Dental W12

Church Street Dental Practice

Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 14 November 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.
- The practice had infection control procedures which reflected published guidance.
- Staff knew how to deal with medical emergencies. Appropriate medicines and life-saving equipment were available.
- There were systems in place to ensure most equipment was safe to use. The practice did not have effective systems to manage risks for patients, staff and the premises.
- Safeguarding processes were in place. Improvements were needed to ensure all members of staff completed safeguarding training at a level appropriate to their role.

Summary of findings

- The practice did not have suitable recruitment procedures to comply with current legislation.
- 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.
- Improvements were needed to ensure there was effective leadership and a culture of continuous improvement.
- Staff felt involved, supported and worked as a team.
- Staff and patients were asked for feedback about the services provided.
- Complaints were dealt with positively and efficiently.
- The practice had information governance arrangements.

Background

Church Street Dental Practice is in the London Borough of Enfield and provides NHS and private dental care and treatment for adults and children.

There is step free access to the practice for people who use wheelchairs and those with pushchairs. Car parking spaces, including dedicated parking for disabled people, are available near the practice. The practice has made reasonable adjustments to support patients with access requirements.

The dental team includes 1 principal dentist, 7 dentists, 1 foundation dentist, 4 dental nurses, 4 trainee dental nurses, 6 receptionists and 1 administrator. The practice has 6 treatment rooms.

During the inspection we spoke with the principal dentist, 1 qualified nurse, 1 trainee dental nurse and 2 receptionists. We looked at practice policies, procedures and other records to assess how the service is managed.

The practice is open:

Monday to Thursday from 8am to 5pm

Friday from 8am to 3pm.

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.

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

- Take action to ensure audits of record keeping and antimicrobial prescribing are undertaken at regular intervals to improve the quality of the service. The practice should also ensure that, where appropriate, audits have documented learning points and the resulting improvements can be demonstrated.
- Improve the practice's protocols and procedures for the use of X-ray equipment in compliance with The Ionising Radiations Regulations 2017 and Ionising Radiation (Medical Exposure) Regulations 2017 and taking into account the guidance for Dental Practitioners on the Safe Use of X-ray Equipment. In particular, ensure that elector-mechanical servicing of the radiation equipment is carried out in line with the manufacturer`s guidance or annually and rectangular collimators are used with the intraoral X-ray units.

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

The impact of our concerns, in terms of the safety of clinical care, is minor for patients using the service. Once the shortcomings have been put right the likelihood of them occurring in the future is low.

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

The practice had safeguarding processes for safeguarding vulnerable adults and children. Improvements were needed to ensure all members of staff completed safeguarding training at a level appropriate to their role.

The practice had infection control procedures which reflected published guidance.

The practice did not have effective procedures to reduce the risk of Legionella, or other bacteria, developing in water systems. A Legionella risk assessment dated 15 February 2016 was made available for review. This included a high-risk recommendation, requiring immediate action, stating that the cold water tank upstairs was concealed by a fixed panel and access was required to the unit to ensure that it was operating within the parameters for the control of Legionella and that it was complaint with the Water Supply (Water Fittings) Regulations 1999. On the day of inspection, the provider could not demonstrate that this recommendation had been immediately actioned upon or at all. The report also identified medium risk recommendations, including the requirement of a Policy for the Management and Control of Legionella for the practice (including management, nominations, responsibilities and detailed operational scheme), maintaining a full site log (including scheme of precautions, management team contacts, training records and all Pre Planned Maintenance records) and a flushing programme for the infrequently used outlets. The provider could not demonstrate that these recommendations had been reviewed and acted upon within the given timeframe.

A second Legionella risk assessment dated January 2022 was also made available for review. However this had not been completed by a person who had the qualifications, skills, competence and experience to do so.

The practice had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. Improvements could be made to ensure clinical waste bags were available at the point of disposal to reduce the need of transferring potentially infectious waste from the white bags used in the surgeries to the orange clinical waste bags used for storage.

