Chronos London Dental Clinic Limited

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Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 11 November 2022 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 was visibly clean.
- Patients were treated with dignity and respect and staff 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 dental clinic had information governance arrangements.

Summary of findings

- The practice did not have infection control procedures which reflected published guidance.
- Staff did not know how to deal with medical emergencies. The medical emergency drugs and equipment were not available as per current national guidance.
- There were ineffective processes in place to prevent abuse of vulnerable adults and children.
- Risks to staff and patients from undertaking of regulated activities had not been suitably identified and mitigated.
- The provider did not ensure that the premises and equipment used for providing care and treatment were safe.
- The provider did not have suitable staff recruitment procedures to comply with current legislation.
- The clinical staff provided patients' care and treatment in line with current guidance. Improvements were needed to ensure patient care was suitably recorded within the dental care records.
- There were ineffective systems to support continuous improvement.
- Staff and patients were not asked for feedback about the services provided.
- Staff generally worked as a team. However, improvements were needed to ensure that they were supported and involved in the delivery of care and treatment.
- There was ineffective leadership and a lack of oversight for the day-to-day management of the service.

Background

Chronos London Dental Clinic is in Kensal Rise, in the London Borough of Brent, and provides NHS and private dental care and treatment for adults and children.

The practice is located close to public transport links and car parking spaces are available nearby.

The dental team includes the principal dentist, 1 associate dentist, 1 qualified dental nurse, and 2 trainee dental nurses who also carry out receptionist duties. The practice has 2 treatment rooms and a separate decontamination room.

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

The practice is open:

Monday, Tuesday, Wednesday, Friday 9am to 5pm.

The practice is closed for lunch between 1pm and 2pm.

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

- Ensure care and treatment is provided in a safe way to patients.
- Ensure patients are protected from abuse and improper treatment.
- 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.

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

Summary of findings

- Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the College of General Dentistry.
- Implement an effective system for monitoring and recording the fridge temperature to ensure that medicines and dental care products are being stored in line with the manufacturer's guidance.
- Improve the practice protocols regarding auditing patient dental care records to check that necessary information is recorded.
- Implement processes and systems for seeking and learning from patient feedback with a view to monitoring and improving the quality of the service.

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 Enforcement Actions section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

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

The practice did not have effective safeguarding processes to prevent abuse of vulnerable adults and children. Internal safeguarding arrangements were not communicated effectively. One member of staff we spoke to was unaware of safeguarding arrangements within the practice.

The provider could not demonstrate that staff received safeguarding training that was relevant, and at a suitable level for their role. We looked at 5 training records and noted that one member of clinical staff had not received any safeguarding training.

Information about current procedures, and guidance about raising concerns about abuse were not accessible to people who use the service and to staff. The contact details of the Local Authority`s safeguarding board were not available or shared with all members of staff.

The practice had infection control procedures which reflected broadly published guidance. However, we found shortcomings in the infection prevention and control procedures. There were no systems in place to monitor the temperature of water throughout the cleaning procedure to ensure the temperature of water was 450C or lower. This is not in line with the guidance set out in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health , which states that water temperature should be monitored using a mercury-free thermometer. Using water with a temperature of 450C or lower is used to prevent protein coagulation and fixing of soil to the instrument.

The provider could not demonstrate that they had systems in place to ensure used dental instruments were kept moist if they were not processed as soon as it was practical after use.

In addition, there was no evidence that long-handled brushes used to scrub instruments were single use or if reusable, were washed in hot water after use and replaced at the manufacturer`s recommended intervals.

On the day of inspection, the provider did not have a written manual cleaning procedure staff could follow to ensure the risks arising from infections were sufficiently prevented and controlled. Following the inspection, the provider submitted a 'Manual Cleaning Procedure for Dental Instruments' document dated 2011. This was a generic document, had not been regularly reviewed and did not contain a clear decontamination process specific to the practice as it referred to arrangements in a different service.

The procedures to reduce the risk of Legionella or other bacteria developing in water systems were ineffective. A Legionella risk assessment was not available for review on the day of inspection. Following the inspection, the provider submitted a risk assessment dated 25 May 2018. The provider could not demonstrate that the risk assessment had been regularly reviewed by a person who had the qualification, skills, competence and experience to do so. There was no evidence that the tasks listed in the water maintenance program, including the hot and cold running water temperature checks had been carried out within the recommended timeframes. Following the inspection, the provider submitted a copy of their 'Legionnaire`s disease daily check' document, with the most recent entry dated 30 June 2022. It was unclear what the daily checks included and there was no reference to hot and cold outlet temperature checks. Another document made available for review was a 'Water Management Register'. This was a blank template with no entries.

