Super White Dental Clinic Ltd

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Inspection report

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Overall summary

We carried out this announced focused inspection on 27 May 2021 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 Care Quality Commission (CQC) inspector who was supported by a CQC specialist dental adviser.

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

• Is it safe?

• Is it effective?

• 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 this practice was not providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services well-led?

Summary of findings

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

Background

Super White Dental Clinic Ltd is in the London Borough of Lambeth and provides private dental care and treatment for adults and children.

The dental team includes the principal dentist, one associate dentist, one dental nurse and one trainee dental nurse. The practice has two treatment rooms.

The practice is owned by an organisation and as a condition of registration must have a person registered with the CQC 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 Super White Dental Clinic Ltd is the principal dentist.

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

Our key findings were:

- The practice appeared to be visibly clean.
- The infection control procedures were not monitored to ensure that they were followed in accordance with published guidance.
- There were ineffective systems in place to reduce the risks associated with the transmission of Covid-19.
- There were ineffective systems to ensure that medicines and life-saving equipment were available.
- There were ineffective systems to assess and manage risk to patients and staff.
- The provider had safeguarding procedures. However, staff had not undertaken training and were not aware of their responsibilities for safeguarding vulnerable adults and children.
- The practice recruitment procedures were not followed, and important checks were not carried out when staff were recruited to work at the practice.
- There were ineffective management and governance arrangements to monitor and improve quality and safety at the practice.

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 recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.
- 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 the duties.

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

Summary of findings

Following our inspection, the provider voluntarily closed the practice and employed the services of a compliance consultant to assist with making changes and the required improvements. The provider submitted documentary evidence in relation to the improvements they had made and were continuing to undertake.

We will review these improvements at a follow inspection visit.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**Enforcement action** 
Are services effective?	**Enforcement 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 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.

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

There were ineffective systems to keep patients and staff safe.

The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. However; there were no records to demonstrate that staff had undertaken training in safeguarding adults and children. We spoke with a staff member and they were unable to demonstrate that they understood how to recognise and report concerns about the safety and welfare of patients.

The provider had in place infection prevention and control policy and procedures. However, these were not bespoke to the practice and there were ineffective arrangements to ensure that they were followed in accordance with the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care. We observed a staff member when they were cleaning and sterilising dental instruments. They were unable to demonstrate that they understood the correct water temperature or the ratio of detergent to use for effective cleaning. We observed that the brush used to clean instruments was worn off by long use and not the long-handled type brush recommended for cleaning. A metal bur brush was used to remove any debris that the cleaning process had not removed. This is contrary to the guidance in HTM 01-05.

There were no records to show that equipment used by staff for cleaning and sterilising instruments was validated, maintained in line with the manufacturers' instructions; the provider was unable to tell us when the last validation service had been carried out.

We saw that the said staff member had not undertaken training in infection prevention and control.

Infection prevention and control audits were not carried out in line with national guidance to monitor infection control practices and procedures. The provider told us that these audits had not been carried out every six months. We were provided with one audit which was carried out in 2021. This did not accurately reflect staff practice or identify the issues in regard to infection prevention measures which we found.

The provider did not have effective procedures in relation to COVID-19 to minimise the risk of transmission of the virus. We asked about the standard operating procedures to minimise risks of transmission of COVID-19 virus. The provider was unable to demonstrate there were procedures including systems to calculate fallow time (period of time allocated to allow aerosol to settle following treatments involving the use of aerosol generating procedures). The inspection team observed that one of the treatment rooms used to carry out aerosol generating procedures (AGPs) had no means of ventilation, for example, windows or mechanical means to extract air.

We asked if staff had been fit tested for filtering facepiece masks (FFP) as part of personal protective equipment (PPE) when carrying out AGPs. These masks are designed to protect wearers against inhalation of liquids and aerosols and testing is required to ensure that they work effectively. The provider told us that staff had not undergone these tests.

We asked to see records of screening checks carried out before patients attended the practice for treatment. These checks help to ensure that risks such as contact with people who have tested positive to the COVID-19 virus, people who have had symptoms of the virus and people who have recently returned from travel outside the UK are assessed. The provider told us that these checks were not recorded.

