Dental Centre 100

Dental Centre

Inspection report

67 Askew Road
London
W12 9AH
Tel: 02087403021

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Overall summary

We carried out this announced, focused inspection on 9 December 2020 under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection due to concerns highlighted during a Transitional Monitoring Call undertaken on 28 October 2020 and 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 specialist dental adviser.

We asked the following questions:

• Is it safe?

• 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 well-led?

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

Background

Dental Centre is located in the London Borough of Hammersmith & Fulham and provides NHS and private dental care and treatment for adults and children.

Summary of findings

Car parking spaces are available in surrounding roads and the practice is located close to public transport links. The practice has one treatment room located on the first floor.

The dental team includes two dentists, two dental nurses and one receptionist.

The practice is owned by an individual who is the principal dentist there. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

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

The practice is open:

Our key findings were:

- The practice appeared to be visibly clean and well-maintained.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- Risks to staff and patients from undertaking of the regulated activities had not been suitably identified and mitigated.
- Decontamination of used dental instruments was not carried out in accordance with current guidelines.
- The provider had limited staff recruitment procedures. Improvements were needed to ensure that checks were carried out consistently for all staff at the time of recruitment.
- There was ineffective leadership and a lack of management oversight for the day-to-day running of the service.
- The provider did not have suitable information governance arrangements.
- There were ineffective systems to ensure facilities were safe and equipment was serviced and maintained according to manufacturers' guidance.
- Accurate, complete and contemporaneous dental care records were not maintained in respect of each service user.
- Infection prevention and control (IPC) and Disability Access audits were not completed.
- There were ineffective arrangements to monitor staff training and development needs.

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.

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

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

- Review the practice protocols regarding audits for prescribing of antibiotic medicines taking into account the guidance provided by the Faculty of General Dental Practice.
- 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.

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 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)

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw evidence that staff had received safeguarding training, however improvements were needed to ensure staff training was kept up-to-date. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC.

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

The provider had an infection prevention and control policy. On the day of the inspection we could not be assured all staff had completed infection prevention and control training. We noted that the dental nurses did not follow guidance as set out in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health and Social Care.

There were ineffective arrangements to ensure that dental instruments were decontaminated and sterilised appropriately. Staff were not scrubbing instruments unless visible debris was present and were using a metal burr brush. There was no separate receptacle set up to rinse the instruments.

Since the inspection the practice has taken steps to immediately rectify the concerns highlighted.

The staff had systems in place to ensure that patient-specific dental appliances were disinfected prior to being sent to a dental laboratory and before treatment was completed.

We saw the practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems in the form of a risk assessment. We looked at the risk assessment carried out in 2012 and noted that there were a number of areas where improvements were needed. These included dead-leg pipework to be removed, having a system for disinfecting the dental unit waterlines and monitoring the temperature of hot and cold water from the taps in the surgery. A system to monitor the hot and cold temperatures was implemented shortly after our monitoring call on 28 October 2020; however there was no evidence that this was ongoing. The hot and cold temperatures were not being monitored at the time of the inspection.

We saw effective cleaning schedules to ensure the practice was kept clean. When we inspected we saw the practice was visibly clean.

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

No infection prevention and control audit was available on the day of the inspection, nor was there any evidence these had ever been carried out.

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

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

Are services safe?

The provider had limited staff recruitment procedures to help them employ suitable staff. We looked at four staff recruitment records. These showed that checks including Disclosure and Barring Services (DBS) had been carried out for most of the staff after our monitoring call on 28 October 2020. Improvements were needed to ensure risks are mitigated by carrying out all checks at the time of recruitment.

The provider did not ensure facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. On the day of the inspection we noted the fixed-wire electrical installation testing, carried out in 2017 had expired. There was also no evidence the electrical water heaters had been serviced nor were we assured that the PAT testing, for the small electrical devices, had been carried out.

