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Cricklewood Dental Clinic

Inspection report

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Overall summary

We carried out this announced inspection on 23 July 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 advisor.

To consider the concerns we received 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 providing effective 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.

Summary of findings

Background

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

The dental team includes the principal dentist, one associate dentist, one visiting dentist and one trainee dental nurse. The clinical team are supported by a receptionist. The practice has two treatment rooms.

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 the principal dentist, the associate dentist, the trainee dental nurse and the receptionist. We looked at practice policies and procedures and other records about how the service is managed.

The practice opening times are:

9am to 6pm Mondays to Fridays

Our key findings were:

- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider had staff recruitment procedures which reflected current legislation. Improvements were needed to ensure that all the required employment checks were carried out and records of these were maintained.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff provided preventive care and supported patients to ensure better oral health.
- The practice appeared to be visibly clean and well-maintained.
- The provider had arrangements to manage risks of COVID-19 virus in accordance with current guidelines.
- Infection prevention and control procedures were not followed in accordance with national guidance.
- Staff knew how to deal with emergencies. Emergency equipment and medicines were not available in accordance with the Resuscitation Council UK 2021 guidelines.
- The provider had ineffective systems to help them manage risks to patients and staff.
- The provider had ineffective leadership to support a culture of openness and continuous improvement.
- There were ineffective governance systems to monitor the day to day running of 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.

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

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?	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 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.

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 provider did not have systems that were operated effectively to keep patients safe.

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. This information was easily accessible and included contact details for the local child and adult safeguarding teams.

We saw evidence that staff had received safeguarding training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns.

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 and procedures. Staff completed infection prevention and control training and received updates as required.

However, infection prevention and control procedures were not followed in accordance with the guidance 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.

During the inspection we observed the practices for cleaning and sterilising dental instruments. There were no procedures to check the temperature of the water used to manually clean dental instruments to ensure the temperature did not exceed 45 degrees so as to minimise coagulation of proteins in dental debris. The manually cleaned instruments were not checked for the presence of debris using a magnified light device and dental instruments were not dry before they were packaged for sterilising. There were no dates on packaged dental instruments to indicate when they had been sterilised.

We were shown cleaning schedules to ensure the practice was kept clean. When we inspected, we saw the practice looked visibly clean. However, we observed that there was only one mop used to clean both clinical and non-clinical areas. This is contrary to the national guidance on cleaning to minimise the spread of infections.

The provider had procedures in relation to COVID-19 and these were being followed. Additional standard operating procedures had been implemented to protect patients and staff from Coronavirus. Appropriate Personal Protective Equipment was in use and staff had been fit tested for filtering facepiece masks (FFP). There were arrangements for fallow time and cleaning the treatment room following treatments using aerosol generating procedures (AGPs).

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.

Are services safe?

We saw staff had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. The risk assessment was kept under review and there were arrangements to disinfect dental unit water lines and monitor hot and cold water temperatures to minimise risks.

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

The provider had ineffective arrangements to monitor the infection prevention control procedures at the practice. Infection prevention and control audits were not carried out twice a year in accordance with published guidance. The latest audit was carried out in 2019 and prior to this an audit was carried out in 2013.

The dentist 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. We were told that no new staff had been recruited to work at the practice for many years and that the majority of staff had worked there for at least 10 years. We looked at staff recruitment records for each of the five members of staff. Improvements were needed to ensure that all of the required employment checks were carried out. We noted that a standard Disclosure and Barring Service (DBS), and not the required enhanced level check had been carried out for the associate dentist.

Improvements were needed to ensure that clinical staff were qualified and registered with the General Dental Council and had professional indemnity cover. These records were not available for the visiting dentist.

There were ineffective procedures to ensure that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. We saw that a portable electric test (PAT) was carried out on the day of the inspection. However, there were no records available to demonstrate that a five-yearly test for the electrical installations was carried out at the practice. The principal dentist told us that they were unaware if this test had been carried out.

The autoclave had been last tested on 20 July 2020 and was due its annual service. The principal dentist could not assure us that this test had been booked as part of a continuous system for ensuring that equipment is maintained.

There were ineffective systems for assessing and managing risks of fire at the practice. The last fire risk assessment was carried out in 2010. A number of actions were identified to improve fire safety systems at the practice. These included reviewing the fire detection arrangements and installing a hard wired fire alarm system. We observed that there were no fire alarm systems other than battery operated smoke detectors. Staff told us that these were regularly tested. However, when we asked staff to demonstrate how they tested these, they found that the smoke detection equipment was not operating, and did not alarm when tested. We observed that the battery did not appear to be fitted correctly. Once staff fitted the battery, we noted this equipment was still not working and staff told us that the battery may be dead.

