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Haringey Dentalcare

Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 8 February 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 dental clinic appeared clean.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The dentist provided patients' care and treatment in line with current guidelines.
- Patients were treated with dignity and respect. Staff took care to protect patients' privacy and personal information.
- The dentist provided preventive care and supported patients to ensure better oral health.
- The appointment system worked efficiently to respond to patients' needs.

Summary of findings

- The frequency of appointments was agreed between the dentist and the patient, giving due regard to National Institute of Health and Care Excellence (NICE) guidelines
- The practice had information governance arrangements.
- Complaints were dealt with positively and efficiently.
- Patients were asked for feedback about the services provided.
- The practice infection control procedures required improvements and they did not reflect published guidance.
- There were ineffective arrangements to deal with medical emergencies.
- The practice had ineffective systems to manage risks for patients, staff, equipment and the premises.
- Improvements were needed to the practice recruitment procedures so that they reflected current legislation.
- Staff did not receive appropriate training and supervision.
- There was ineffective leadership and a lack of culture of continuous improvement.

Background

Haringey Dentalcare is in the London Borough of Haringey and provides NHS and private dental care and treatment for adults and children.

There is step free access to the practice for people who use wheelchairs and those with pushchairs. Car parking spaces, including dedicated parking for disabled people, are available near the practice.

The dental team includes the principal dentist and 2 trainee dental nurses. The practice has 2 treatment rooms.

During the inspection we spoke with the principal dentist and 1 trainee dental nurse. We looked at practice policies, procedures and other records to assess how the service is managed.

The practice is open between 9am and 6.30pm on Mondays to Fridays.

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, supervision and appraisal necessary to enable them to carry out their duties
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed

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

There were areas where the provider could make improvements.

- Improve the practices' arrangements for sepsis recognition and management taking into account the guideline issued by the National Institute for Health and Care Excellence, Sepsis: recognition, diagnosis and early management.
- Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the College of General Dentistry.

Summary of findings

- Take action to ensure the clinicians take into account the guidance provided by the College of General Dentistry when completing dental care records.
- Implement a system to ensure routine patient referrals to other dental or health care professionals are centrally monitored to ensure they are received in a timely manner and not lost.

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

Are services safe?

Our findings

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

The 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.

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

The practice had safeguarding processes. Improvements were required to ensure that staff undertake training in safeguarding children and vulnerable adults.

Improvements were required to the practice infection control procedures so that they reflected published guidance. The trainee dental nurse had not undertaken training in infection prevention and control or decontamination procedures, which they performed. The required tests were not carried out for the ultrasonic bath to ensure safe and effective cleaning of dental instruments. Cleaned dental instruments were not checked properly for debris using an illuminated magnifier in accordance with published guidelines.

The practice had ineffective procedures to reduce the risk of Legionella, or other bacteria, developing in water systems. Risk assessments were carried out in 2013, 2015 and 2020. These risk assessments had identified that hot water was not being maintained at the appropriate temperature to reduce the risk of bacteria growth in the water systems (55 degrees Celsius), braided hoses were present and that staff did not have training in Legionella awareness. There was no evidence that action had been taken to address these areas for improvement.

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

The practice appeared clean and there was an effective schedule in place to ensure it was kept clean.

Improvements were required to the practice recruitment policy and procedure. We looked at the staff records. There were no records in respect of identity, no Disclosure and Barring Service checks and no induction records for staff.

The dentist was qualified, registered with the General Dental Council and had professional indemnity cover.

The practice had ineffective systems to ensure equipment was safe to use, maintained and serviced according to manufacturers' instructions. There were no records to show when the compressor had been last tested or serviced.

There were no records for testing the portable electrical appliances and no records for the 5-year fixed electrical systems testing. The dentist could not say when these tests had been carried out.

The gas boiler has not has a service check or gas safety test since 2017.