Are services safe?

We saw staff had some procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. There were arrangements for flushing and disinfecting dental unit waterlines. We noted that records for monitoring the hot and cold water temperatures (so as to ensure these minimised the risk of bacterial growth in the water systems) had not been maintained since 2019. There was no thermometer available at the practice on the day of the inspection.

The dentists used dental dam in line with guidance from the British Endodontic Society when providing root canal treatment.

The provider had a recruitment policy and procedure to help them employ suitable staff. These reflected the relevant legislation. However, staff records which we looked at showed that this policy was not followed when recruiting staff to work at the practice. There were numerous records for staff who were, and who had previously worked at the practice. These records were disorganised, and many were incomplete. For example; we looked at the records for the dental nurse and the trainee dental nurse. There were no records to show that Disclosure and Barring Service (DBS) checks had been carried out for these members of staff.

There were ineffective arrangements for ensuring that clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover. There were no records available in respect of registration with the GDC for the dental nurse.

There were ineffective arrangements to ensure that equipment was maintained according to manufacturers' instructions. For example; there were no records available to demonstrate that service or testing had been carried out for equipment including the autoclave, ultrasonic bath or the compressor. The provider was unable to tell us when these tests had been last carried out.

There were ineffective arrangements to assess and mitigate risks of fire at the practice. There was no fire safety risk assessment. There were no records to demonstrate that the fire alarm and emergency lighting systems were regularly tested. We saw there were fire extinguishers had been last tested in 2019.

The practice did not have effective arrangements to ensure the safety of the X-ray equipment. There were no records available to show that the required checks had been carried out to determine that the X-ray equipment was safely maintained. There were no records available in respect of the required annual electrical and mechanical tests or the three yearly radiological tests for the X-ray equipment. There was no radiation protection adviser (RPA) to advise on complying with the Ionising Radiations Regulations 2017 (IRR17).

We saw evidence the associate dentist justified, graded and reported on the radiographs they took. Records for the principal dentist showed that they did not justify the reason for taking dental radiographs, report on the findings or clinical quality of dental radiographs taken.

Audits of dental radiographs were not carried out following current guidance and legislation to monitor and improve quality in relation to dental radiography.

Training records were not available to show that clinical staff completed continuing professional development in respect of dental radiography.

Risks to patients

The provider did not have effective systems to assess, monitor and manage risks to patient safety.

The provider had current employer's liability insurance.

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

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

Are services safe?

However, there were a number of areas where improvements were required

The practice's health and safety policies, procedures and risk assessments were not bespoke to the practice or reviewed regularly to help manage potential risk.

We looked at the practice's arrangements for safe dental care and treatment. There were no systems to assess and mitigate risks associated with the use and disposal of dental sharps. The dental nurses told us that they disposed of needles. This is contrary to the relevant safety regulation when using needles and other sharp dental items.

The provider did not have a system in place to ensure clinical staff had received appropriate vaccinations, including vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked. We saw that there were no records available to show that the dental nurses had Hepatitis vaccinations.

Sepsis information prompts for staff, and patient information posters were not available in the practice. There were no sepsis related procedures to ensure staff made triage appointments effectively to manage patients who present with dental infection and where necessary refer patients for specialist care.

There were ineffective arrangements to respond to medical emergencies.

There were arrangements to check emergency medicines and equipment. However, these were not effective in ensuring that the relevant medicines and equipment were available.

Some emergency equipment and medicines were not available as described in recognised guidance. One medicine used to treat low blood glucose (Glucagon) and the medicine used to treat seizures (Midazolam) were not available. The Midazolam had not been available at the practice for several months. There was no portable suction equipment.

The provider sent us photographic evidence that these items were available prior to them re-opening the practice. Staff had undertaken training in basic life support. The provider told us that in-house refresher sessions were held with all members of staff before the practice re-opened.

Information to deliver safe care and treatment

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at dental care records with clinicians to confirm our findings. We noted that the dental care records completed by the associate dentist were typed and managed in a way that kept patients safe. We discussed with the principal dentist improvements which were required in relation to their record keeping.