Staff told us they carried out periodic evacuation exercises. However, these were not recorded and there were no fire safety procedures for staff to follow.

We saw there were fire extinguishers located throughout the building and that these had been recently tested in 2020. Fire exits were clearly identified and were kept clear.

The practice had arrangements to ensure the safety of the X-ray equipment and we saw the required radiation protection information was available. Records were available to show that annual mechanical and electrical checks and three yearly radiological tests were carried out for the dental X-ray equipment.

We saw evidence the dentist justified, graded and reported on the radiographs they took. The provider carried out radiography audits every year following current guidance and legislation. The results from the most recent audit showed that the provider has systems to monitor and improve the quality of the dental radiographs they took.

Are services safe?

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 practice's health and safety policies, procedures and risk assessments were reviewed regularly; however risk assessments were not carried out to help minimise risks. The provider had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. Staff were not aware of or following the relevant safety regulation when using needles and other sharp dental items. A sharps risk assessment had been not been undertaken. The dentists and dental nurse told us they used a needle block to remove used needles from the syringes. However, this was not present in the treatment room when we checked, and staff later located this in the reception area.

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. However, improvements were needed to the arrangements to ensure the effectiveness of the vaccination was checked. There were no records to confirm the effectiveness of the Hepatitis B vaccine for the trainee dental nurse or the visiting dentist.

We looked at the arrangements for dealing with medical emergencies. We saw basic life support training records for staff, with the exception of the visiting dentist. These showed that staff completed training in emergency resuscitation and basic life support every year.

Emergency equipment and medicines were not available as described in accordance with the Resuscitation Council UK 2021 guidelines. One of the medicines used to treat low blood glucose (Glucagon) was not available. The principal dentist told us that this had expired and had been re-ordered. We were shown records for checks carried out by staff to ensure that emergency medicines were available and in date. These records were dated between January and July 2021. Glucagon was not included in the list of medicines and the provider could not provide assurances that this medicine has been available at the practice.

We checked the emergency equipment. We found that the adult and child self-inflating masks with reservoir did not operate properly.

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. Staff had access to information in relation to the handling, disposal and action to take in the event of accidental exposure to hazardous materials.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

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 and observed that individual records were typed and managed in a way that kept patients safe. Dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation requirements.

The provider had 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.

Safe and appropriate use of medicines

The dentist were aware of current guidance with regards to prescribing medicines.

Are services safe?

Improvements were needed to ensure that prescription documents were handled and stored. We found pre-stamped prescriptions which were stored in an unlocked cupboard. There were systems for monitoring prescriptions issued to minimise misuse.

Track record on safety, and lessons learned and improvements

The provider had systems for reviewing and investigating when things went wrong. There were comprehensive risk assessments in relation to safety issues. Staff monitored and reviewed incidents. This helped staff to understand risks which led to effective risk management systems in the practice as well as safety improvements.

The provider had a system for receiving and acting on safety alerts. Staff learned from external safety events as well as patient and medicine safety alerts. We saw they were shared with the team and acted upon if required.

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. We saw clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

Helping patients to live healthier lives

The practice provided preventive care and supported patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentist prescribed high concentration fluoride products if a patient's risk of tooth decay indicated this would help them.

The dentists discussed smoking, alcohol consumption and diet with patients during appointments.

The associate dentist described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients with preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition.

Records showed patients with severe gum disease were recalled at more frequent intervals for review and to reinforce home care preventative advice.

Consent to care and treatment

Staff obtained consent to care and treatment in line with legislation and guidance.

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentist gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions. We saw this documented in patients' records.

The practice's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who might not be able to make informed decisions and staff undertook training in relation to mental capacity issues. The policy also referred to Gillick competence, by which a child under the age of 16 years of age may give consent for themselves in certain circumstances. Staff were aware of the need to consider this when treating young people under 16 years of age.

The dentists 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 dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dental care records which we viewed showed the dentist assessed patients' treatment needs in line with recognised guidance.

The provider had quality assurance processes to encourage learning and continuous improvement. Staff kept records of the results of these audits, the resulting action plans and improvements. The most recent audit showed that dental care records were monitored and maintained in accordance with relevant guidance.

Effective staffing

Are services effective?

(for example, treatment is effective)

Improvements were needed to ensure that staff had the skills, knowledge and experience to carry out their roles.

