

B & A Group Limited

Finest Dental Bermondsey

Inspection Report

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Overall summary

We carried out this announced inspection on 24 July 2019 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

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

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

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

Our findings were:

Are services safe?

We found that this practice was not providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

We found that this practice was not providing well-led care in accordance with the relevant regulations.

Background

Finest Dental Bermondsey is in Bermondsey in the London Borough of Southwark. The practice provides dental implants to adults on a private paying basis.

The practice is located close to public transport services. The practice has two treatment rooms both located on the ground floor.

The dental team includes the principal dentist, two associate dentists, one dental nurse and one trainee dental nurse. The dental team are supported by a practice manager and three treatment coordinators.

Summary of findings

The practice is owned by a company and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at Finest Dental Bermondsey is the principal dentist.

We collected feedback from six patients who completed CQC comment cards.

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

The practice is open:

Between 9am and 6pm on Mondays, Wednesdays and Fridays.

Between 10am and 8pm on Tuesdays and Thursdays.

Our key findings were:

- The premises appeared clean and well maintained.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.
- The provider asked patients for feedback about the services they provided.
- The provider dealt with complaints positively and efficiently.
- The provider had suitable information governance arrangements.
- The provider had infection control procedures which reflected published guidance. Improvements were needed so that infection control audits were carried out in line with current guidance.
- There were ineffective arrangements to deal with emergencies. Some of the recommended medicines and life-saving equipment were not available.
- The provider's systems to help them manage risk to patients and staff required improvement.

- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children. Improvements were needed so that staff undertook safeguarding training.
- There were no arrangements to gain assurances in relation to sedation equipment checks or the sedationists' qualifications and skills.
- The provider's staff recruitment procedures were not followed and the required documentation was not available.
- There were ineffective arrangements to support staff and ensure that they completed training including continuing professional development (CPD)
- The provider did not have effective leadership to support continuous improvement.

Following discussions with the principal dentist they assured us that the practice would cease providing dental treatment procedures under conscious sedation until such time as they had reviewed their procedures and addressed the issues and concerns we identified.

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

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development and supervision necessary to enable them to carry out the duties.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

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

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

- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid

Summary of findings

response reports issued by the Medicines and Healthcare products Regulatory Agency, the Central Alerting System and other relevant bodies, such as Public Health England.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Are services safe?

Our findings

We found that this practice was not providing safe care in accordance with the relevant regulations. The impact of our concerns, in terms of the safety of clinical care, is minor for patients using the service. Once the shortcomings have been put right the likelihood of them occurring in the future is low.

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.

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

Staff knew their responsibilities if they had concerns about the safety of adults who were vulnerable due to their circumstances. The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC. The practice manager was the safeguarding lead and they had undertaken safeguarding training to an appropriate level. Improvements were needed to the arrangements to monitor training in this area. There were no safeguarding training records available for the principal dentist, the two associate dentists, the dental nurses or the treatment co-ordinators. The practice manager told us that safeguarding training was scheduled for all members of staff.

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

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

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

The provider had a recruitment policy and procedure to help them employ suitable staff and had checks in place for agency and locum staff. These reflected the relevant legislation, however they were not followed. We looked at

seven staff recruitment records. There were no records available for the principal dentist, no proof of identity, and Disclosure and Barring Service (DBS) checks for one associate dentist and no proof of suitable conduct in previous employment for any staff.

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

Improvements were needed to the systems to ensure that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions.

Records showed that fire detection and firefighting equipment had been recently tested and serviced in July 2019 and a risk assessment had also been carried out. The findings from the risk assessment indicated that checks on the fire safety equipment had not been carried out.

Records were available for two dental X-ray units to show that they were tested and serviced in line with current guidance. Staff were unable to locate the critical examination documents for two other dental X-ray units. The practice had a cone beam computed tomography machine (CBCT). Staff had not received training for the use of this machine and there were no appropriate safeguards in place for patients and staff. There were no critical examination or other records in relation to tests for the CBCT machine.

We saw evidence that the dentists justified, graded and reported on the radiographs they took. The provider had carried out an annual radiography audit as per current guidance and legislation. The audit had not been reviewed or used to monitor, and if required to improve the quality of dental X-rays taken by the dentists.

Improvements were needed to the arrangements for monitoring staff training and ensuring that relevant staff completed continuing professional development (CPD) in respect of dental radiography including the safe use of CBCT equipment. There were no training records relating to radiography available on the day of our inspection for any of the dentists.

Risks to patients

Are services safe?

There were some systems to assess, monitor and manage risks to patient safety. The majority of risk assessments had been carried out within the two weeks from when the inspection visit was announced.

