Rose Garden Dental Practice

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Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 11 August 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 and well-maintained.
- Staff knew how to deal with medical emergencies. Appropriate medicines and life-saving equipment were available.
- Clinical staff 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.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system worked efficiently to respond to patients' needs.
- 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.

Summary of findings

- Staff felt involved and worked as a team.
- Staff and patients were asked for feedback about the services provided, and complaints were dealt with positively and efficiently.
- The practice undertook regular audits of record keeping, infection control, disability access and radiography to support continuous improvements.
- The practice infection control procedures did not reflect published guidance.
- The practice had systems to ensure equipment was safe to use. However, systems to manage risks for patients, staff, and the premises were ineffective.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children. Improvements were needed to ensure that all members of staff completed safeguarding training at a suitable level to their role.
- The practice recruitment procedures did not reflect current legislation.
- There was ineffective leadership and a lack of effective supervision of trainee nurses.

Background

Rose Garden Dental Practice is in Kingsbury, in the London Borough of Brent 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 are available near the practice. The practice has made reasonable adjustments to support patients with access requirements.

The dental team includes 2 principal dentists, 3 associate dentists, 1 qualified dental nurse, 2 trainee dental nurses, 1 dental hygienist, 1 practice manager and 1 receptionist. The practice has 3 treatment rooms.

During the inspection we spoke with one of the principal dentists, the qualified dental nurse, the receptionist and the practice manager. 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 7pm.

Friday from 9am to 3pm.

Saturday from 9am to 1pm.

We identified regulations the provider was 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 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.

Summary of findings

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

Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the College of General Dentistry.

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 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). 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 and staff knew their responsibilities for safeguarding vulnerable adults and children. On the day of inspection there was no evidence that all members of clinical staff, including the trainee dental nurses, had completed safeguarding training at a level appropriate to their role. Furthermore, there was no evidence that staff received safeguarding training as part of their induction.

The practice infection control procedures did not reflect published guidance. The decontamination process and the storage of sterilised instruments were not in line with the national guidelines as laid out in the Department of Health publication 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05). We saw that the enzymatic solution used to disinfect instruments was not measured to ensure correct dilution of the solution was achieved as recommended by the manufacturer. There were no systems and processes in place to monitor the use of long-handled brushes and domestic gloves used during the decontamination process. We were not assured that staff visually inspected all decontaminated items under an illuminated magnifier ensuring they were clean. We noted that the practice did have an illuminated magnifier; however it had a 2-point plug and the practice did not have an adaptor to connect it to the 3-point UK system.

We observed that a large number of dental instruments were stored unwrapped and uncovered in the drawers of Surgery 1 and Surgery 2. Staff gave inconsistent accounts about how and when these instruments were reprocessed. One member of staff told us that all unwrapped instruments were re-sterilised at the end of the day, while the practice manager told us that all unwrapped instruments were re-sterilised at the end of the working week on Fridays. We looked at the autoclave data logger records and did not find evidence to verify these statements. The guidance set out in HTM01-05 states that the maximum storage time of unwrapped instruments stored in the clinical area is 1 day and the maximum storage time of instruments stored in the non-clinical area is 1 week. We were not assured that this guidance had been followed or that the practice had effective systems in place to ensure sterilised instruments were not used beyond their expiry date. Furthermore, we noted that instruments were stored in cluttered drawers, preventing the retrieval of dental instruments for use without contaminating other instruments.

Following the inspection, we received photographic evidence that dental instruments stored in the drawers of Surgery 1 and Surgery 2 had been reprocessed, wrapped, sterilised and dated.

We noted that the container used to disinfect dental impressions was kept inside the wash-hand basin in Surgery 2. This was not in line with the HTM01-05 guidance which stated that the wash-hand basin should be distinctly separate from the sinks used in decontamination.

Cotton rolls were kept uncovered and loose in the drawers, and local anaesthetic cartridges were not kept in the original blister packs. Following the inspection we received photographic evidence that local anaesthetic cartridges were now kept in their original packaging.

Are services safe?

The practice had some systems in place to ensure both sterilisers were tested in line with the manufacturer`s guidance. Daily automatic control tests had been undertaken on both autoclaves. The practice was carrying out weekly air leakage tests on one of the autoclaves, in line with the engineer`s recommendations following the most recent annual servicing. However, there was no evidence that weekly air leakage tests had been performed on the second autoclave and staff did not know what the manufacturer`s guidance was in relation to this.

The practice had procedures to reduce the risk of Legionella, or other bacteria, developing in water systems, in line with a risk assessment.