Dental care records were kept securely and complied with General Data Protection Regulation requirements.

The provider did not have systems for referring patients with suspected oral cancer under the national two-week wait arrangements. These arrangements were initiated by National Institute for Health and Care Excellence to help make sure patients were seen quickly by a specialist. There were no systems for making, monitoring and following up on referrals.

Are services effective?

(for example, treatment is effective)

Our findings

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

We have told the provider to take action (see full details of this action in the Requirement 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.

Monitoring care and treatment

There were ineffective arrangements so that the practice kept detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. We looked at a sample of dental care records to confirm our findings. We found that the records maintained by the associate dentist were detailed in respect of the dental assessments, discussions around treatment options and the dental treatments carried out.

The dental care records maintained by the principal dentist lacked detail in respect of assessments carried out, such as assessments of hard and soft tissue examination, cancer screening and basic periodontal examinations (BPE) were not recorded.

The were no quality assurance processes, such as audits of dental care records to encourage learning and continuous improvement.

Effective staffing

There were systems for staff new to the practice to undertake a period of induction. There were induction records for both the dental nurses. However, these were incomplete and there were no dates to show when the induction was carried out.

There were ineffective systems to ensure that staff had the skills, knowledge and experience to carry out their roles. There were limited systems to staff training and development needs and to monitor staff training. From documents made available to us we noted that there were no training records available for the trainee dental nurse, there were no records available to show that the dental nurse had undertaken training in safeguarding, basic life support, fire safety dental radiography or Legionella awareness. The training records for both the principal and associate dentist were incomplete and

records were not maintained to demonstrate that clinical staff completed the continuing professional development required for their registration with the General Dental Council.

Co-ordinating care and treatment

There were ineffective systems for referring patients to specialists in primary and secondary care for treatment the practice did not provide.

There were no arrangements to monitor referrals to ensure they were responded to promptly.

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 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

The principal dentist had been outside UK for some months prior to the inspection. They had been unable to travel back due to COVID-19 restrictions. They told us that the practice manager had left the practice in November 2020 and that both these occurrences had impacted on the overall leadership and the day-to-day management of the practice. The provider acknowledged that they had over relied on the practice manager and had failed to oversee the management of the practice. They also acknowledged that improvements were needed in a number of areas.

Following our inspection, the provider voluntarily closed the practice and employed the services of a compliance consultant to assist with reviewing the service and taking prompt action to address the areas of concern, which we identified.

Culture

The principal dentist demonstrated an openness, transparency, candour and a willingness to promptly rectify the shortcomings we identified during the inspection. They accepted that the current culture in the practice was not so as to support learning and improvement.

Staff told us that they enjoyed working at the practice. They told us that they felt supported.

Governance and management

There was a lack of clear and effective processes for managing risks, monitoring and improving the service.

There was a lack of governance systems. For example; the practice infection control procedures were not in accordance with current guidance. There were no systems to ensure that staff were following these procedures. There were ineffective systems to assess and manage risks in relation to areas including fire safety, infection prevention and control and Legionella management.

There were no audits of dental radiographs to assess the quality of dental radiograph images taking into account the Ionising Radiation (Medical Exposure) Regulations 2017 and taking into account the guidance for Dental Practitioners on the Safe Use of X-ray Equipment.

There were ineffective systems to ensure that equipment, including the autoclave, compressor and the dental X-ray equipment were maintained, tested and serviced in line with the manufacturer's instructions and relevant legislation and guidance.

There were ineffective arrangements for staff recruitment, monitoring staff learning and development needs and ensuring that staff completed training relevant to their roles and responsibilities.

There were ineffective arrangements to ensure that dental care records were detailed to reflect the assessment and treatment provided to patients.

The provider did not have systems in place to monitor or follow up on referrals to other dental / health providers where patients required urgent or specialist dental treatments, which the practice did not provide. There were no arrangements to ensure that patients would receive this treatment in a timely manner.

Are services well-led?

The provider did not have systems in place for receiving, managing and sharing safety alerts such as those reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies, such as Public Health England (PHE).