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

The practice recruitment procedure to help them employ suitable staff did not reflect the relevant legislation. We looked at 15 staff records and noted that not all information was available in relation to staff as specified in Schedule 3 of the Health and Social Care Act 2008. 8 members of the team did not have the required level or any Disclosure and Barring Service (DBS) checks on record. Evidence of conduct in previous employment had not been obtained for 12 members of staff. In response to our feedback the provider submitted references for 3 members of staff; however, it was not clear who completed these reference requests as they only contained details of the employee and principal dentist of the practice. Photographic identification and employment history had not obtained at the point of employment for all members of staff. Vaccination records, such as Hepatitis B and the subsequent antibody blood tests results were not available for 6 members of clinical staff. Our discussions with support staff revealed that they requested recruitment and training documents in response to the inspection being announced and moving forward they were planning to implement a system that allowed easier monitoring of these documents.

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

Are services safe?

The practice ensured equipment was safe to use, maintained and serviced according to manufacturers' instructions. We were shown evidence of the autoclave, compressor and portable appliance testing and servicing records.

The practice did not ensure the facilities were maintained in accordance with regulations. The gas safety certificate and the electrical installation condition report were not available for review.

The management of fire safety was not effective. A fire risk assessment dated 22 November 2022 was made available for review, however this had not been completed by a person who had the qualifications, skills, competence and experience to do so. The assessment did not suitably consider 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. In addition, the member of staff who completed the assessment told us that they 'did not know much about fire safety'. On the day of the inspection, we observed a large amount of combustibles, including cardboard and gas canisters in the storage rooms of the basement, without appropriate fire safety equipment in place. We further noted that the practice had not considered how wheelchair users could exit the premises in the event of a fire, as the level access exit suitable to their use was not marked as a fire exit. There were no records of periodic in-house checks of the fire safety equipment, fire evacuation drills were not being carried out and only 3 members of staff had completed fire safety training.

Following the inspection, the provider submitted photographic evidence that they had installed a push bar on the rear door that led to the level access to the building. We were further provided evidence that 2 staff had completed fire awareness training and 1 had completed fire marshal training after the inspection.

The practice had some arrangements to ensure the safety of the X-ray equipment and the required radiation protection information was available. Improvements were needed to ensure recommendations made in the 3-yearly performance reports had been acted upon and the practice installed rectangular collimators to the intraoral radiography units. In addition, improvements could be made to ensure the electro-mechanical servicing was carried out in line with the manufacturer's guidance or annually.

Risks to patients

The practice had implemented systems to assess, monitor and manage risks to patient and staff safety. This included sharps safety and sepsis awareness.

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.

On the day of the inspection, the provider had some information available in relation to the use and storage of hazardous substances as per Control of Substances Hazardous to Health regulations 2002 (COSHH). However, improvements were needed to ensure that safety data information and risk assessments were available for all hazardous materials used in the practice. Following the inspection, the provider submitted the safety data sheets for the hazardous materials they used.

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 2-week wait arrangements.

Safe and appropriate use of medicines

Are services safe?

The practice had some systems for appropriate and safe handling of medicines. Improvements were needed to ensure that the practice had an effective log to identify missing NHS prescriptions. Antimicrobial prescribing audits were not carried out.

Track record on safety, and lessons learned and improvements

The practice had some systems in place to report accidents and incidence. We noted that a member of staff suffered a sharps injury in June 2023, and we were not shown evidence that it had been investigated and suitably followed up. Improvements could be made to ensure that accidents, including sharps injuries were suitably recorded, investigated and learning from these were shared with the whole team to reduce the risk of recurrence.

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. Improvements were needed to ensure all members of staff, including trainee nurses and support staff completed Mental Capacity Act 2005 training.

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.

The dentist conveyed an understanding of supporting more vulnerable members of society such as patients living with dementia or adults and children with a learning disability. Improvements were needed to ensure all members of staff received training on interacting with people with a learning disability and autistic people.

We saw evidence the dentists justified, graded and reported on the radiographs they took. We were shown the radiography audit carried out in December 2021. Improvements could be made to the frequency of radiography audits to ensure they were following current guidance and legislation, in particular, by carrying out the audits at 6-monthly intervals.