The practice had policies and procedures in place to ensure clinical waste was segregated in line with guidance. However, clinical waste was not stored securely. Clinical waste bags awaiting collection were stored in an unlocked shed, in an area accessible to the public.

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

The practice recruitment procedure did not reflect the relevant legislation. We saw that a patient had been seen for an All-on-Four restoration, a procedure that involved the insertion of 4 dental implants and fitting of an immediate temporary bridge. Staff told us that the dentist performing the procedure did 'not work at the practice' and they had no recruitment documents on file.

We were not assured that the provider had systems in place to satisfy themselves that the person employed for the purposes of carrying on a regulated activities was of good character and had the qualifications, competence, skills and experience which was necessary for the work to be performed by them. (The interpretation of 'employment' in The Health and Social Cate Act 2008 (Regulated Activities) Regulations 2014 is 'employment under a contract of service, an apprenticeship, a contract for services or otherwise than under a contract'.)

Following the inspection, we received documentary evidence for the dentist carrying out the dental implant procedure. These included a record of Hepatitis B antibody level blood tests, immunisation record and indemnity certificate. We were not provided with evidence that proof of identity including a recent photograph had been obtained, that Disclosure and Barring Service (DBS) records had been requested, or that checks on full employment history including satisfactory conduct in previous employment and qualifications had been carried out. We were not assured that the provider understood the risks around employing a clinical member of staff to carry out a complex dental implant procedure in the absence of these documents.

In addition, we looked at 5 staff records and found these to be incomplete. We noted that 2 members of clinical staff had completed a basic DBS check rather than the enhanced DBS check required. One member of staff had an out of date indemnity certificate on record and their professional registration certificate was also not up to date. Two members of clinical staff did not have evidence of a blood test to show their response to the hepatitis B vaccination they received and there was no evidence that the provider had assessed the risks associated with this.

Following the inspection, we received a copy of the missing indemnity certificate and risk assessments for the 2 members of staff awaiting blood test results to show their response to the Hepatitis B vaccination.

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

The practice ensured equipment was safe to use, maintained and serviced according to manufacturers' instructions. The practice ensured the facilities were maintained in accordance with regulations.

The management of fire safety was ineffective. A fire risk assessment dated June 2021 was made available for review. This made a number of recommendations, including testing of the fire panel weekly, monthly emergency lighting testing and fire drills to be conducted every 6 months. We were not assured that all recommendations had been acted upon. The last entry in the emergency light testing log was dated February 2022 and the most recent fire drill record was from 23 December 2021.

Are services safe?

In addition, there was no evidence that the fire alarm system and the emergency lighting system had been serviced since their installation in July 2021.

The practice had arrangements to ensure the safety of the X-ray equipment and the required radiation protection information was available. This included cone-beam computed tomography (CBCT) equipment.

Risks to patients

The practice had some systems to assess, monitor and manage risks to patient and staff safety. This included sharps safety and sepsis awareness. The practice did not have arrangements in place to identify and mitigate the risks arising from lone-working.

Emergency equipment and medicines were available and checked in accordance with national guidance.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year.

The practice did not have individual risk assessments for all hazardous materials they used. In addition, improvements were needed to ensure staff had access to the relevant safety data sheets in line with the guidance set out in the Control of Substances Hazardous to Health (COSHH) 2002 regulations.

Information to deliver safe care and treatment

Patient care records were complete, 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

The practice did not have systems for the appropriate and safe handling of medicines. Prescription only medication was not stored securely. On the day of inspection, we found Amoxicillin (an antibiotic medication) and Dexamethasone (a steroid) stored in an unlocked fridge in the staff room. We noted that NHS prescription pads were stored in an unlocked drawer in the electrical room. In addition, improvements could be made to ensure that clinicians followed the relevant guidance for antimicrobial prescribing. 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.

Antimicrobial prescribing audits were not carried out.

Track record on safety, and lessons learned and improvements

The practice had systems to review and investigate incidents and accidents. The practice had a system for receiving and acting on safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

The practice had systems to keep dental professionals up to date with current evidence-based practice.

Helping patients to live healthier lives

The practice provided preventive care and supported patients to ensure better oral health.

Consent to care and treatment

Staff 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

The practice kept detailed patient care records in line with recognised guidance.

Staff 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 dentists justified, graded and reported on the radiographs they took. The practice carried out radiography audits six-monthly following current guidance.