The practice had health and safety policies, procedures and risk assessments to help manage potential risk. The provider had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The staff followed relevant safety regulation when using needles and other sharp dental items. A sharps risk assessment had been recently carried out.

Improvements were needed to the system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked. There were no immunisation records available for the principal dentist, one associate dentist and the trainee dental nurse.

There were ineffective arrangements to deal with medical emergencies. Staff had completed training in emergency resuscitation and basic life support (BLS) in July 2019. Staff who provided treatment and chairside support during dental procedures undertaken under conscious sedation had not completed Immediate Life Support training with airway management for sedation.

There were limited arrangements to carry out checks to ensure that emergency equipment and medicines were available as described in recognised guidance, within their expiry date, and in working order. Staff maintained records of monthly checks they carried out. However these checks did not identify that some medicines and equipment were not available. Emergency equipment and medicines were not available as described in recognised guidance. We found no medicines to treat a seizure and the medicine to treat low blood sugar was not stored in line with the manufacturers' instructions to be assured of its efficacy.

Some recommended items of equipment were not available; There was no portable suction equipment and no spacer for use with medicine to treat asthma. The automated external defibrillator (AED) was in its original packaging and the battery pack was not inserted so that it was set up for use.

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

The provider had some arrangements to minimise the risk that can be caused from substances that are hazardous to health. There were policies and some safety data information available to staff. Improvements were needed so that a risk assessment was in place to identify risks and arrangements to mitigate these.

The provider had an infection prevention and control policy and procedures. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health and Social Care. Improvements were needed to ensure that staff completed infection prevention and control training and received updates as required.

The provider had arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. The records showed equipment used by staff for cleaning and sterilising instruments was used in line with the manufacturers' guidance and daily checks were carried out. We were told that the steriliser had been installed less than one year and a service check was due in August 2019. Improvements were needed so that staff monitored temperature for water used to manually clean dental instruments so that it was at or below 45 degrees to ensure effective cleaning and avoid risk of retained protein residue.

We found staff had systems in place to ensure that any work was disinfected prior to being sent to a dental laboratory and before treatment was completed.

We saw staff had some procedures to reduce the possibility of Legionella or other bacteria developing in the water systems. A risk assessment was carried out in July 2019. The majority of recommendations had been actioned and records of dental unit water line management were in place. Temperature checks of hot and cold water were not being undertaken as per current national guidance.

We saw cleaning schedules for the premises. The practice was visibly clean when we inspected.

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

Are services safe?

The dental nurse carried out infection prevention and control audits once a year. The latest audit showed the practice was meeting the required standards. Improvements were needed so that these audits were carried out bi-annually in line with national guidance.

Information to deliver safe care and treatment

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

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

Safe and appropriate use of medicines

The dentists were aware of and following guidance in relation to prescribing and dispensing medicines.

The practice did not keep a log to record stock levels of medicines such as antibiotics and analgesic medication or records when these were dispensed to patients. This made it difficult to monitor stock and minimise risks of misuse.

Track record on safety and Lessons learned and improvements

There were procedures to monitor and review incidents.

In the previous 12 months there had been no safety incidents reported.

There were procedures for reviewing and investigating when things went wrong. These included arrangements to learn, share lessons and identify themes to improve safety in the practice.

There were some systems for receiving and acting on safety alerts. The practice manager was aware of some but not all relevant safety alerts that had been issued within the previous 12 months. We saw that alerts were received and shared with the team and acted upon if required.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

The practice provides dental implants. As part of this service general dental treatments are provided as needed. Dental implants were placed by dentists in the practice. There were training records for one of the dentists to show that they had undergone post graduate training in dental implantology. The provision of dental implants was in accordance with national guidance.

The clinicians kept up to date with current evidence-based practice through reviewing relevant guidance. We saw that they assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

The practice had systems to carry out detailed assessments of patients before placing dental implants. If dental examinations identified dental disease appropriate treatments were carried out prior to completing any implant work. The dentists would advise against dental implants if the level of dental disease present was likely to affect the overall success of the implants.

Helping patients to live healthier lives

Prior to the surgical placement of dental implants the dentists carried out an assessment of patients' oral health including gum health. This involved taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition.

The dentists discussed oral hygiene, smoking, alcohol consumption and diet with patients during appointments. Patients were provided with detailed post procedure information to help maintain their dental implants.

Consent to care and treatment

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

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

risks and benefits of these, so they could make informed decisions. We saw this documented in patients' dental care records. Patients confirmed their dentist listened to them and gave them clear information about their treatment.

The practice's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who might not be able to make informed decisions.

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly. Patients told us that they received appropriate and clear information to help them make decisions and consent to treatment.

