters only remained outstanding.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

On 24 June 2015 we found that the practice carried out consultations and assessments in line with recognised guidance from the National Institute for Health and Care Excellence (NICE) and General Dental Council (GDC) guidelines. Dentists we spoke with were aware of the latest NICE guidelines and the preventative care and advice known as "Delivering Better Oral Health Toolkit". This involved identifying patients at high risk of tooth decay and then applying fluoride varnish to the teeth at specific intervals. High fluoride toothpastes were also prescribed for patients who had a high risk of tooth decay.

Each patient received an oral examination prior to deciding whether further care and treatment was required. This assessment included an examination covering the condition of a patient's teeth, gums and soft tissue and whether there were any signs of mouth cancer. Patients were then made aware of the condition of their oral health and treatment discussed with them.

The practice had software which was used to show patients the condition of their oral health through images of their teeth displayed on a screen. This also enabled them to provide before and after treatment images to show patients how they were progressing and the effectiveness of their care and treatment.

We were told that at each visit the medical history of patients was checked and updated and that this was maintained in the patient's record. We found that this was not being consistently undertaken.

Following the consultation X-rays were taken in line with Faculty of General Dental Practice (FGDP) guidelines. This identifies patient's risk factors and gives suggested intervals to take X-rays in order to diagnose or monitor tooth decay. All X-rays taken were recorded in the clinical records. A diagnosis was then discussed with the patient and appropriate treatment was planned.

There was evidence that recall intervals were adjusted to an individual patient's needs. This was in line with NICE guidelines. This recall interval was based on risk factors including tooth decay, gum disease, medical history and soft tissue condition. These recall intervals were discussed with the patients and an explanation given.

We saw evidence that patients requiring treatment were supplied with a written treatment plan which included details of the treatment required. This also included the costs associated with the treatment.

Health promotion & prevention

On 24 June 2015 we found that the waiting room and reception area at the practice contained a range of posters that explained the services offered at the practice in addition to information about effective dental hygiene and how to reduce the risk of poor dental health. These included dietary, alcohol and smoking information and the effect they have on maintaining good oral health.

There was information for parents to encourage and promote their children to maintain healthy teeth. An area had been designated that was child friendly and contained posters and information that was fun for them and encouraged them to read. There was an A – Z wall display that helped teach children the benefits of good oral health in a way that they would understand. The dentists we spoke with confirmed that children attending the practice were advised during their consultation of steps to take to prevent tooth decay and this was monitored at subsequent visits to ensure it had been effective.

Patients were recalled at appropriate intervals to check on their teeth to ensure that prevention methods were effective.

Staffing

On 24 June 2015 we found that the practice did not have an appraisal policy or system in place. We spoke with three dental nurses, the previous and current practice manager and the associate dentist; none of them had received an appraisal and this had been the case for a number of years. We looked at staff files for confirmation and no appraisals were present. Members of staff who had been employed in May 2013 and January 2009 respectively had not received appraisals since the date of their employment.

We spoke with the managers and lead dentist at the practice who confirmed that appraisals were not being completed. We asked if there was another system in place to monitor the effectiveness of staff. We were told by the lead dentist that they would work with dental nurses to assess their competency if an issue about performance had been raised, but no records were being kept.

Are services effective?

(for example, treatment is effective)

Staff spoken with told us that they received an annual pay review but their performance was not discussed. There was no system in place to identify training needs or development opportunities or to comment on their performance throughout the year to reflect that they were competent. Staff told us they felt supported and advice from the dentists was readily available. They told us that it was a nice place to work.

We looked at the staff files for a number of the clinical staff working there and found that training records and evidence of qualifications was inconsistent. The previous practice manager told us that records were requested from staff but if they did not supply them this was not followed up. No staff member at the practice had oversight of the current training position of any of the staff. We were told by clinical staff members we spoke with that they were encouraged to maintain their continuing professional development (CPD) to maintain their skill levels. However there was no evidence in the files that this was being completed.

We found no system in place to confirm that clinical staff were registered annually with their professional bodies. Some documentation we viewed reflected that staff registration had expired in 2014 and this had not been checked to ensure they were still qualified to practice and did not have any restrictions applied to them.

On 22 July 2015 we visited the practice again to assess whether sufficient progress had been made in relation to the evidence we found on 24 June 2015.

We found that the provider had put in place a supervision and appraisal process, including identifying development and learning opportunities for their staff. We accepted that this was work in progress and that the practice was looking at updating the personnel records of their staff and conducting appraisals in the future.

Working with other services

On 24 June 2015 we found that the practice had systems in place to refer patients for specialist treatment if it was required. Records we viewed reflected that relevant information was recorded and sent with the referral that identified the reason and the symptoms necessitating the referral including copies of X-rays if relevant. We found that there was no backlog on the day of our inspection.