A fire risk assessment was carried out in line with the legal requirements. The protocols for managing risks associated with fire, as detailed in a risk assessment, were not being followed. During the inspection we noted the smoke detectors and the emergency lighting had not been tested or checked since 2018. Improvements were also needed to the monitoring system to ensure staff received regular fire safety awareness training as recommended in the risk assessment. The last staff training in relation to fire safety was carried out after our monitoring call and records available to us showed previous training was in 2013.

The practice had arrangements to ensure the safety of the X-ray equipment. We were shown the required radiation protection information. Immediately after the inspection we were sent confirmation that a rectangular collimator had been installed and the practice had implemented a radiation protection folder.

On the day of the inspection we looked at patient records and saw that improvements were needed to ensure the dentists justified, graded and reported on the radiographs they took consistently. A radiography audit had been carried out.

Clinical staff completed continuing professional development in respect of dental radiography.

Risks to patients

The provider had ineffective systems to assess, monitor and manage risks to patient safety.

Improvements were needed to the practice's health and safety policies, procedures and risk assessments. We found not all were reflective of current protocols and were not reviewed regularly to help manage potential risks. A Health and Safety policy dated 05/08/2015 and reviewed 23/8/2017, made reference to the use of a lift, however there was no lift at the practice.

The provider had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. A sharps risk assessment had not been undertaken nor had the provider considered the risks associated with the handling and disposal of dental sharps.

The provider had 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.

Staff knew how to respond to a medical emergency. We saw that staff had completed training in emergency resuscitation and basic life support shortly after our monitoring call. Improvements were needed to ensure this training is carried out annually as recommended.

Emergency equipment and medicines were available as described in recognised guidance. An automated electronic defibrillator (AED) had been purchased immediately after our monitoring call in October 2020. The medicine to treat low blood sugar was stored in the fridge however the fridge temperature was not being monitored to ensure that medicines and dental care products were being stored in line with the manufacturer's guidance. A system to monitor the emergency equipment and medicines, to make sure they were available, within their expiry date, stored correctly and in working order, was also implemented shortly after the call.

Are services safe?

A dental nurse worked with the dentists when they treated patients in line with General Dental Council Standards for the Dental Team. A risk assessment had not been carried out for when staff worked alone.

On the day of the inspection, we saw the folder containing the information relating to the storage and handling of hazardous substances. Improvements were needed to include individual risk assessments in relation to each material. Due to the information available and the way that information was stored, the provider could not be assured staff would know how to act in the event of an incident.

Information to deliver safe care and treatment

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. Dental and other personal records were kept securely.

On the day of the inspection there was no Information Governance Policy nor had the provider considered the General Data Protection Regulation (GDPR) requirements. They could not be assured information was being handled line with current national guidelines. The registration with the Information Commissioners Office (ICO) had expired in September 2020. The provider re-registered for this on the day.

The Closed Circuit TV (CCTV) policy did not reflect the current practices nor was a privacy impact assessment in place in relation to the use of CCTV. There was no information for patients to consider in relation to the; purpose for use, length of time data is kept, how it is stored and who has access to this information.

The provider had systems for referring patients with suspected oral cancer under the national two-week wait arrangements. There were no arrangements to check that the referral had been received or that the patient had been called for assessment or treatment.

Safe and appropriate use of medicines

The provider had systems for appropriate and safe handling of medicines. We saw staff stored and kept records of NHS prescriptions as described in current guidance. The dentists were aware of current guidance with regards to prescribing medicines. The provider should consider carrying out an antibiotic prescribing audit to monitor prescribing procedures.

Track record on safety, and lessons learned and improvements

We were not assured that the provider had systems for reviewing and investigating when things went wrong. The implementation of systems to manage risks were needed to ensure any safety incidents are investigated, documented and any learning discussed with the rest of the dental practice team.