Effective staffing

Permanent qualified staff had the skills, knowledge and experience to carry out their roles. We noted that there was no record of the induction trainee dental nurses received. This was not in line with the relevant guidance published by the General Dental Council (GDC), which stated that trainee nurses 'must receive a formal structured induction, which should include training regarding patient safety and confidentiality; infection control; the protection of vulnerable children and adults; and how to deal with medical emergencies'. In addition, there was no evidence to demonstrate trainee nurses received training in safeguarding children and vulnerable adults, infection prevention and control, training on interacting with people with a learning disability and autistic people, Legionella awareness and mental capacity. In response to our inspection feedback about the lack of evidence for training, the provider stated that 'We always were advised that trainees and admin staff did not need to do CPD'. Training requirements relate not only to statutory training but also to the systems in place to ensure training, learning and development needs of individual staff members are met and reviewed at regular intervals, and that there are effective processes to support staff to undertake training and development to enable them to fulfil the requirements of their role.

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.

Patients said staff were compassionate and understanding when they were in pain, distress or discomfort.

Privacy and dignity

Staff were aware of the importance of privacy and confidentiality. Improvements could be made to ensure information about accidents were kept securely.

The practice had installed closed-circuit television to improve security for patients and staff. Relevant policies and protocols were in place.

Staff password protected patients' electronic care records and backed these up to secure storage. They stored paper records securely.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care and gave patients clear information to help them make informed choices about their treatment.

The 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 and X-ray images.

Are services responsive to people's needs?

Our findings

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

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs and preferences.

Staff were clear about the importance of providing emotional support to patients when delivering care.

The practice had made reasonable adjustments, including level access 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. When the practice was unable to offer an urgent appointment, they worked with partner organisations to support urgent access for patients. 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 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 overall responsibility for the management and clinical leadership of the practice and members of the administration and reception team were responsible for various aspects of 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 management of training, ineffective risk management and not adhering to published guidance in respect of recruitment, all impacted the day to day management of the service.

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 in informal discussions. However, improvements were needed to ensure all members of staff had regular formal appraisal to discuss performance, learning needs, general wellbeing and aims for future professional development.

The practice had some arrangements to ensure clinical staff's training was up-to-date. Improvements were needed to ensure the systems in place were adequate to ensure that trainee nurses and support staff carried out training to enable them to fulfil the requirements of their role. In addition, the provider did not have systems in place to monitor staff training to ensure appropriate action was taken quickly when training requirements were not being met.

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, fire safety COSHH and Legionella.

Appropriate and accurate information

The practice had information governance arrangements and staff were aware of the importance of protecting patients' personal information.

Engagement with patients, the public, staff and external partners

Staff gathered feedback from patients, the public and external partners and demonstrated a commitment to acting on feedback.

Feedback from staff was obtained through meetings, 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

Are services well-led?

The practice had some systems and processes for learning, quality assurance, continuous improvement. These included audits of disability access and infection prevention and control. Improvements were needed to ensure audits of radiography, record keeping and antimicrobial prescribing are undertaken at regular intervals and in line with the relevant guidance to improve the quality of the service and that audits have documented learning points and the resulting improvements can be demonstrated.

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 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 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. • Systems in place to place to identify and mitigate the risks associated with fire were not effective. • Recommendations made in the Legionella risk assessment dated 15 February 2016 had not been reviewed and acted upon within the given timeframes. • 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. • Electrical installation condition checks had not been carried out in line with the relevant regulations. • The provider did not have a gas safety certificate to demonstrate that the appliance had been checked for safety or maintained regularly. • The practice did not have effective systems in place to monitor NHS prescriptions to ensure missing prescriptions can be identified. Regulation 12 (1)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 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 practice could not demonstrate that they had carried out risk assessments for all hazardous materials used within the practice as per Control of Substances Hazardous to Health Regulations 2002 (COSHH). 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 audits were not being carried out 6-monhtly in line with the relevant guidance. • The practice did not have effective processes to support staff to undertake training and development to enable them to fulfil the requirements of their role. • The provider did not have systems in place to monitor staff training to ensure appropriate action was taken quickly when training requirements were not being met. • There was no evidence that all members of staff, including trainee nurses received induction at the point of employment to prepare them for their new role. • Not all members of staff received regular appraisal of their performance to ensure learning and development needs were identified. Regulation 17 (1)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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 (Regulated Activities) Regulations 2014 was available for each person employed. In particular:

- The provider did not have robust recruitment processes in place. A DBS check, evidence of conduct in previous employment, employment history and photographic ID had not been obtained for newly appointed staff at the point of employment.

Regulation 19 (3)