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The registered person's recruitment procedures did not ensure that potential employees had the necessary qualifications, competence, skills and experience before starting work. In particular:** • There were no references available for the dental nurse. • Disclosure and Barring Service (DBS) checks were not available for the dental nurse or the trainee dental nurse. • There were no records in respect of registration with the General Dental Council (GDC) for the dental nurse. • There were ineffective arrangements for induction for new staff. Induction records for the dental nurse and the trainee dental nurse were incomplete. These records did not demonstrate that the practice procedures were followed so as to ensure staff were familiar with the practice policies, procedures and ways of working. 19 (1) (2)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular:** • There were no arrangements to assess staff learning and development needs. or to ensure that clinical staff

This section is primarily information for the provider

Requirement notices

undertook required training including continuing professional development (CPD) in accordance with the General Dental Councils *Standards for the Dental team* for clinical staff:

- We checked staff records and found that there were no training records for the trainee dental nurse.
- There were no training records in relation to basic life support, safeguarding, Legionella awareness, fire safety awareness or dental radiography for the dental nurse.
- Records for the principal dentist and the associate dentist were not maintained to demonstrate that they were up to date with the required training including continuing professional development (CPD) in accordance with the General Dental Councils *Standards for the Dental team* for clinical staff:

18 (2)

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. 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 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.** **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:** • There were ineffective systems to monitor and improve the quality of dental radiographs. Audits of dental radiographs were not carried out and there was inconsistent recording in relation to justification, reporting on findings and recording clinical grade of dental radiographs taken. • There were ineffective systems to ensure that dental records were maintained so as to accurately reflect assessments carried out and treatments provided to patients. • Information, such as a detailed assessment including hard and soft tissue examination, oral cancer screening and (BPE) were not recorded in some of the dental care records we were shown. • There were no audits of dental care records so as to monitor and improve the quality of dental records. • There were no arrangements for monitoring and acting on patient safety information such as information issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies, such as Public Health England (PHE).

This section is primarily information for the provider

Enforcement actions

There were ineffective governance systems to assess and manage risks in relation to the service.

- There were no health and safety risk assessments for the practice
- There were ineffective systems to ensure that staff had received effective vaccinations against Hepatitis B
- There were no records of vaccines for the dental nurse the trainee dental nurse
- There were ineffective arrangements for referring patients' referrals to other dental practitioners or other clinical specialists in instances where this was indicated, such as where the practice did not offer a service, or a patient required specialist dental treatment or urgent care due to suspected oral cancer.
- There were no procedures available in respect of making or following up on referrals made by the practice for routine or urgent assessment or treatment.

17 (1) (2)

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:

- The provider did not have proper arrangements to deal with medical or other emergencies at the practice
- The medicine used to treat seizures and one medicine used to treat low blood glucose were not available
- Portable suction equipment was not available.

- The provider did not have suitable infection prevention and control arrangements to monitor and minimise the risks of cross infection including the risk of transmission of the COVID-19 virus. In particular:

This section is primarily information for the provider

Enforcement actions

- The provider did not have systems to determine and employ safe and suitable fallow time when treatments involving the use of aerosol generating procedures would be carried out
- Staff had not been fit tested for use of filtering facepiece masks (FFP)
- There were ineffective arrangements to ensure that the cleaning and sterilising of dental instruments was carried out in accordance with in accordance with the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05)
- There were ineffective systems to assess and mitigate risks associate with the use and disposal of dental sharps in accordance with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013
- Infection prevention and control audits carried were not completed accurately to reflect infection control procedures in the practice.

- The provider did not have suitable arrangements to monitor and mitigate the risks of fire at the practice. In particular:

- There were ineffective systems to ensure that fire detection and safety equipment including emergency lighting fire alarms and fire extinguishers were tested.
- Staff working at the practice had not undertaken training in fire safety awareness.
- The provider does not have effective systems to monitor and maintain equipment and systems for the safe running of the practice:
- There were no records available to demonstrate when the autoclave, compressor, annual electrical and mechanical test, and three-yearly radiological test for the dental X-ray equipment and the five – year fixed electrical wire installation report had been carried out to ensure that these equipment and installations were operating effectively and safely.

12 (1) (2)