Monitoring care and treatment

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

The practice carried out conscious sedation for patients who were nervous. This included people who were very nervous of dental treatment and those who needed complex or lengthy treatment. The practice had systems to help them do this safely. Conscious sedation was carried out by a visiting sedationist.

Improvements were needed to ensure that the procedures in relation to conscious sedation were in accordance with guidelines published by the Royal College of Surgeons and Royal College of Anaesthetists in 2015.

The practice had systems to carry out patient checks before and after treatment. The staff assessed patients appropriately for sedation. The dental care records showed that patients having sedation had important checks carried out first. These included a detailed medical history; blood pressure checks and an assessment of health using the American Society of Anaesthesiologists classification system in accordance with current guidelines.

They also included patient checks and information such as consent, monitoring during treatment, discharge and post-operative instructions. The records showed that staff recorded important checks at regular intervals. This included pulse, blood pressure, breathing rates and the oxygen saturation of the blood.

Are services effective?

(for example, treatment is effective)

Appropriate emergency equipment and medicines were not available. There were no arrangements to gain assurances in relation to sedation equipment checks or the sedationists' qualifications and skills. Practice staff who treated patients and staff who provided chairside support had not undertaken training in conscious sedation or immediate life support (ILS).

Following discussions with the principal dentist they assured us that the practice would cease providing dental treatment procedures under conscious sedation until such time as they had reviewed their procedures and addressed the issues and concerns we identified.

Effective staffing

There were ineffective arrangements for monitoring staff skills, knowledge and experience to carry out their roles. Staff training records were not available to show that staff undertook training and development in areas relevant to their roles. There were no training or continuing

professional development (CPD) records other than basic life support available for any staff except the practice manager and one associate dentist who was undertaking training in dental implantology.

The practice had been operating for one year. There were arrangements and plans to appraise staff performance. Appraisal meetings were scheduled for all staff to commence in August 2019.

Co-ordinating care and treatment

Staff had systems to identify, manage and where required refer patients for specialist care when presenting with dental infections.

The provider also had systems for referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist.

There were systems in place to monitor all referrals to make sure they were dealt with promptly.

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff treated patients with dignity and respect.

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

Patients commented positively that staff were professional, respectful and kind. We saw that staff treated patients with care and kindness and were friendly towards patients at the reception desk and over the telephone.

Patients said staff were professional, non-judgemental and caring.

Patients told us staff were understanding and kind when they were anxious about their dental treatments.

Privacy and dignity

Staff respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting area was open plan in design and staff were mindful of this when dealing with patients in person or on the telephone. If a patient asked for more privacy, staff would take them into another room. The reception computer screens were not visible to patients, and staff did not leave patients' personal information where other patients might see it.

Staff password protected patients' electronic care records and backed these up to secure storage. They stored paper records securely.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care and were aware of the requirements under the Equality Act. For example;

- Interpretation services were available for patients who did not speak or understand English.
- The practice had access to deaf blind interpretation services and British sign language interpreters.
- Written information could be made available in large font if required.

Staff gave patients clear information to help them make informed choices about their treatment. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. The dentists described the conversations they had with patients to satisfy themselves they understood their treatment options.

The practice's website and a range of information leaflets provided patients with information about the range of treatments available at the practice.

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

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

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

Staff understood the needs of patients with dental phobias and provided suitable support.

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

A disability access audit had been completed and an action plan formulated to continually improve access for patients. The practice premises and facilities were purpose built and accessible for patients with disabilities. These included step free access to the treatment rooms, a hearing induction loop, a magnifying glass and accessible toilet with hand rails and a call bell.

Timely access to services

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

The practice displayed its opening hours in the premises and on their website.

The practice had an appointment system to respond to patients' needs. Patients had enough time during their appointment and did not feel rushed. Appointments ran smoothly on the day of the inspection and patients were not kept waiting.

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

Listening and learning from concerns and complaints

The practice team took complaints and concerns seriously and there were arrangements to respond to any concerns raised promptly and appropriately to improve the quality of care.

The provider had policies providing guidance to staff on how to handle a complaint and information for patients which explained how to make a complaint.

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

The practice aimed to settle complaints in-house and invited patients to speak with them in person to discuss these. Information was available about organisations patients could contact if not satisfied with the way their concerns had been dealt with.

We looked at comments, compliments and complaints the practice received within the previous 12 months. These showed the practice responded to concerns appropriately and discussed outcomes with staff to share learning and improve the service.

Are services well-led?

Our findings

We found that this practice was not providing well-led care in accordance with the relevant regulations.

Leadership capacity and capability

We found the company had the capacity and skills to deliver high-quality, sustainable care. However a lack of managerial oversight impacted the day-to day management of the service as demonstrated in our findings. The practice manager who had been recently appointed told us that the previous management arrangements meant that the previous practice manager held responsibilities for the management of three practice locations. This had impacted on the day-to-day management of the service. These arrangements had been reviewed recently and there were plans to ensure that each practice location was managed by a dedicated practice manager.

