The Dental Surgery

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Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 20 November 2023 under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

We planned the inspection to check whether the registered practice was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations.

The inspection was led by a Care Quality Commission (CQC) inspector who was supported by a specialist dental advisor.

To get to the heart of patients' experiences of care and treatment, we always ask the following 5 questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

Our findings were:

- The practice had staff recruitment procedures which reflected current legislation.
- Patients were treated with dignity and respect. Staff took care to protect patients' privacy and personal information.
- Staff felt involved, supported and worked as a team.
- Patients were asked for feedback about the services provided.
- Complaints were dealt with positively and efficiently.
- The practice had information governance arrangements.
- The dental clinic appeared generally clean. However, work surfaces in the clinical area and the decontamination room were cluttered and not impervious.

Summary of findings

- The practice infection control procedures did not reflect published guidance.
- Appropriate medicines and life-saving equipment were not available. Improvements were needed to staff`s knowledge about the management of medical emergencies.
- The practice did not have effective systems to manage risks for patients, staff, equipment and the premises.
- There were ineffective processes in place to prevent abuse of vulnerable adults and children.
- Improvements were needed to clinical staff`s understanding of the current clinical guidelines.
- Improvements were needed to ensure patient care records were complete and included adequate details of the care provided.
- There was a lack of effective governance and there were no systems in place to support continuous improvement.

Background

The Dental Surgery is in Temple Fortune, in the London Borough of Barnet and provides private dental care and treatment for adults and children.

The practice had two small steps at the entrance and there were processes in place to communicate this to patients prior to their appointments. Car parking spaces are available near the practice.

The dental team includes 2 principal dentists and 1 qualified dental nurse. The practice has 2 treatment rooms.

During the inspection we spoke with all members of staff. We looked at practice policies, procedures and other records to assess how the service is managed.

The practice is open:

Monday to Thursday from 9am to 5pm

Friday from 9am to 1pm.

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

- Ensure care and treatment is provided in a safe way to patients.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.
- Ensure persons employed in the provision of the regulated activities receive appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out their duties.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

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

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

- Take action to ensure audits of record keeping and antimicrobial prescribing are undertaken at regular intervals to improve the quality of the service. The practice should also ensure that, where appropriate, audits have documented learning points and the resulting improvements can be demonstrated.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?	**Enforcement action**
Are services effective?	**Requirements notice**
Are services caring?	**No action**
Are services responsive to people's needs?	**No action**
Are services well-led?	**Requirements notice**

Are services safe?

Our findings

We found this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement Actions section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

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

The practice did not have effective safeguarding processes to prevent abuse, and staff did not know their responsibilities for safeguarding vulnerable adults and children. Internal safeguarding arrangements were not communicated effectively. One of the staff members we spoke with, was unaware of the safeguarding arrangements within the practice, and another staff member could not tell us the correct procedures to follow if they suspected abuse of a service user. Furthermore, on the day of the inspection there was no evidence that staff had completed safeguarding training at a level appropriate to their role.

The decontamination process demonstrated by staff was not in accordance with the Department of Health publication 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05). There were no systems and processes to monitor the use of long-handled brushes and domestic gloves. Water temperature was not monitored throughout the cleaning process to ensure it was 45C or lower. The practice did not have clearly marked containers for the transportation of sterilised instruments to ensure the segregation of contaminated products from clear. Staff used washing-up liquid for the cleaning of instruments. This is not in line with the guidance set out in HTM01-05 which states that detergents specifically formulated for the cleaning of instruments should be used. We noted that staff used tissue for drying instruments processed in the vacuum steriliser. This is not in line with the guidance which states that disposable non-linting cloth should be used.

We observed that work surfaces in the treatment rooms were not impervious, to ensure they were easily cleansable, and the clinical area was cluttered. The dental chairs showed visible damage.

Flooring in the clinical area and in the decontamination room was not impervious and coved to the wall to prevent the accumulation of dirt where the floor meets the wall.