Improvements were required to ensure the facilities were maintained in accordance with regulations and repairs are carried out in a timely manner. In October 2022 we had been told about a leak from the roof which affected one of the treatment rooms and the room where some equipment was stored. On the day of our inspection we observed maintenance personnel attended the practice to repair the roof.

Are services safe?

Improvements were required to the practice's fire safety arrangements. A fire safety risk assessment was carried by the dentist in January 2023. The risk assessment was basic and did not cover all risks, such as those associated with electrical equipment. The risk assessment was not completed so that it accurately reflected the practice and premises. In particular; the risk assessment incorrectly indicated there was no mains gas supply to the premises, that staff had undertaken training in fire safety awareness and that annual electrical safety testing was carried out.

The practice had ineffective arrangements to ensure the safety of the X-ray equipment. There were no records to show when the last electrical, mechanical and radiological tests had been carried out for the dental X-ray equipment. The dentist could not say when these tests had been carried out.

Risks to patients

The practice had ineffective systems to assess, monitor and manage risks to patient and staff safety. The dentist had completed a sharps safety risk assessment in January 2023. This assessment indicated that safer sharps systems were in use and that the dentist dismantled all sharps. However, there were no safer sharps systems in use and discussions with a member of staff indicated that sharps were not always dismantled. The risk assessment did not consider risks to staff who had not completed vaccination against Hepatitis B virus.

There was no sepsis awareness information and the dentist lacked awareness of the importance of identifying signs and symptoms of sepsis.

There were ineffective arrangements to deal with medical emergencies.

Emergency medicines were available in accordance with national guidance. However, there were ineffective systems to monitor the storage temperature for one of the medicines used to treat low blood glucose, in accordance with the manufacturer's instructions. Emergency equipment was not available. In particular; there were no size 0,1 or 4 guedel airways, no Volumatic spacer for use with the medicine used to treat asthma, no child size self-inflating bag with reservoir, and no masks for the adult self-inflating bag. The adhesive pads on the automated external defibrillator (AED) had expired in 2019.

Staff did not complete training in basic life support every year in accordance with guidelines. The trainee dental nurses had not completed training. The dentist had last completed online training in 2019.

The practice had risk assessments to minimise the risk that could be caused from substances that are hazardous to health.

Information to deliver safe care and treatment

Patient care records were legible, kept securely and complied with General Data Protection Regulation requirements.

The practice had systems for referring patients with suspected oral cancer under the national two-week wait arrangements.

Safe and appropriate use of medicines

Improvements were needed to systems for appropriate and safe handling of medicines. Antimicrobial prescribing audits were not carried out.

Track record on safety, and lessons learned and improvements

The practice had written procedures and templates for recording incidents and accidents. There were ineffective arrangements to ensure these procedures were followed.

The practice had a system for receiving safety alerts. However, there was no evidence that alerts received were reviewed and acted on.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

The dentist undertook training to keep up to date with current evidence-based practice.

Helping patients to live healthier lives

The practice provided preventive care and supported patients to ensure better oral health. The dentist offered advice to patients and information leaflets were available.

Consent to care and treatment

Staff obtained patients' consent to care and treatment in line with legislation and guidance. They understood their responsibilities under the Mental Capacity Act 2005.

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

Monitoring care and treatment

Improvements were needed so that the dentist kept detailed patient care records in line with recognised guidance. Patient records which we viewed were completed in respect of the treatments offered and delivered. Improvements were needed so that a detailed assessment of each patient was recorded.

The dentist conveyed an understanding of supporting more vulnerable members of society such as patients living with dementia or adults and children with a learning disability.

We saw evidence the dentist justified, graded and reported on the radiographs they took. Improvements were required to ensure that audits of dental radiographs are carried out as per current guidance. The dentist showed us 1 audit of dental radiographs which was carried out in February 2023. However, there was no analysis of the findings or action plans as part of a system for monitoring and improving the quality of dental radiography in accordance with current guidance. No other audits were available.

