Care Quality Commission

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Gentle Dental Care

Inspection report

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Overall summary

We carried out this announced focused inspection on 7 July 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 adviser.

To get to the heart of patients' experiences of care and treatment, we usually ask five key questions, however due to the ongoing COVID-19 pandemic and to reduce time spent on site, only the following three questions were asked:

• 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:

- Staff provided preventive care and supported patients to ensure better oral health.
- Improvements were needed to ensure that clinical staff kept up to date with current guidelines, and information related to patient care was suitably recorded within the dental care records.
- The practice infection control procedures were not in accordance with published guidance.
- The practice did not have effective arrangements for dealing with medical emergencies. Some of the life-saving medical emergency medicines and equipment were not available and staff were unclear about emergency procedures.
- 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.
- There were ineffective systems to ensure that staff were up to date with their training.
- There was ineffective governance and leadership and a lack of continuous improvement.

Summary of findings

- There were ineffective systems to ensure facilities were safe and equipment was serviced and maintained according to manufacturers` guidance.
- Improvements were needed to ensure that appropriate chairside support was provided by a dental nurse at all times.

Due to the nature of the concerns the provider was issued with a letter stating our intent to take urgent enforcement action. They were given an opportunity to submit (within one working day) an action plan as to how they intended to mitigate the risks identified by our inspection. The provider submitted an action plan, which included the urgent action they had taken and further improvements they had planned. As the improvements were not of a sufficient nature to mitigate the concerns, we undertook immediate enforcement action, and the provider's CQC registration to undertake regulated activities is suspended for a period of one month.

Background

Gentle Dental Care is in Golders Green, in the London Borough of Barnet and provides NHS and private dental care and treatment for adults and children.

Metered parking spaces are available near the practice and it is also located close to public transport services.

The dental team includes a principal dentist and one qualified dental nurse.

During the inspection we spoke with principal dentist and the dental nurse.

The practice is open:

Monday to Thursday 8.30am to 5pm

Fridays 8.30am to 1pm

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 persons employed in the provision of regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them carry out their duties.

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:

- Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the College of General Dentistry (CGDent)
- Improve staff awareness of sepsis.
- Improve the practice protocols regarding auditing patient dental care records to check that necessary information is recorded.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**Enforcement action**
Are services effective?	**Enforcement action**
Are services well-led?	**Enforcement action**

Are services safe?

Our findings

We found this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the 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. Staff were uncertain about safeguarding arrangements within the practice and did not know how to raise safeguarding concerns.

The provider could not demonstrate that staff received safeguarding training that was relevant, and at a suitable level for their role. The safeguarding training the dental nurse received was provided by the principal dentist and did not include clear objectives and learning outcomes.

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 staff.

The practice infection control procedures did not reflect published guidance.

We looked at the practice decontamination policy and asked the dental nurse to show us the steps they would take for decontamination of used dental instruments. We noted that the decontamination policy was last modified on 30 August 2013. There was no evidence of cleaning schedules and checklists in relation to the decontamination of used dental instruments. There were no arrangements to monitor water temperature used to clean used dental instruments. We observed that some instruments were soaked in water without detergent. The decontamination room did not have a dirty to clean flow, and dirty and clean transportation boxes were not clearly marked.

We noted that the ultrasonic cleaner was not validated in line with the relevant guidelines to ensure that instruments cleaned by this method were reliably and consistently cleaned using predetermined and reproducible conditions.

The provider could not demonstrate that periodic safety checks, including daily automatic control tests and the weekly residual and air leakage tests were carried out on the autoclave in line with the relevant guidelines.

For the autoclave, only three tests strips were available for dates between 4 and 6 July 2022. Two of these strips did not turn black, as per the manufacturers` guidance, to confirm the cycles were successful. We noted the test strips prior to 4 July 2022 were not available to confirm that the sterilisation had been successful. We were told by practice staff that these had been disposed of.

Following the inspection, the provider told us that the '*inconsistency in the autoclave test results*' was due to the type of strips used, as '*the original is out of stock in the UK and Europe*'. However, we were not provided evidence that the practice now had the necessary test strips available or that these have now been ordered.

We noted that at least 12 pieces of unwrapped dental instruments were stored in the top drawer of the cabinet in the treatment room and at least 24 unwrapped dental instruments were stored in the top drawer of the cabinet in the decontamination room. The provider could not demonstrate that they had effective systems in place to reprocess unwrapped instruments stored in the non-clinical area after one week and unwrapped instruments stored in the clinical area at the end of the working day as per current national guidelines.

Are services safe?

We observed that a cloth cushion over the head rest of the dental chair was exposed to contamination as the head rest cover used to protect it during treatment was not fitting tightly around the lower edges. The provider told us that the cushion was replaced weekly.