The practice did not have effective systems and processes in place to control the storage time of sterilised instruments. Staff could not demonstrate that all unwrapped dental instruments stored in the clinical area were reprocessed at the end of the working day. The principal dentist told us that 4 instrument trays were reprocessed each morning; however, we noted that not all unwrapped instruments kept in the clinical area were reprocessed daily. These included burs, matrix band holders, local anaesthetic syringes, needle holders and scissors. Staff were unable to tell us when these instruments had been sterilised. We further noted that some instruments kept in unsealed pouches in the decontamination room passed their shelf life as they had been processed on 16 and 17 October 2023. Staff told us that since processing, instruments had been removed from these pouches. The HTM01-05 guidance states that the maximum storage time of unwrapped instruments kept in a non-clinical area is one week.

The practice did not have a suitable infection prevention and control policy staff could refer to for guidance about the practice specific infection prevention and control processes. The policy stated that 'instruments that are stored for use at a later date should be put in pouches and dated'. The policy did not reflect on the processes in the practice where some unwrapped instruments were kept in the clinical area and reprocessed in the mornings, while others remained unwrapped in the clinical zone for an unspecified period of time.

The practice could not demonstrate that the protein residue tests, automatic control tests and cleaning efficacy tests had been carried out on the ultrasonic cleaner in line with the manufacturer`s guidance or in the absence of this, in accordance with HTM01-05.

Are services safe?

The procedures to reduce the risk of Legionella or other bacteria developing in water systems were ineffective.

A Legionella risk assessment dated 30 October 2012 was made available for review. This made a number of recommendations, including cleaning and disinfecting the condensate trays 6 monthly, undertaking monthly checks of the hot and cold-water outlets and annual servicing of the boiler by an engineer. The provider could not demonstrate that these recommendations had been acted upon. In addition, we were not shown evidence that the Legionella risk assessment had been regularly reviewed or at all since it was carried out in October 2012. Following the inspection, the provider informed us that they had arranged a Legionella risk assessment for 22 December 2023.

The provider failed to ensure that clinical waste was managed in line with the current guidance. We observed that clinical waste was not disposed of in the orange bags made available inside the cabinets for the disposal of clinical waste. Instead, they were placed inside white buckets which were not lined with clinical bags. In addition, we noted that the clinical waste bins were not foot operated.

The practice did not have colour coded mops and buckets to prevent cross contamination between the clinical areas, waiting room, toilet, office and the kitchen area. In addition, they did not have a cleaning log to ensure the effectiveness of cleaning.

The practice had a recruitment policy and procedure to help them employ suitable staff, including for agency or locum staff. These reflected the relevant legislation.

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

The practice had some systems in place to ensure equipment was safe to use, maintained and serviced according to manufacturers' instructions. We saw evidence that the autoclave, ultrasonic bath and compressor had been serviced. However, the provider could not demonstrate that the air conditioning system had been serviced annually or at all.

The provider did not have systems in place to ensure the premises were safe. Electrical installation condition tests had not been carried out in line with the relevant regulations. The practice did not have a gas safety certificate to demonstrate that the appliance had been checked for safety or maintained regularly.

The management of fire safety was ineffective.

A fire risk assessment dated 22 February 2011 was made available for review. This made a number of recommendations, including the implementation of management procedures to undertake testing and checking of fire safety equipment, creating an emergency plan for evacuations (and displaying this in the premises), maintaining a fire log-book, installing sufficient means of raising the alarm in the event of fire, ordering new fire extinguishers and ensuring that there is a maintenance contract in place, installing emergency lighting and regular checking of the fire safety features. The provider could not demonstrate that these recommendations had been acted upon. In addition, we were not shown evidence that the fire risk assessment had been regularly reviewed or at all since it was carried out in February 2011.

The principal dentist told us that the fire extinguishers had been purchased from an online company after they received our announcement email of the on-site assessment. We noted that there was no maintenance contract in place, and we were not assured that the practice took steps to reassure themselves that the new fire extinguishers were in working order.

We were not shown evidence that fire evacuation drills were being carried out. Staff had not completed fire awareness training. There were no records of periodic in-house checks of the fire safety equipment.

The practice had some arrangements to ensure the safety of the X-ray equipment. Local rules communicating the main working instructions intended to restrict any exposures arising from work in the controlled area were made available for review. We were shown evidence that the 3-yearly performance survey on the 2 intraoral units had been completed in July 2022. Electro-mechanical servicing was being undertaken annually. Improvements were needed to ensure there were quality assurance procedures in place for wet film processing.