The practice did not undertake conscious sedation for nervous patients but those wishing this kind of service were referred to a practice that carried out the procedure. Once the treatment had been completed the patient was transferred back to the practice for any follow-up treatments.

Consent to care and treatment

On 24 June 2015 we spoke with two dentists on the day of our visit and found that one of them was unaware of the Mental Capacity Act 2005. We explained what the Act meant in relation to patients that may have had a reduced mental capacity and the need to explain things in a way they understood to assess whether they were able to consent to care and treatment. The dentist concerned did not know that in some cases there might be a need to make a decision in the best interests of the patient and to involve carers or relatives in the process, if they were available.

Some clinical and non-clinical staff spoken with were not aware of Gillick competency. This is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Patients indicated their consent to care and treatment verbally but written treatment plans were supplied for both NHS and private treatments. These were signed by the patients when written consent was required.

On 22 July 2015 we visited the practice again to assess whether sufficient progress had been made in relation to the evidence we found on 24 June 2015.

The provider had plans in place to ensure staff understood the Mental Capacity Act 2005 and Gillick consent.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

On 24 June 2015 we found that staff at the practice treated patients with dignity and respect and maintained their privacy. The reception area was open plan but if a confidential matter arose, a private room was available for use.

We observed that reception and clinical staff were kind and caring and treated them with dignity and respect. The CQC comment cards we reviewed reflected that patients were satisfied with the way they were treated at the practice by clinical and non-clinical staff.

Involvement in decisions about care and treatment

On 24 June 2015 we were unable to speak with patients on the day of the inspection but CQC comment cards we viewed reflected that patients felt that the dentists listened to them and involved them in the decisions about their care and treatment. We were told that consultations and treatment options were clearly explained to them followed up by a written treatment plan and the costs involved.

Dentists spoken with explained that they outlined the options, risks and benefits of treatment and recorded these in the patient record.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

On 24 June 2015 we found that the practice offered mainly NHS and a small amount of private treatments. The costs of each were clearly displayed in the practice and on their website. The website contained information that described the different types of services that patients could receive and a description of the treatment that would take place. This included information for new patients about the initial assessment of their oral health to identify any relevant issues or treatment that might be required.

The facilities and premises were appropriate for the services that were planned and delivered.

The practice did not offer conscious sedation for patients who were nervous but referrals could be made to a practice that carried out this procedure.

The practice did not undertake patient surveys to enable them to respond to patient feedback. We were told that appointment availability met the needs of patients and they were rarely kept waiting. CQC comment cards reflected that the majority of patients were satisfied with the services provided at the practice.

Tackling inequity and promoting equality

On 24 June 2015 we found that all the surgeries were on the ground floor and accessible to all patients. Patients with mobility issues were supported by staff when they needed it. One particular surgery was used for patients with limited mobility as it was the easiest to access.

The practice did not have translation services but the dentists spoke a variety of languages between them. There had not been a need to use a translator as patients were supported by their friends and family.

We were told that there were a number of patients that attended who had learning disabilities. They were supported to understand their care and treatment and explanations given in a way they understood after consulting with carers or relatives.

Access to the service

On 24 June 2015 we found that the appointment times and availability met the needs of patients. The practice was open Monday to Thursday between the hours of 8.30am and 5.30pm and Fridays between the hours of 8.30am and 3pm. The practice closed during the lunch period. Information about opening times was displayed in reception.

Patients with emergencies could usually get an appointment on the same day or sit and wait to be seen if one was not available. If a patient could wait they would be seen the following morning. Outside of surgery hours an answer phone message directed patients to an out of hour's service for the local area.

Patients that completed CQC comment cards prior to our inspection stated that they were satisfied with the appointment system and that they were rarely kept waiting.

Concerns & complaints

On 24 June 2015 we found that the practice had a complaint procedure that was advertised in the reception area. Forms were available for patients to use. The practice manager was the current designated lead for the handling of complaints. We were told that the provider had oversight of all complaints but we found that this was not the case. Staff we spoke with were aware of the procedure to follow if they received a complaint and forms were available for the purpose.

The procedure explained to patients the process to follow, the timescales involved for investigation, the person responsible for handling the matter and details of other external organisations that a complainant could contact.

We looked at the three complaints that the practice had received in the last 12 months. We found that although replies had been sent expressing apologies, there was a lack of investigation that identified the cause or any learning from the incidents. Complainants were not provided with explanations and there was a lack of clinical oversight by the provider.

One complaint related to a patient swallowing a piece of dental equipment and when we spoke with the provider about it they were unaware that it had happened. There had been an offer of compensation made by the staff member dealing with the complaint but there had been no cause or learning identified that could be cascaded to staff.

Are services responsive to people's needs?

(for example, to feedback?)