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

The provider did not have a system for receiving and acting on safety alerts, recalls and rapid response reports issued by the Medicines and Healthcare products Regulatory Agency (MHRA), the Central Alerting System (CAS) and other relevant bodies, such as Public Health England (PHE). The principal dentist was unaware of any safety alerts issued within the previous 12 months.

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 provider could not assure us that they understood risks pertaining to the management of the service and the delivery of care.

Culture

There was a lack of managerial oversight and understanding to monitor staff performance.

Governance and management

The principal dentist had overall responsibility for the management and clinical leadership of the practice and was responsible for the day-to-day running of the service.

The practice did not have effective systems for governance in relation to the management of the service. The practice policies and procedures were not always specific to the practice and did not appear to be reviewed regularly. There were a number of areas where the provider was unaware, lacked understanding or did not follow relevant guidance in relation to the running of the service and the delivery of care and treatment.

The processes for managing risks were ineffective. The practice did not have adequate systems in place for recognising, assessing and mitigating risks in areas such as the handling and disposal of hazardous substances, lone working, sharps or infection prevention and control. Where risks had been highlighted and recommendations made in risk assessments, there were no systems in place to ensure the relevant audits, reviews and training had been carried out. This included, for example Legionella risk assessments.

Appropriate and accurate information

The provider did not have information governance arrangements and could not be assured staff were handling and protecting patients' personal information effectively. Improvements were also required to take into account current General Data Protection Regulations requirements.

Continuous improvement and innovation

The principal dentist did not demonstrate an understanding or a commitment to learning and improvement.

The practice did not have systems or adequate quality assurance processes to promote learning, continuous improvement or innovation.

Reviews and audits were not carried out to effectively monitor the management of the service in areas such as infection prevention and control, disability access and risk management.

On the day of the inspection we could not be assured staff completed 'highly recommended' training as per General Dental Council professional standards. The provider told us he encouraged staff to complete continuing professional development; however there were no systems in place to monitor this is carried out as required.

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
Surgical procedures Diagnostic and screening 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 systems in place to ensure the effective decontamination of dental instruments were not robust and they did not highlight failings in the process.** • The fixed-wire electrical installation testing, carried out in 2017 had expired. • There was no evidence of servicing of the electrical water heaters. • We were not assured that the PAT testing, for the small electrical devices, had been carried out. • There was no rectangular collimator available on the intra-oral X-ray unit as recommended and no radiation protection folder was in place. • Risks identified in the Legionella risk assessment in 2012 had not been acted upon. **In addition, the hot and cold water temperature monitoring, implemented in November 2020 had not continued in December 2020.** • The provider did not monitor or follow up on urgent and routine referrals to ensure patients were seen in a timely manner. **Regulation 12 (1) (2)**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury

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 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:

- Risks relating to fire safety had not been properly considered and mitigated.
- There was no sharps risk assessment at the practice and the provider had not considered nor mitigated the risks to staff.
- Individual risk assessments had not been carried out in relation to the storage and handling of hazardous substances and the folder was also disorganised.
- There was no risk assessment available for staff when working alone.
- There was no system to receive and act on patient safety alerts. The provider had not considered nor mitigated the risks associated with the recall of products and equipment for safety reasons.

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 was no information governance policy and no consideration had been made to the General Data Protection Regulations (GDPR) requirements. The provider could not be assured data was handled in line with current national guidelines.
- The Closed Circuit TV (CCTV) policy did not reflect the current practices nor was a privacy impact assessment in place in relation to the use of CCTV.
- Practice policies and procedures were not bespoke to the practice.

This section is primarily information for the provider

Enforcement actions

- Accurate, complete and contemporaneous dental care records were not maintained in respect of each service user.
- Infection prevention and control (IPC) audits and Disability Access audits were not completed and we did not see evidence of previous audits undertaken at the practice.
- There were ineffective arrangements to monitor staff training and development needs.
- Risks around recruitment had not been identified and mitigated at the time of staff recruitment.

Regulation 17(2)