Are services safe?

Risks to patients

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

A sharps risk assessment that considered risks relating to all forms of sharps used in the practice had not been undertaken. An undated document titled 'Sharps' was made available for review. This stated that 'after use the needle guards are immediately replaced' and 'disposed of in the yellow sharps box situated outside on the balcony'. We noted that the practice did not have needle guards and the principal dentist told us that sharps were disposed of at the point of use in the surgery. In addition, the Sharps injury policy did not include the contact details of the nearest Accident & Emergency or Occupational Health Department. We were not assured that the provider was complying with the requirements of Health and Safety (Sharps Instruments in Healthcare) Regulation 2013 which states that employers are required to ensure that risks from sharps injuries are adequately assessed, and appropriate control measures are in place.

Staff told us that the clinicians occasionally worked without chairside support. The practice did not have arrangements in place to identify and mitigate the risks arising from staff working alone.

Sepsis prompts for staff, and information posters were not available within the practice. We discussed the advantages of staff undertaking sepsis awareness training to ensure they were able to triage patients with sepsis symptoms correctly.

Medical emergency drugs and equipment were not available in line with the guidance issued by the British National Formulary and the Resuscitation Council (UK). Glucagon was not stored in the fridge and this meant that the shelf life had to be reduced by 6 months. Subsequently the Glucagon kept on site expired in September 2023. The practice did not have child self-inflating bag with reservoir and a spacer device for inhaled bronchodilators, clear face masks for self-inflating bag, and the oropharyngeal airways expired in 2001. The oxygen cylinder was 340L, smaller than the 460L size recommended by the guidance. There was no portable suction, bodily spillage fluid kit and mercury spillage kit.

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

The provider could not demonstrate that all clinical staff completed regular face to face training in the management of medical emergencies. Medical emergency scenarios were not discussed in practice meetings. Staff were not confident in the use of medical emergency equipment. In particular, staff did not know how to connect the tubing to the oxygen cylinder.

The practice had risk assessments to minimise the risk that could be caused from substances that are hazardous to health. Improvements could be to ensure relevant Safety Data Sheets were available to staff in case of an accident while handling hazardous materials.

Information to deliver safe care and treatment

Patient care records were kept securely. However, improvements were needed to ensure that patient care records were complete and legible.

The practice did not have systems for tracking and monitoring referrals for patients with suspected oral cancer under the national two-week wait arrangements.

Safe and appropriate use of medicines

The practice did not have effective processes for the appropriate and safe handling of medicines. We found expired dental materials in Surgery 1. This included calcium hydroxide for pulp capping which expired in March 2021 and root canal sealer which expired in November 2022.

Are services safe?

Antimicrobial prescribing audits were not carried out. We noted that Amoxicillin 500mg was prescribed on multiple occasions for 7 days. This was not in line with the 'Antimicrobial Prescribing in Dentistry' guidance published by the College of General Dentistry (CG Dent), which stated that Amoxicillin 500mg should be prescribed for up to 5 days.

Track record on safety, and lessons learned and improvements

The practice did not have an accident book and they could not demonstrate that they had systems and processes in place for reporting on accidents and incidents internally to ensure information about these were shared with staff to promote learning.

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

Are services effective?

(for example, treatment is effective)

Our findings

We found 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 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.

Effective needs assessment, care and treatment

The practice had some systems to keep dental professionals up to date with current evidence-based practice. Improvements were needed to ensure clinicians read and implemented relevant nationally recognised guidance, including the most recent guidelines around antimicrobial prescribing and antibiotic prophylaxis for endocarditis patients, the use of rubber dam in line with guidance published from the British Endodontic Society when providing root canal treatment, and awareness of periodontal classifications.

Helping patients to live healthier lives

Improvements were needed to ensure the practice provided preventative care and supported patients to ensure better oral health in line with the Delivering Better Oral Health Toolkit issued jointly by the Department of Health and Social Care, the Welsh Government, the Department of Health Northern Ireland, Public Health England, NHS England and NHS Improvement.