Effective staffing

Permanent qualified staff had the skills, knowledge and experience to carry out their roles. However, trainee dental nurses were not supervised effectively to ensure that shortcomings in the infection control process were identified and improved. We noted that trainee dental nurses were supervised by a member of staff who only recently completed their nurse training and was awaiting their GDC (General Dental Council) registration number at the time of the inspection.

Improvements were needed to ensure the provider had documentary evidence to demonstrate that the visiting clinician undertaking dental implant procedures had the skills, knowledge and experience to carry out their role.

The practice had a structured induction programme in place. However, we noted that not all members of staff had a record of the induction they received. Improvements could be made to ensure safeguarding was covered as part of the induction.

Clinical staff completed continuing professional development required for their registration with the General Dental Council. Improvements were needed to ensure that clinicians involved in referring, justifying, performing and interpreting dental CBCT examinations undertook CBCT core and further training at a level appropriate to their role. Following the inspection, we received evidence that the two principal dentists had enrolled to Level 1 (Core) training and Level 2 (Further) training for operators performing dental CBCT imaging.

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.

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.

Staff told us they understood the importance of being compassionate and understanding when patients were in pain, distress or discomfort.

On the day of inspection, we reviewed patient feedback which was wholly positive about the care and treatment received at the practice.

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.

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 website and information leaflet provided patients with information about the range of treatments available at the practice.

The dentist explained the methods they used to help patients understand their treatment options. These included for example photographs, study models, videos, X-ray images and an intra-oral camera.

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.

The practice had made reasonable adjustments, including a disabled toilet and a hearing loop, for patients with access requirements. Staff had carried out a disability access audit and had formulated an action plan to continually improve access for patients.

Timely access to services

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

The principal dentists had overall responsibility for the management and clinical leadership of the practice and the practice manager was responsible for 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 capacity, values and commitment to deliver high quality sustainable services. However, the lack of oversight and supervision, ineffective risk management and not adhering to published guidance in respect of infection control, all impacted the day to day management of the service.

Arrangements for supervision of staff were not effective in that those overseeing trainee dental nurses did not identify shortcomings in the infection control process and did not ensure that the decontamination and sterilisation of instruments were carried out in line with the current guidance.

The information and evidence presented during the inspection process was clear and well documented.

Culture

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

Staff discussed their training needs during annual appraisals and 1 to 1 meetings. They also discussed learning needs, general wellbeing and aims for future professional development.

The practice had some arrangements to ensure staff training was up-to-date and reviewed at the required intervals. Improvements were needed to ensure the practice systems in place were adequate to satisfy themselves that trainee nurses and visiting clinicians were up-to-date with their training requirements.

Governance and management

The practice had a governance system which included policies, protocols and procedures that were accessible to all members of staff and were reviewed on a regular basis.

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 recruitment of staff, infection prevention and control, lone working and fire safety.

Appropriate and accurate information

We found that accurate and appropriate information was not always shared with staff. The provider could not demonstrate that trainee nurses were effectively supervised to ensure that they carried out infection control processes in line with the current guidelines.

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, the public and external partners and demonstrated a commitment to acting on feedback.

Are services well-led?

Feedback from staff was obtained through meetings, surveys, and 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 had systems and processes for learning, quality assurance and continuous improvement. These included audits of patient care records, disability access, radiographs, and infection prevention and control. Staff kept records of the results of these audits and the resulting action plans and improvements. Improvements could be made to ensure the practice implemented audits for prescribing of antibiotic medicines taking into account the guidance provided by the College of General Dentistry.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the Regulation was not being met 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: • Infection prevention and control processes were not in line with the published guidance. • Clinical waste awaiting collection was not stored securely. • Prescription only medication was not stored securely. • NHS prescription pads were not stored securely. • Not all members of clinical staff had completed safeguarding training at a level suitable to their role. Regulation 12 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the Regulation was not being met 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: • The management of fire safety was ineffective.

This section is primarily information for the provider

Requirement notices

- The provider did not undertake risk assessments for all hazardous materials used in the practice. In addition, the relevant safety data sheets were not made available to staff.
- Lone worker risk assessment had not been carried out.

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:

- Arrangements for supervision of staff were not effective in that those overseeing trainee dental nurses did not identify shortcomings in the infection control process.

Regulation 17 (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 information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) 2014 was available for each person employed. In particular: • Proof of identity including a recent photograph, an enhanced criminal record certificate, evidence of conduct in previous employment, satisfactory evidence of qualification relevant to their duties, and a full employment history were not available for the visiting dentist carrying out a dental implant procedure on the day of the inspection. • Two additional members of clinical staff did not have an enhanced criminal record certificate. Regulation 19 (3)