The principal dentist told us that staff new to the practice had a structured induction programme. All staff currently working at the practice had been employed for many years. We looked at records to determine that clinical staff completed the continuing professional development required for their registration with the General Dental Council. We noted there were no records available for the visiting dentist and there were no records in relation to basic life support training for the associate dentist.

Staff who we spoke with and staff told us that they felt supported to deliver care and treatment in a safe way. However, there were no appraisal records to demonstrate that staff training and development needs were monitored. Staff who we spoke with and staff told us that they felt supported to deliver care and treatment in a safe way.

Co-ordinating 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. There were arrangements to ensure that referrals were monitored so that patients received treatment in a timely way.

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 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

There was a lack of clear leadership arrangements within the practice. The practice team was small, and the principal dentist had overall accountability for leadership and the day-to day management of the service. There was a lack of oversight for the day to day management of the service. The provider made improvements in a reactive manner rather than as part of an ongoing system for monitoring and improving quality and safety. This was demonstrated in a number of assessments carried out and staff training undertaken following the inspection being announced.

Staff had access to policies and procedures, and these were reviewed annually by the practice team. However, there was a lack of overall leadership to ensure that the practice procedures in relation to infection prevention and control and fire safety were understood and followed.

Culture

The principal dentist was aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

There was a lack of culture to support learning and improvement at the practice. There were ineffective arrangements to monitor staff training and development needs. There were no arrangements for annual performance appraisal for staff.

Staff told us they could raise concerns and were encouraged to do so, and they had confidence that these would be addressed. Staff who we spoke with told us that they were happy working at the practice. They told us the principal dentist was supportive and that they worked well as a team.

Governance and management

There were ineffective processes for governance and managing risks.

There were ineffective arrangements for assessing and minimising risks to patients and staff. This relates to the lack of monitoring infection prevention and control procedures, acting on the findings from fire safety risk assessments and failure to monitor the arrangements for maintaining equipment and dealing with medical emergencies.

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 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 provider is failing to establish and operate effectively systems and processes to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure good governance in accordance with the fundamental standards of care. In particular: There were ineffective arrangements to ensure that equipment and systems were maintained to help keep people safe: • There was no five year fixed electrical systems test carried out at the practice. • There were ineffective systems to ensure that the sterilising equipment was tested in accordance with the manufacturer's instructions. • There were ineffective arrangements to ensure that clinical staff had immunity against Hepatitis B virus. • There were ineffective arrangements to assess and mitigate risks associated with the handling and disposal of dental sharps. The provider has failed to establish and operate effective recruitment procedures. • There were ineffective systems to ensure that all the required recruitment checks including proof of identity, Disclosure and Barring Service (DBS) checks were carried out when staff are employed, and these records are maintained for all staff.

This section is primarily information for the provider

Requirement notices

- An enhanced DBS check had not been carried out for the associate dentist.
- Records including proof of indemnity insurance and registration with the General Dental Council (GDC) were not available for the visiting dentist.

The provider has failed to establish an effective system to monitor staff training.

- Training records were not available for the visiting dentist.
- There were no basic life support training records for the associate dentist.
- There were no arrangements to monitor staff development and training needs.

Regulation 17 (1) (2)

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 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: • Emergency medicines and equipment were not available in accordance with Resuscitation Council UK Guidelines 2021. One of the medicines use to treat low blood glucose (Glucagon injection) was not available and there was no assurance that this medicine had been available between January and July 2021. • The self-inflating mask with reservoir equipment for both adults and children did not operate. • Risks in relation to the control and spread of infections had not been assessed and mitigated, in accordance with the Department of Health publication "Health Technical Memorandum 01-05: Decontamination in primary care dental practices". • Dental instruments were not cleaned and stored in accordance with HTM-01-05 guidance • We observed that there was only one mop used to clean both clinical and non-clinical areas. This is contrary to the national guidance on cleaning to minimise the spread of infections. • There were ineffective arrangements to monitor infection prevention and control procedures. Infection prevention and control audits were not carried out to assess and improve procedures at the practice. • There were ineffective arrangements to assess and mitigate risks of fire at the practice:

This section is primarily information for the provider

Enforcement actions

- The last fire risk assessment was carried out in 2010. The findings from this risk assessment had not been acted on to reduce risks.
- The smoke detection system was not operating to detect smoke on the day of the inspection.
- There were no fire safety procedures for staff to follow in the event of a fire.

Regulation 12 (1) (2)