Consent to care and treatment

Staff told us they obtained patients' consent to care and treatment in line with legislation and guidance. Improvements were needed to ensure details around consent taken were recorded in the patient care records. In addition, the dentists also needed to improve their knowledge and awareness of gaining consent from patients who have limited capacity to consent and of Gillick competency, by which a child under the age of 16 years of age may give consent for themselves in certain circumstances.

Monitoring care and treatment

The practice did not keep detailed patient care records in line with recognised guidance. We looked at 7 patient care records and found that the information in relation to care was not always recorded in accordance with the relevant guidance. Missing details included medical history, intraoral and extraoral examination, Basic Periodontal Examination (BPE), risk assessment of periodontal disease, caries and oral cancer, oral health instructions, recall intervals according to risk, diagnosis, costs explained, consent taken and treatment options. Our discussion with the dentists revealed that it was their normal practice to have a discussion with patients about diagnosis, treatment options, risks and benefits of each option and cost but they accepted that this was not always suitably detailed in the patient care records.

The dentists did not always justify, grade and report on all the radiograph they took. The practice did not carry out six-monthly radiography audits.

Effective staffing

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

The provider told us that newly appointed staff would receive structured induction. Induction records were not available for review as the practice had a long-standing staff for the past 10 years. Staff had not completed face to face medical emergency, Mental Capacity Act (2005), safeguarding, fire awareness and interacting with people with a learning disability and autistic people training.

Are services effective?

(for example, treatment is effective)

Co-ordinating care and treatment

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

The dentists told us that they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide. Improvements could be made to ensure there were systems in place to track and monitor routine referrals made externally.

The provider did not ensure that they employed sufficient numbers of staff to make sure they can meet people`s care and treatment needs. The practice had 1 qualified dental nurse who was employed to undertake chairside support and reception duties. We noted that on Mondays, Tuesdays and Thursday both dentists worked at the same time. This meant that the dentists did not have continuous chairside support during treatment as they only had 1 dental nurse. This is not in line with the relevant standard published by the General Dental Council, which states that 'You should work with another appropriately trained member of the dental team at all times when treating patients in a dental setting'.

Are services caring?

Our findings

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

Kindness, respect and compassion

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

On the day of inspection, the practice did not have patients booked in for treatment and we did not have the opportunity to speak with patients about the care they received. However, we were shown a sample of completed feedback forms and these demonstrated that patients were mostly positive about their experience at the practice.

Privacy and dignity

Staff were aware of the importance of privacy and confidentiality.

Patient care records were stored securely.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care and gave patients clear information to help them make informed choices about their treatment.

The practice's information leaflet provided patients with information about the range of treatments available at the practice.

The dentists explained the methods they used to help patients understand their treatment options. These included for example study models 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 and preferences.

Staff were clear about the importance of providing emotional support to patients when delivering care.

Staff had not carried out a disability access audit and they had not formulated an action plan to continually improve access for patients. An undated document titled 'Disability Access' was made available for review. This was a brief document, stating that the practice was on the ground floor, with two low level steps and the toilet was accessible to wheelchair users. We noted that the toilet was not an accessible toilet. In addition, the document did not consider other additional needs, such as visual or hearing impairment, or the needs of people with autism and learning disabilities.

Timely access to services

The practice displayed its opening hours and provided information on their patient information leaflet.

Patients could access care and treatment from the practice within an acceptable timescale for their needs. The practice had an appointment system to respond to patients' needs. Patients had enough time during their appointment and did not feel rushed.

The practice's answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open.

Patients who needed an urgent appointment were offered one in a timely manner. Patients with the most urgent needs had their care and treatment prioritised.

Listening and learning from concerns and complaints

The practice responded to concerns and complaints appropriately. Staff discussed outcomes to share learning and improve the service.

Are services well-led?

Our findings

We found this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

Leadership capacity and capability

One of the principal dentists had overall responsibility for the management and clinical leadership of the practice and other members of the dental team were responsible for various aspects of the day to day running of the service. Staff were aware of the management arrangements within the practice.

We found that the provider had the values and commitment to deliver high quality sustainable services. However, the lack of oversight and management of training, ineffective risk management and not adhering to published guidance in respect of evidence based clinical guidance all impacted the day to day management of the service.