Effective staffing

Improvements were required to ensure staff had the skills, knowledge and experience to carry out their roles. The trainee dental nurses had not undertaken training in respect of the tasks they were to perform. In particular; staff had not completed training in infection prevention and control, basic life support or safeguarding.

Newly appointed staff did not have an induction to the practice to help them familiarise themselves with ways of working and the practice policies and procedures.

Co-ordinating care and treatment

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

The dentist confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide. Improvements were required to ensure that routine referrals were followed up to ensure patients received care in a timely manner.

Are services caring?

Our findings

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

Kindness, respect and compassion

The dentist was aware of their responsibility to respect people's diversity and human rights.

Privacy and dignity

Staff were aware of the importance of privacy and confidentiality.

Staff password protected patients' electronic care records and backed these up to secure storage. 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 gave patients clear information to help them make informed choices about their treatment.

The dentist explained the method they used to help patients understand their treatment options. These included for discussions 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.

Improvements were required so that the practice considered and made reasonable adjustments to support patients with access requirements. A disability access audit had not been carried out to continually improve access for patients.

Timely access to services

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. The frequency of appointments was agreed between the dentist and the patient, giving due regard to NICE guidelines. 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 and 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.

Leadership capacity and capability

Improvements were required to promote a transparent and open culture in relation to people's safety.

Systems and processes were not effectively embedded and the inspection highlighted a number of significant issues and omissions.

The information and evidence presented during the inspection process was not organised, clear or well documented.

Culture

Improvements were needed to support a culture for reviewing the service and ensuring improvements over time. Evidence obtained during the inspection indicated that numerous records in relation to risk management were made once the inspection was announced rather than as part of a continuous system for improving the service.

Governance and management

The practice had ineffective governance systems.

We saw there were in effective processes for managing risks, issues and performance. Risk assessments were not kept under review and there was no evidence that where areas for improvement were required that these were acted on.

Appropriate and accurate information

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 comments made by patients.

Continuous improvement and innovation

The practice had ineffective systems and processes for learning, quality assurance, continuous improvement. Audits and reviews were not carried out in accordance with guidelines and regulations. Where audits were carried out, these were incomplete and were not kept under review or used as part of a system for monitoring and improving the service. A disability access audit had not been undertaken. The audits of dental radiographs and dental care records were incomplete with no analysis and there were no audits in respect of antibiotic prescribing.

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: • There were no records available to evidence that the trainee dental nurses completed training in basic life support, infection prevention and control, safeguarding children and vulnerable adults, Legionella awareness of fire safety. Regulation 18(1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed 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 in respect of proof of identity for 1 trainee dental nurse. • There were no Disclosure and Barring Services (DBS) checks for each of the 2 trainee dental nurses Regulation 19(3)

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 persons 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: • Infection prevention and control procedures were not carried out in accordance with the Health Technical Memorandum 01-05: Decontamination in Primary Care Practices (HTM-01-05) to protect patients against unsafe care. ■ Protein residue tests and quarterly soil tests were not carried out for the ultrasonic bath used to clean dental instruments, in accordance with the manufacturer's guidelines and the guidance in the HTM 01-05. ■ We observed that the light was broken on the illuminated magnifier used to check dental instruments for debris once they have been cleaned. • There were ineffective procedures to protect patients and staff against the risk of the Hepatitis B virus: ■ Clinical staff had not completed their course of Hepatitis B vaccinations and the sharps risk assessment did not take this risk into consideration. ■ The sharps risk assessment was not completed accurately to assess and mitigate risks. ■ There were ineffective arrangements to assess and mitigate the risk of fire at the practice. ◦ Fire safety risk assessments were not carried out regularly to assess fire risks. Only 1 risk assessment dated February 2023 was available. ◦ The fire risk assessment did not identify risk factors including risks associated with gas and electrical systems ◦ There was no evidence that staff had completed training in fire safety awareness, equipment such as smoke detectors were tested to ensure they were working effectively or that fire evacuation drills were carried out.