Are services safe?

The systems for flushing and disinfecting Dental Unit Waterlines (DUWLs) were not in line with the recognised national guidance. Staff told us they flushed the DUWLs for 30 seconds at the beginning of the day and for 30 seconds between patients. The national guidance states that DUWLs should be flushed for at least 2 minutes at the beginning and end of the day and for at least 20-30 seconds between patients.

The practice had policies and procedures in place to ensure clinical waste was segregated in line with guidance. However, on the day of inspection we found that the clinical waste bin used to store clinical waste bags awaiting collection was not locked. The bin was stored in an area that was easily accessible to the public from the side road.

We saw the practice was visibly clean. Improvements could be made to ensure there was an environmental cleaning checklist in place to monitor the effectiveness of the cleaning.

The recruitment procedure to help the practice employ suitable staff did not reflect national legislation. We checked 5 staff recruitment records and found these to be incomplete. Enhanced Disclosure and Barring Service (DBS) checks had not been undertaken at the time of employment or re-employment for 2 clinical members of staff and there was no evidence that the risks around these had been considered. In addition, records were not available to show that satisfactory evidence of conduct in previous employment had been sought for all members of staff. Right to work in the UK checks had not always been carried out and there was no evidence that one member of staff had their Hepatitis B antibody level checked.

The practice had some systems in place to ensure equipment was safe to use, maintained and serviced according to manufacturers' instructions. The portable appliance testing to ensure portable appliances were safe to use was completed in November 2022. The autoclave was serviced annually, with the last service being undertaken on 10 September 2021; the annual service was now overdue. There was no evidence that the suction unit had been serviced regularly and we noted that it broke down on the day of the inspection.

The provider did not have systems in place to ensure the premises were safe. The annual gas safety checks and the electrical installation condition tests had not been carried out.

The risks related to fire safety had not been assessed and mitigated and neither reviewed regularly by a person with the qualifications, competence and experience to do so.

When we asked the principal dentist about fire safety arrangements within the practice, they told us that 'staff know if there is a fire, they have to exit the building'.

The fire risk assessment dated 2 June 2022 was a one-page document which listed electrical equipment, flammable materials, cigarettes and building and maintenance work as significant hazards and the control measures of these. The emergency routes and exits, fire detection systems, firefighting equipment, the removal and storage of dangerous substances, emergency fire evacuation, the needs of vulnerable people and staff training had not been assessed and documented.

The practice did not have procedures in place to mitigate risks associated with fire. There was no evidence that the fire extinguishers had been serviced. There were no records of periodic in-house testing of the fire safety equipment, including the smoke detection system. The practice did not have emergency lighting installed and the principal dentist told us they would rely on external streetlights in case of a fire. There was no evidence that fire drills had been carried out. The provider could not demonstrate that they had appointed a fire marshal and that staff had undertaken fire awareness training.

The provider was unable to show us evidence of radiation protection arrangements to ensure that dental radiography was carried out safely in accordance with Ionising Radiation (Medical Exposure) Regulations 2000/2018 [IRMER 2000/2018] and

Are services safe?

The Ionising Radiations Regulations 2017 [IRR 2017]. The practice had appointed a Radiation Protection Advisor (RPA) on 8 November 2022 but there was no evidence that they had been consulted regarding the layout of the dental radiography facilities, including required structural protection, safety and warning devices and the required control measures in line with a risk assessment.

The Equipment Performance Report dated 21 July 2022 for the intraoral unit in Surgery 1 and the Critical Examination and Acceptance Test Report dated 27 July 2021 for the intraoral unit in Surgery 2 stated that the patient entrance and doses for adult child exposures were greater than the national diagnostic levels and should be reduced. It stated that the provider should seek advice from their Medical Physics Expert (MPE) on the appropriate exposure setting to use. There was no evidence that the provider had acted upon this recommendation.

There was no evidence that the provider had registered with the Health and Safety Executive as per current national requirements.

Risks to patients

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

A comprehensive sharps risk assessment that considered risks relating to all forms of sharps had not been undertaken. The practice could not demonstrate that they had taken reasonable steps to reduce the risk of sharps injuries in line with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The principal dentist recapped needles and the practice did not have appropriate devices, for example needle-blocks, to control the risk of injury.

The needlestick injury poster was displayed; however, it did not include the Occupational Health, or the nearest Accident & Emergency department contact details to guide staff in the event of a sharps injury.