The information and evidence presented during the inspection process was not always well documented. Improvements were needed to ensure that records in relation to the management of regulated activities were readily available and easily accessible to all members of staff and those who would need to review them.

Culture

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

Staff discussed their training needs in informal discussions. However, improvements were needed to ensure all members of staff had regular formal appraisal to discuss performance, learning needs, general wellbeing and aims for future professional development.

Improvements were needed to ensure provider had effective systems in place to monitor staff training to ensure appropriate action was taken quickly when training requirements were not being met or when staff did not have the required knowledge to enable them to fulfil the requirements of their role. We noted that not all members of staff had completed training in the Mental Capacity Act 2005, management of a medical emergency, infection control, fire and legionella awareness, safeguarding and autism and learning disability training. The practice was unaware of this. In addition we identified gaps in staff`s knowledge in the areas of safeguarding, infection prevention and control, consent and evidence based clinical guidance.

Governance and management

The practice did not have effective governance and management arrangements.

The (undated) Practice risk assessment was not reflective of our findings on the day and was not suitable to identify hazards and appropriate control measures. For example, it stated that electrical equipment was inspected and tested by a qualified electrician at regular intervals (every three years), the fire alarm systems was checked and tested annually, firefighting equipment was checked and tested annually by a service engineer and 'fire drills were held twice yearly'. None of these statements were substantiated by our findings on the day of the inspection. In addition, the document stated that individual workstation assessment was undertaken for regular users and training in 'software used was provided'. We noted that the practice was fully paper based, and they did not have computers or used a clinical software.

The (undated) Sharps document stated that needle guards were used. We noted that the practice did not have needle guards.

The (undated) Practice training policy stated that individual and practice-wide training needs were identified at annual appraisal and development reviews. We were not shown evidence that annual appraisal were being carried out. In

Are services well-led?

addition, the same document stated that Continuing Professional Development (CPD) requirements for dentists included 75 hours verifiable CPD and 175 general CPD and for Dental Care Professional (DCPs) 50 hours verifiable CPD and 100 general CPD. We noted that this was no longer the GDC requirement for continuous professional development as the Enhanced CPD scheme had been implemented in 2018.

The practice did not have a Whistleblowing or Speak up policy and a Business Continuity plan.

Overall, improvements were needed to ensure the practice policies, risk assessments and documents were regularly updated and reflected the arrangements within the practice.

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

Appropriate and accurate information

Staff did not act on appropriate and accurate information. Policies were not regularly updated and information about internal processes, such as safeguarding were not made available to staff.

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

Engagement with patients, the public, staff and external partners

Staff gathered feedback from patients and demonstrated a commitment to acting on feedback.

Feedback from staff was obtained through informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on where appropriate.

Continuous improvement and innovation

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

The practice infection prevention and control audit dated October 2023 was not reflective of the arrangements within the practice and was not suitable to drive improvement. For example, it stated that the practice had a bodily fluid spillage kit, the dental chairs were free of rips, surfaces were all intact, the practice had clearly marked donning and doffing areas. None of these statements were substantiated during our assessment.

We were not shown evidence that a disability access audit, radiography audits, record card audits and antimicrobial prescription audits had been carried out in line with the relevant national guidance.

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 18 HSCA (RA) Regulations 2014 Staffing The registered person had failed to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed in order to meet the requirements of fundamental standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In particular: • The practice did not have sufficient numbers of staff to ensure that the dentists worked with another appropriately trained member of the dental team at all times when treating patients. The service provider had failed to ensure that persons employed in the provision of a regulated activity received such support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular: • Information about current procedures, and guidance about raising concerns about abuse were not made available to staff • The provider could not demonstrate that staff received safeguarding training that was relevant, and at a suitable level for their role. • There was no evidence that all members of staff received training in Fire safety and Legionella awareness, Mental Capacity Act (2005), interacting with people with a learning disability and autism, and face to face emergency resuscitation and basic life support. • We identified gaps in staff`s knowledge in the management of medical emergencies, safeguarding and infection prevention and control.

This section is primarily information for the provider

Requirement notices

- There was no evidence to support that staff had received an appraisal.