The practice did not have procedures to reduce the risk of Legionella or other bacteria developing in water systems, in line with a risk assessment. There was no evidence that a risk assessment in respect of Legionella contamination had been carried out and reviewed by a person with the qualifications, skills, competence and experience to do so. The provider was unaware if any actions arising from a risk assessment were required in order to appropriately maintain water systems in the practice. Additionally, the provider did not have a written waterline management scheme.

The practice had procedures in place to ensure clinical waste was segregated. However, on the day of inspection, we observed that clinical waste and sharps awaiting collection were not stored securely. Following the inspection, the practice submitted photographic evidence that clinical waste awaiting collection was now locked away.

We observed that surfaces and drawer handles in the decontamination room were dusty and there was dust and dried paint chippings in the window seal of the treatment room.

The provider could not demonstrate that there was an effective cleaning schedule to ensure the practice was kept clean.

Clinical staff were qualified and registered with the General Dental Council. However, we noted that the dental nurse was not familiar with the process of declaring their Continuing Professional Development (CPD) hours with the GDC and they were unable to recall the CPD training they undertook in the last 12 months.

Following the inspection, we received CPD certificates for the dental nurse for infection control, medical emergencies and safeguarding. The course provider was the principal dentist and all training we were provided evidence of was completed on 13 August 2021.

The practice had not ensured that the facilities were safe. We noted the 5-year fixed wiring electrical testing had not been completed. The provider could not demonstrate that portable appliances had been safety checked.

The practice had not ensured all equipment were safe, and that equipment was maintained according to manufacturers` instructions. We saw evidence that the autoclave was serviced on 8 July 2022. Howevere, there were no records of previous validation and servicing of the autoclave and there was no evidence the suction motor, the compressor and the dental chair had been serviced to ensure they were operating safely.

The risks around fire safety had not been assessed and the management of fire safety was ineffective.

There was no evidence that a risk assessment in respect of fire had been carried out and reviewed by a person with the qualifications, skills, competence and experience to do so.

The provider did not have records to indicate that the fire extinguishers, smoke detectors, the emergency lighting system and the fire alarm system were tested and serviced regularly. The fire evacuation plan was not displayed and there was no evidence that fire-drills were being carried out. The provider could not demonstrate that staff received fire safety awareness training.

On the day of inspection, in the two rooms adjoining the main treatment room, a large amount of combustibles, including paper and carboard, and hazardous material, including paint, were piled up. Following the inspection, the provider submitted photographic evidence that the combustible and hazardous materials from the two rooms adjoining the treatment room had now been removed.

The practice did not have arrangements to ensure the safety of the X-ray equipment.

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 [IRMER2000/2018] and The Ionising Radiations Regulations 2017 [IRR2017].

Are services safe?

There were no records to demonstrate that X-ray equipment was tested and serviced to ensure safe operation. There were no records to show that installation, three yearly radiological tests and annual electrical and mechanical tests were carried out. A Radiation Protection Advisor (RPA) had not been appointed.

The practice could not demonstrate that they had registered the use of radiographic equipment with the Health and Safety Executive (HSE).

The clinician did not grade radiographs appropriately and a radiography audit was not available for review.

Risks to patients

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

We noted that the medicine used to treat epileptic seizures (Buccal Midazolam) was not available. Glucagon (an emergency medicine used to treat severe low blood sugar) was stored in the fridge and the fridge temperature not monitored. The oxygen cylinder was not the correct size and had an expiry date of 1 October 2016. Oropharyngeal airways and oxygen face mask with reservoir were out of date and the self inflating bags for adult and child were not available.

Following the inspection, the provider submitted photographic evidence that they had procured Midazolam 5mg/ml solution for injection or infusion. However, this was not oromucosal solution as set out in the relevant guidance issued by the National Institute for Health and Care Excellence (NICE).

Systems and processes to check medical emergency equipment were ineffective. Staff told us that they checked the medical emergency equipment once a year. No written records were available to confirm that these checks had ever been undertaken. The national guidance recommends that resuscitation equipment is checked weekly as a minimum.

Staff did not know how to respond to medical emergencies. When asked, staff were unable to attach the battery to the Automated External Defibrillator (AED) and they could not demonstrate that they had an understanding of how it was to be used in the event of a service user suffering a cardiac arrest. Staff told us that they '*would not touch*' the AED and oxygen cylinder, *'even if they were trained*' in how to use them.

On the day of inspection there were no records to demonstrate that staff undertook training in medical emergency and basic life support. Following the inspection, the provider submitted training certificates for both members of staff. The medical emergency training the dental nurse received was provided by the principal dentist and did not include clear objectives and learning outcomes.

The practice did not carry out risk assessments to minimise the risk that could be caused from substances that are hazardous to health. Information in relation to the use and storage of hazardous substances as per Control of Substances Hazardous to Health regulations 2002 (COSHH) was not made available to staff in case of an incident while using hazardous materials.

Information to deliver safe care and treatment

Dental care records were kept securely and complied with General Data Protection Regulation requirements. However, improvements were needed to ensure that dental care records are complete.