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

Emergency medicines were not available in accordance with national guidance. On the day of inspection Buccal Midazolam (an emergency medicine to treat epileptic seizures) was not available. We were not assured that the provider took action in a timely manner to ensure that the expired medical emergency drug was replaced when it had expired in July 2022. The provider placed an order for the missing out of date medical emergency drug on the day of the inspection. Following the inspection, we received evidence that an injectable Midazolam, but not an oromucosal solution as set out in the relevant national guidance, had been delivered to the practice.

Clear face masks for self-inflating bag in sizes 0,2,3 and 4 were not available and the practice did not have a portable suction.

Glucagon (an emergency medicine used to treat severe low blood sugar) was stored in the fridge but the fridge temperature was not monitored.

Staff did not know how to respond to medical emergencies. When asked, staff were unable to attach the battery to the AED and they could not demonstrate that they had an understanding of how to connect the oxygen tubing to the oxygen cylinder.

The provider could not demonstrate that they carried out risk assessments for hazardous materials used within the practice as per Control of Substances Hazardous to Health regulations 2002 (COSHH). Safety data information for hazardous materials used within the practice were not available to staff.

Information to deliver safe care and treatment

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

Are services safe?

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 had systems for the safe storage of medicines. However, improvements were needed to ensure that there was an adequate stock control system of medicines which were held on site. Antimicrobial prescribing audits were not carried out.

Prescribing of antibiotics was not in line with current national guidance (https://bnf.nice.org.uk/treatment-summaries/oropharyngeal-infections-antibacterial-therapy/#abscess-periapical-or-periodontal). Following the inspection, the provider submitted a dispensing log which stated that Amoxicillin 500mg was prescribed orally three times a day for seven days and Metronidazole 400mg orally three times a day for 7 days. The guidance states that the antibiotic therapy in both cases should be for up to 5 days.

On the day of the inspection we found out of date materials in surgery 1. These included for example; rubber dam (exp.2019, gelatin sponge (exp. September 2021) and adhesive (exp. May 2022). The provider did not have suitable or effective systems for ensuring dental materials were disposed of adequately once they were beyond their recommended use by date.

Track record on safety, and lessons learned and improvements

The provider told us that in the previous 12 months there had been no safety incidents. The provider told us they had systems in place to review any safety alerts, though staff we spoke with told us they were unaware how they could access alerts issued by the Medicines and Healthcare products Regulatory Agency (MHRA).

Are services effective?

(for example, treatment is effective)

Our findings

We found this practice was 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.

Staff 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 digital and paper dental care records. We looked at 4 dental care records and found that they were missing details, including reason for attendance, details of social history, treatment options, recall intervals according to risk assessment and cost of treatment.

We saw evidence the dentists justified, graded and reported on the radiographs they took. The practice did not carry out radiography audits six-monthly following current guidance and legislation.

Effective staffing

Staff had some level of skills, knowledge and experience to carry out their roles. however, based on our findings on the day, we could not be assured staff had an adequate understanding of medical emergencies and basic life support.

We noted that there were no arrangements for staff new to the practice to have a structured induction programme.

Clinical staff completed continuing professional development required for their registration with the General Dental Council; however, there was no evidence of infection control training for one member of clinical staff within the last 12 months. Based on our findings on the day, training was not always effective, and the learning outcomes did not lead to a clear understanding of the management of medical emergencies.

Co-ordinating care and treatment

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

The dentists confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide. However, improvements were needed for monitoring referrals made, including urgent referrals where there were oral cancer was suspected.

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.

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.

Staff gave patients clear information to help them make informed choices about their treatment.

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

The dentist described to us the methods they used to help patients understand treatment options discussed. These included for example photographs 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. It took account of patient needs and preferences.

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

The practice had made reasonable adjustments for patients with disabilities. Staff had carried out a disability access audit and had formulated an action plan 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.

Listening and learning from concerns and complaints

The practice responded to concerns and complaints appropriately and discussed outcomes with staff 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 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

We found that there was ineffective leadership which impacted on the practice`s ability to deliver safe, high quality care. The principal dentist could not assure us that they understood risks pertaining to the management of the service and the delivery of care.

We found that staff members worked well together. However, improvements were needed to ensure information about systems and processes were communicated effectively across the organisation.

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

The practice did not have systems in place to support staff in their development. For example, we could not be assured staff had an adequate understanding of medical emergencies and basic life support.

We noted that there were no arrangements for staff new to the practice to have a structured induction programme. The provider failed to identify that the training clinical staff had undertaken was ineffective.

Culture

There were no records to demonstrate that individual training needs during annual appraisals or one to one meeting had been discussed.

There were no systems in place to monitor staff training to ensure continuing professional development and other training requirements relevant to staff in carrying out their role was up-to-date and reviewed at the required intervals.