This section is primarily information for the provider

Enforcement actions

- There were ineffective arrangements to assess and mitigate the risk of Legionella at the practice.
  - Risk assessments carried out in 2013, 2015 and 2020 identified areas where improvements to the arrangements to reduce the risk of Legionella had been identified. There was no evidence that action had been taken to address the issues identified.

- There were ineffective arrangements to deal with medical emergencies:
  - Dental nurses had not undertaken training in basic life support and the dentist had last undertaken this training in 2019.
  - Emergency equipment was not available in accordance with the recommendations of the Resuscitation Council. There were no sizes 0, 1 or 4 guedel airways, no child size self-inflating bag with reservoir and no oxygen mask for use with the adult size self – inflating bag with reservoir. The adhesive pads for use with the automated external defibrillator (AED) had expired in 2019.
  - The temperatures of the fridge used to store Glucagon (emergency medicine to treat hypoglycaemia) were not monitored effectively.

- There were ineffective arrangements to ensure that equipment was serviced and tested in accordance with relevant regulations and the manufacturer's instructions
  - There were no records to evidence when the compressor had last been tested. You could not tell us when this test had been carried out.
  - There were no records to evidence when the annual electrical and mechanical tests or the 3-yearly radiological tests had been carried out for the dental X-ray equipment had been carried out.
  - There were no records to evidence when the 5-year electrical installation test or the tests for the portable electrical appliances had been carried out.
  - The provider could not tell us when these tests had been carried out.
  - Records provided to us indicated that the annual safety test for the gas boiler had last been carried out in 2017.

Regulation 12 (1)

This section is primarily information for the provider

Enforcement actions

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the Regulation was not being met

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:

- Infection prevention and control audits were not completed every 6 months in accordance with the Health Technical Memorandum 01-05: Decontamination in Primary Dental Practices. An infection prevention and control audit was dated January 2023. No other audits were available.
- The infection prevention and control audit was not completed accurately or used as part of a system to monitor and improve infection control procedures at the practice. The audits failed to identify issues such as incomplete tests for the ultrasonic bath, faulty equipment for checking dental instruments and lack of staff training in infection prevention and control.
- There was no analysis of the audit as part of an effective system to monitor infection prevention and control procedures and no action plan to address areas where improvements were required.
- Audits of dental radiographs were not carried out every 6 months in accordance with relevant guidance. A radiograph audit was carried out in February 2023. No other audits were available.
- Audits of dental radiographs were not completed in a way to assess, monitor and improve the quality of dental X-rays. The audit completed in February 2023 consisted of a list of dental radiographs taken. There was no analysis of the findings as part of a system for monitoring the quality of dental radiographs.

This section is primarily information for the provider

Enforcement actions

- There were ineffective systems to ensure that the premises are maintained in a suitable condition and necessary repairs are carried out promptly.

- There was no disability access audit available or other evidence to demonstrate that the needs of people who have access requirements had been considered and made reasonable adjustments to meet in accordance with relevant regulations.
- There were ineffective arrangements for receiving, reviewing and actioning patient safety information. There was no evidence that information contained safety alerts had been checked against medicines and equipment in the practice as part of a system for monitoring safety within the practice.
- There were ineffective arrangements for reporting and acting on accidents, incidents and other significant issues. Incidents such as lack of emergency equipment and the impact of a faulty gas boiler had not been reviewed to learn and improve the service.

There were no systems or 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. In particular:

- Audits in relation to infection control, dental radiography and record keeping were carried out in 2023 following announcement of our inspection visit. No evidence of previous audits were available on the day of our inspection.
- Risk assessments in relation to fire safety, sharps safety and fire safety were carried out in 2023 following announcement of our inspection visit. No evidence of previous risk assessments were available on the day of our inspection.

Regulation 17 (1)