Replies sent to complainants reflected that the practice had offered an apology but there was no explanation. It was evident form the record of the complaints that their complaints process was ineffective.

On 22 July 2015 we visited the practice again to assess whether sufficient progress had been made in relation to the evidence we found on 24 June 2015.

The practice had identified a lead member of staff to handle complaints and the provider assured us that they would oversee all complaints, investigations, analysis and ensure that learning opportunities were identified and cascaded to staff. They said they would be responding to complaints in line with their new complaints policy and providing suitable explanations and apologies if appropriate, to their patients. We were unable to assess the effectiveness of this new procedure as no complaints had been received since our visit on 24 June 2015 but the system in place was satisfactory.

Are services well-led?

Our findings

Governance arrangements

We were told by the lead dentist that the practice manager was responsible for all matters relating to governance, including compliance with the regulations. We found that the provider was not overseeing any of the systems and processes at the practice.

We spoke with the new practice manager who had been appointed in March 2015. We were told that they had not received any training for the role. They had not been given a job description so were unclear of their role and what was required of them. They told us that the previous practice manager was responsible for the day to day running of the practice. When we spoke with the previous practice manager, they informed us that they only worked one day each week and only on financial matters relating to the practice. They told us they were not given the responsibility for mentoring the new practice manager but we had been told the contrary by the provider. We found that the governance arrangements lacked clarity.

Although there was evidence of some policies and procedures in place they were incomplete and not bespoke to the practice. There was no system in place to ensure staff had read and understood them. We noticed that several policies that we expect to be in place at a dental practice were missing. These included infection control, needle-stick injury and information governance. There were no regular reviews of policies and procedures taking place. Those policies in place included health and safety, significant events, clinical governance and whistle blowing.

We found that there was no clear system in place to undertake audits or to monitor and assess the quality of the services they provided. We were told that an X-ray audit had been started but there was no evidence of this available to view. We found no history of X-ray audits being completed.

Infection control audits should take place every six months. In recent years this requirement was every three months. The latest infection control audit took place seven months before the inspection which is acceptable. Other infection audits were not taking place at the required intervals and this had been the case for a number of years.

The infection control audit that had been recently completed reflected that infection control procedures were robust. However we found many areas during the inspection that made it clear that ineffective systems and processes were in place in relation to infection control and the decontamination of used instruments. These had not been identified in the audit and this reflected that the checking system was neither robust nor thorough.

On 22 July 2015 we visited the practice again to assess whether sufficient progress had been made in relation to the evidence we found on 24 June 2015.

A new practice manager was now in place and was responsible for governance and compliance with the regulations. The provider had assumed full responsibility for the practice and the way it was managed. They told us they would have more oversight, be present at meetings, provide visible leadership and take an active role in the management of the practice.

We found that a range of policies were now in place, were in the process of being reviewed and tailored to the individual requirements of the practice. The practice manager and provider had received support and training in relation to governance and were about to start a programme of clinical and non-clinical audit. These included X-ray quality, infection control, the appointment system, emergency procedures and recalls of patients. The improvements required remain ongoing.

Leadership, openness and transparency

There was a lack of leadership and oversight at the practice by the provider.

The provider had insufficient knowledge of the Health and Social Care Act Regulations and how they should be applied to a dental practice, the staff and their patients. Systems and process were not being monitored to ensure compliance with the regulations. Upon registration, the provider had indicated in writing that the regulations were being complied with but they demonstrated to us on the day that they were not aware of them or their responsibilities as provider.

There was a lack of policies and procedures to support staff and to make clear the standards expected of them. There was no-one at the practice responsible for oversight of systems and processes to ensure that standards were being followed and maintained. The provider was not pro-active

Are services well-led?

in ensuring that staff working at the practice were up to date with training, qualifications and registration with their professional bodies. There was no follow-up to ensure they supplied the appropriate information. Staff were not receiving supervision or appraisal as required by the regulations and recruitment processes were not being followed. There was a clear lack of understanding of how the Health and Social Care Act Regulations linked to safe patient care.

Prior to the inspection we were provided with information about one of the dentists who had allegedly been re-using dental instruments designed for single use only. We asked the practice manager whether they had received any information from staff members about poor clinical practices and they told us that they had not. When asked again, later in the day, they changed their mind and told us that they were aware of this allegation. This had not been recorded by the provider as a complaint, a significant event, a safety issue or as under-performance in the personnel record of the staff member concerned.

We asked what action the provider had taken to investigate this allegation as this was clearly a safety and performance issue. We were told that they had investigated it by personally speaking to the dentist to re-assure themselves that this was not taking place. This had not been recorded in any form at the practice. This demonstrated that under-performance was not being investigated and managed effectively as no records of any investigation had been recorded.