Regulation 18 (1) (2)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • A sharps risk assessment had not been undertaken and there were no systems in place to reduce the risk of sharps injury. • A lone worker risk assessment had not been undertaken. • The general risk assessment was not reflective of the arrangements within the practice and was not suitable to appropriately identify hazards and control measures. • Staff were not aware of the most recent recalls and rapid response reports relevant to your service issued by the Medicines and Healthcare products Regulatory Agency (MHRA). • Systems in place to ensure that dental materials were not used beyond their expiry date were not effective. • The practice did not have systems for tracking and monitoring referrals made under the national two-week wait arrangements. The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • Radiography audit had not been undertaken.

This section is primarily information for the provider

Requirement notices

- The infection control audit available for review was not reflective of the actual arrangements within the practice and it was not suitable to drive continuous improvement.
- A disability access audit had not been undertaken.
- The practice did not have effective systems and processes in place for reporting on accidents and incidents internally to ensure information about these were shared with staff to reduce the risk of recurrence.
- Improvements were needed to ensure clinicians read and implemented relevant nationally recognised guidance, including the most recent guidelines around antimicrobial prescribing and antibiotic prophylaxis for endocarditis patients, the use of rubber dam in line with guidance published from the British Endodontic Society when providing root canal treatment, awareness of periodontal classifications, consent, the concept of Gillick competency and guidance about providing preventative care advice.
- The practice did not have a quality assurance system for wet film processing.

The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular:

- Information in relation to care was not recorded in accordance with the relevant guidance. For example, medical history was not always up to date. Intraoral and extraoral examination, Basic Periodontal Examination (BPE), risk assessment of periodontal disease, caries and oral cancer, oral health instructions, recall intervals according to risk, radiography justification and reporting, diagnosis, costs explained, consent taken, and treatment options were not always recorded.

There was additional evidence of poor governance. In particular:

This section is primarily information for the provider

Requirement notices

- The practice did not have effective systems in place to ensure that policies and documents were regularly updated.

Regulation 17 (1)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: • The decontamination process did not reflect the Department of Health publication 'Health Technical Memorandum 01-05: Decontamination in primary dental practices' (HTM01-05). • Work surfaces in the treatment rooms and decontamination room were not impervious. • Flooring in the treatment rooms and decontamination room was not impervious and coved to the wall. • The provider did not have effective systems and processes in place to control the storage time of sterilised instruments. • The practice could not demonstrate that the protein residue tests, automatic control tests and cleaning efficacy tests had been carried out on the ultrasonic cleaner in line with the manufacturer`s guidance or in the absence of this, in accordance with HTM01-05. • The practice did not have a suitable infection prevention and control policy staff could refer to for guidance. • Colour coded mops and buckets were not available in line with the current guidance. • The practice did not have a cleaning log to ensure the effectiveness of cleaning.

This section is primarily information for the provider

Enforcement actions

- The provider did not ensure that clinical waste was disposed of in line with the relevant guidance.
- Electrical installation condition checks had not been carried out in line with the relevant regulations.
- The provider did not have a gas safety certificate to demonstrate that the appliance had been checked for safety or maintained regularly.
- The air conditioning system had not been serviced.
- The provider could not demonstrate that recommendations made in the fire risk assessment dated 2011 had been acted upon. In addition, the fire risk assessment had not been regularly reviewed by a person who had the qualification, skills, competence and experience to do so.
- Fire drills were not being carried out. Staff had not completed fire awareness training. There were no records of periodic in-house checks of the fire safety equipment.
- There was no maintenance contract in place for the fire extinguishers.
- The provider could not demonstrate that recommendations made in the Legionella risk assessment dated 2012 had been acted upon. In addition, the Legionella risk assessment had not been regularly reviewed by a person who had the qualification, skills, competence and experience to do so.
- Medical emergency drugs and equipment were not available as per current national guidance.
- The practice did not check the medical emergency drugs and equipment at least weekly as set out in the relevant guidance published by the Resuscitation Council (UK).
- The practice did not have a bodily fluid spillage kit and mercury spillage kit.

This section is primarily information for the provider

Enforcement actions

- Clinical staff had not completed regular face to face training in the management of medical emergencies. Medical emergency scenarios were not discussed in practice meetings.
- Staff were not confident on the use of medical emergency equipment.

Regulation 12 (1)