Governance and management

The practice did not have effective governance and management arrangements. We noted that the 'Chronos London Dental Clinic Risk Assessment' document dated 12 August 2022 contained inaccurate information. For example, it stated an L2 fire alarm system was in place, weekly tests were carried out along with 6 monthly inspections from Initial Fire and Electrical Limited and firefighting equipment were tested annually. It further stated that the practice had separate COSHH sheet for each biological agent. None of these statements were substantiated in our findings on the day of inspection.

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 sharps, fire safety, legionella and general health and safety.

Following our inspection, the provider informed us that they had engaged a compliance advisor and they were now implementing systems and processes to ensure future good governance.

Appropriate and accurate information

The practice had ineffective information governance arrangements. In particular, we saw no evidence that the provider had registered to process data with the Information Commissioner's Office.

Engagement with patients, the public, staff and external partners

There were no records to demonstrate that staff gathered feedback from patients, the public and external partners.

Are services well-led?

Continuous improvement and innovation

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

The practice did not have appropriate quality assurance processes to encourage learning and continuous improvement. There was no evidence that radiography audits had been carried out in line with the relevant national guidance. The provider could not demonstrate that infection prevention and control audits had been carried out bi-annually in line with the relevant guidance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person did not have systems and processes in place that operated effectively to prevent abuse of service users. In particular: • Information about current procedures, and guidance about raising concerns about abuse were not accessible to people who use the service and to staff. • The provider could not demonstrate that staff received safeguarding training that was relevant, and at a suitable level for their role. Regulation 13 (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: • Enhanced Disclosure and Barring Services (DBS) checks had not been undertaken at the time of recruitment for all members of clinical staff. • Records were not available to show that satisfactory evidence of conduct in previous employment had been sought for all members of staff at the time of recruitment. 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 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 medical emergency drugs and equipment were not available as per current national guidance. • Staff failed to demonstrate an understanding of how to manage medical emergencies. • The provider could not demonstrate that a fire risk assessment had been undertaken and regularly reviewed by a person who had the qualification, skills, competence and experience to do so. • There was no evidence to show that the fire extinguishers had been serviced. There were no records to demonstrate that fire drills had been carried out and that staff had undertaken training in fire safety. • The provider could not demonstrate that the Legionella risk assessment had been regularly reviewed by a person who had the qualification, skills, competence and experience to do so. There was no evidence that the tasks listed in the water maintenance program, including the hot and cold running water temperature checks had been carried out within the recommended timeframes. • Processes and systems for managing Dental Unit Water Lines (DUWLs), including flushing and disinfection was not in line with the relevant national guidance and the manufacturer`s recommendations. • Risk assessments in relation to the use of substances and materials hazardous to health had not been carried out. The material safety data sheets were not accessible to staff in case of an incident. • Risks from sharps injuries were not adequately assessed and the provider did not have appropriate control measures in place.

This section is primarily information for the provider

Enforcement actions

- The provider did not have effective arrangements for monitoring referrals made, including urgent referrals where - oral cancer was suspected.
- The clinical waste bin used to store clinical waste bags awaiting collection was not locked.
- The cabinet used to store hazardous cleaning materials was not locked.
- Gas safety checks and electrical installation condition checks had not been carried out in line with the relevant regulations.
- There was no evidence that the suction unit was regularly serviced, and the annual service of the autoclave was overdue.
- The provider could not demonstrate that adequate radiation protection arrangements were in place to ensure that dental radiography was carried out safely in accordance with Ionising Radiation (Medical Exposure) Regulations 2000/2018 [IRMER 2000/2018] and The Ionising Radiations Regulations 2017 [IRR 2017].
- The provider had not notified the Health and Safety Executive (HSE) about the use of ionising radiation at the practice.
- Prescribing of antibiotics was not in line with current national guidance.
- The provider did not have effective systems in place to ensure that dental materials were not used beyond their expiry date.
- Staff were unaware how they could access alerts issued by the Medicines and Healthcare products Regulatory Agency (MHRA).

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 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

This section is primarily information for the provider

Enforcement actions

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 provider failed to assess the risk of, and prevent and control the spread of, infections in accordance with the Department of Health publication 'Health and Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05).
- The Manual Cleaning procedure referred to the arrangements in a different service and there was no evidence that this document had been regularly reviewed.
- The Health and Safety risk assessment was not effective to identify issues and was not reflective of our findings on the day.

The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

- Radiography audit had not been undertaken.
- Infection prevention and control audit was not carried out bi-annually.

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

There was additional evidence of poor governance. In particular:

- Governance systems were ineffective as they did not include sufficient oversight, scrutiny and overall responsibility by the registered manager.

Regulation 17 (1)