On the day of our inspection we found evidence that the same dentist was re-using single use items after sterilising them and we seized a number of items using our powers under the Police and Criminal Evidence Act 1984. As a result of these findings the provider took disciplinary action against the dentist concerned. Evidence of this was sent to us after the inspection.

However it was clear that staff thought that the leadership at the practice was visible and that managers were open and transparent. They were encouraged to raise issues and ideas for improvement and felt supported. We were told that occasional team meetings did take place but they were not minuted. They said the provider and practice manager were approachable and available for advice and guidance.

The practice did not provide satisfactory explanations to patients as a result of safety incidents and complaints and therefore did not display a duty of candour, openness and honesty.

On 22 July 2015 we visited the practice again to assess whether sufficient progress had been made in relation to the evidence we found on 24 June 2015.

We found that the leadership at the practice had improved from the perspective of the provider. A new practice manager had been appointed since our last inspection and they were in the process of familiarising themselves with their role and receiving oversight from the provider. Progress had been made in relation to reviewing policies and procedures and setting standards for their staff to follow. Staff were now required to read their policies and sign to indicate they had understood them. Lead roles had been identified such as safeguarding and infection control.

Management lead through learning and improvement

Staff meetings were not held regularly and minutes were not recorded for those that had taken place. The provider told us that the meeting system was ad hoc and usually informal. Significant events, safety issues and complaints were not routinely discussed and staff were not given an opportunity to offer ideas for improvement. We found that learning had not been identified satisfactorily so therefore it could not be cascaded to staff to prevent a re-occurrence.

Staff appraisals were not taking place so training and development needs were not being identified. Staff told us that they were encouraged to undertake their continuous professional development but there was no evidence to show that it was being completed or monitored.

There was no audit timetable in place and no evidence that reflected that any were taking place There was no other system in place to monitor and assess the services provided for the practice to learn and improve.

On 22 July 2015 we visited the practice again to assess whether sufficient progress had been made in relation to the evidence we found on 24 June 2015.

Staff meetings were now being held regularly and minutes recorded. They were being used to discuss governance, safety issues and complaints.

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

Are services well-led?

There was no formal system in place to seek feedback from the staff working at the practice. We were told that staff were encouraged to raise any issue if they wished to do so.

We were told that a patient survey had taken place and that 50 replies to questionnaires had been received. We looked at the replies. There were only 26 available and many were undated and incomplete. Those that were dated ranged from 2011 to 2015. There had been no analysis or findings as a result of the completed questionnaires. When asked about how they conducted the survey, the practice was vague about dates and the system used to capture patient feedback. In summary there was no system in place to obtain feedback from patients about the services provided.

On 22 July 2015 we visited the practice again to assess whether sufficient progress had been made in relation to the evidence we found on 24 June 2015.

We found that team meetings and the appraisal process were going to be used to provide staff with the opportunity to suggest areas for improvement. A patient satisfaction survey was also planned and suitable questions about the services provided were being prepared.

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 **Regulation 12: Safe care and treatment** How the regulation was not being met: a health and safety and legionella risk assessment had not been undertaken; infection control audits were ineffective and not taking place at recommended intervals; some recommended procedures for the decontamination of instruments were not being followed. **Contrary to Regulation 12(1)(2)(a)(b)(c)(e)(g)(h)**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17: Good governance** How the regulation was not being met: The practice did not have a system in place to assess, monitor and improve the quality of the services provided by undertaking clinical and non-clinical audits or other means; risks to patients and staff were not being assessed or mitigated; employment records and documentation was not being kept in relation to staff working at the practice; patient feedback about the services was not being sought; staff feedback was not being sought or recorded about the services provided; **Contrary to Regulation 17(1)(2)(a)(b)(c)(d)(e)**

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	**Regulation 18: Staffing** How the regulation was not being met: Staff at the practice had not received appropriate support, training, professional development, supervision and appraisal and/or it was ineffective in relation to safeguarding, infection control, decontamination of used dental instruments, X-ray procedures, basic life support, whistle blowing, Mental Capacity Act training, awareness of Gillick competence and recruiting procedures. Staff at the practice were not receiving appropriate supervision or appraisal; under performance procedures were not in place or being followed; staff could not evidence their continuous professional development as a condition of their ability to practise, **Contrary to Regulation 18(1)(2)(a)(b)(c)**
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Regulation 19: Fit and proper persons employed** How the regulation was not being met: The practice did not have an effective recruitment process. There was a lack of documentary evidence for staff to demonstrate that they were of good character, suitably qualified, competent, skilled and experienced to carry out their roles. Schedule 3 documentation was either missing form staff files or had not been taken when employing new members of staff. There was an ineffective system in place to check that staff remained registered with their professional body and were not the subject of conditions or suspension. **Contrary to Regulation 19(1)(a)(b) and (2)(a)(3)(a) and (4)(a)(b)**