Culture

Staff stated they felt appreciated and they were happy to work in the practice.

The practice had some arrangements to ensure that behaviour and performance were consistent with the practice's vision and values. There were comprehensive procedures to address staff disciplinary issues.

The provider was aware of and had procedures in relation to the requirements of the Duty of Candour.

Governance and management

There were ineffective governance systems to support good governance and management.

The principal dentist had overall responsibility for the management and clinical leadership of the practice. A newly appointed practice manager had recently taken over the day - to - day running of the service.

The provider had a newly introduced system of clinical governance in place which included policies, protocols and procedures. These were accessible to all members of staff. However they were not fully understood or embedded into practice.

Improvements were needed to ensure effective processes for assessing and managing safety and risks in relation to a number of areas. There were ineffective arrangements for monitoring staff recruitment and training, The systems to manage medical emergencies, assess and mitigate risks and to ensure that equipment was installed and serviced appropriately were not robustly followed or monitored to support good governance and management of the service.

Appropriate and accurate information

Improvements were needed so that quality and safety information was used to ensure and improve performance.

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

Engagement with patients, the public, staff and external partners

Patients were invited to review and make comments and suggestions about the services provided.

The provider used patient surveys and verbal comments to obtain staff and patients' views about the service.

Continuous improvement and innovation

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

There were no ongoing arrangements for reviewing and monitoring areas to identify and act on areas where improvements were needed. Audits and risk assessments which had been carried out were completed within the two week period from when the inspection was announced.

The practice manager told us that there were arrangements to carry out annual appraisals for all staff. There were limited arrangements for monitoring staff training and development or to ensure that staff completed 'highly recommended' training as per General Dental Council professional standards.

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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Care and treatment must be provided in a safe way for service users to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>The provider had ineffective arrangements to deal with medical emergencies. In particular:</p> <ul style="list-style-type: none">• The automated external defibrillator was not set up for use with the battery pack inserted.• There was no portable suction.• There was no spacer for use when treating asthma or exacerbation chronic obstructive pulmonary disease.• The Glucagon injection was not stored in line with the manufacturers' instructions to assure its efficacy. <p>Regulation 12 (1)</p>
Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>The provider must establish effective systems and processes to ensure good governance in accordance with the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>There were limited systems and processes that enabled the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.</p>

Requirement notices

In particular:

- Risk assessments in relation to fire, Legionella and health and safety had only been carried out recently in July 2019 and within the two weeks from the date the inspection was announced. There were no risk assessments carried out prior to this date to demonstrate on-going assessment and mitigation of risks to patients and staff.
- Risks associated with COSHH, and staff not following current national guidance when manually cleaning used dental instruments had not been identified and mitigated.
- Risks associated with undertaking dental procedures under conscious sedation had not been suitably identified and mitigated.

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 improve the quality and safety of the services being provided.

In particular:

Infection prevention and control audits were not undertaken regularly as per current guidance to demonstrate on-going assessment and improvement in relation to quality and safety.

The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to maintain securely such records as are necessary to be kept in relation to the management of the regulated activity or activities.

In particular:

- There were no records available in relation to the installation and critical acceptance testing for two dental X-ray units.

Requirement notices

- There were no records available in relation to the installation, procedures or safeguards for use of the dental cone beam computed tomography (CBCT) equipment.
- There were no arrangements to undertake and document checks related to conscious sedation equipment.
- Immunisation records were not available for the principal dentist, one associate dentist and the trainee dental nurse.

The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to maintain securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity or activities.

In particular:

- There were no arrangements to gain assurances and document the sedationists' qualifications and skills

Regulation 17 (1)

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development and supervision as was necessary to enable them to carry out the duties they were employed to perform.

In particular:

Requirement notices

- There were no records in relation to safeguarding training for staff other than the practice manager.
- There were no records for infection control training for any members of staff.
- Staff who provided dental treatment or chairside support when conscious sedation was carried out had not undertaken additional training such as immediate life support training or continuing professional development training in sedation.
- There were no training records in relation to continuing professional development (CPD) in respect of dental radiography including the safe use of CBCT equipment.

Regulation 18 (2)

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed. In particular:

- There were no records available for the principal dentist in relation to checks including proof of identity, Disclosure and Barring Services checks (DBS) or certificate in respect of registration with the General Dental Council.
- There was no proof of identity or DBS check for one associate dentist.
- There was lack of satisfactory evidence of conduct in previous employment available for any member of staff.

This section is primarily information for the provider

Requirement notices

Regulation 19 (3)