The practice had systems for referring patients with suspected oral cancer under the national two-week wait arrangements. However, improvements were needed for monitoring referrals made, including urgent referrals where there were suspicions of oral cancer. Staff told us that they would rely on service users informing them if they had not been contacted by the provider they had been referred to.

Safe and appropriate use of medicines

Are services safe?

On the day of inspection, we found that all sheets in the prescription pad in use were pre-stamped. Improvements were needed to ensure the monitoring system for NHS prescription pads to ensure they were monitored as described in current guidance.

On the day of the surgery we found a large amount of out of date dental materials in the decontamination room and in the cabinet behind the reception. Improvements were needed to the monitoring system to ensure these were disposed of appropriately. The provider told us that these out of date materials belonged to a service that rented the premises approximately twice a month until March 2020. However, we found no records of another provider registered to carry on the regulated activities at this address.

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.

Are services effective?

(for example, treatment is effective)

Our findings

We found this practice was not providing effective 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.

Effective needs assessment, care and treatment

The dentist was aware of the relevant guidance published by the National Institute of Clinical Excellence (NICE), including guidelines around antibiotic prophylaxis for endocarditis patients, referral for third molar removal following infection and recall periods based upon risk category.

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. The dentist told us that they discussed with patients the treatment options, including risks, benefits and costs. However, we noted that dental care records did not include details of these discussions and we saw no evidence that patients were given a written treatment plan.

The dentist understood their responsibilities under the Mental Capacity Act 2005.

The dentist 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 did not keep detailed dental care records in line with recognised guidance. We looked at five dental care records and found that they were missing details, such as reason for attendance, intraoral and soft tissue checks, extraoral examination, Basic Periodontal Examination (BPE), risk assessment, diagnosis/prognosis, rubber dam/alternatives, recall intervals, consent and cost.

We did not see evidence the dentist 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

The provider did not ensure that they had sufficient number of persons employed in the provision of regulated activities. We noted that on the day of inspection, the dentist on occasions worked without adequate chairside support while the dental nurse carried out reception duties.

On the day of inspection, no training certificates were available for review. The provider could not demonstrate that they had effective systems and processes in place to monitor staff training and development. We saw no evidence that annual appraisals had been carried out.

Following the inspection, the provider submitted training certificates for the principal dentist and the dental nurse. These lacked sufficient information about the learning content, aims and objectives and the anticipated learning outcomes. We noted that the training the dental nurse undertook was provided by the principal dentist. However, we were not assured that the principal dentist had the requisite knowledge to provide continuing professional development training in the areas of safeguarding, infection control and medical emergencies.

Are services effective?

(for example, treatment is effective)

Furthermore, in our discussions with them the dental nurse did not demonstrate the required knowledge, skills and competencies in areas such as basic life support, infection prevention and control and safeguarding of vulnerable adults and children.

Additionally, there was lack of appropriate supervision to ensure they demonstrated and maintained competence required for their role.

Staff could not recall what CPD training they undertook in the last 24 months. Staff told us that they remembered undertaking a first aid course just before the pandemic but were unable to list any other training courses they completed since then.

Staff did not demonstrate that they understood the requirements around declaring their CPD hours annually to the GDC. The dental nurse told us that their annual declarations were completed by the dentist on her behalf and she was unable to offer further details about her training.

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 to ensure the referrals were effectively tracked and monitored.

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 noted that the two members of the dental team worked well together. However, improvements were needed to ensure information about systems and processes were communicated effectively between the dentist and the dental nurse.

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. The training provided by the dentist to the dental nurse was ineffective and did not transfer into effective learning outcomes they could apply in the professional role.

Culture

Staff stated they enjoyed working at the practice.

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

The practice did not ensure that staff training was up-to-date and reviewed at the required intervals.

Governance and management

The practice did not have an effective system of clinical governance in place. We noted that the few policies available for review have not been updated since 2013 and 2014. Systems and processes in relation to the management of the service were ineffective. Several essential requirements, including electrical installation compliance test, safety checks of portable appliances had not been carried out. The provider could not demonstrate that they had systems in place for the regular maintenance and servicing of dental and radiography equipment.

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.

Appropriate and accurate information

There were ineffective systems in place to ensure details of risk assessments and information about the management of risks are effectively distributed among staff.

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.

Continuous improvement and innovation

Are services well-led?

The practice did not have effective systems and processes for learning, continuous improvement and innovation. Records were not available to demonstrate audits of radiographs were undertaken and re-assessed at the required intervals. Infection prevention and control audits were not carried out bi-annually in line with the relevant national guidance. The provider could not demonstrate that audits of dental care records and disability access had been carried out.

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 18 HSCA (RA) Regulations 2014 Staffing The service provider had failed to ensure that persons employed in the provision of regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular: • Staff did not have the skills, knowledge and experience to carry out their roles. • The provider did not have a system for monitoring staff training. • There were no arrangements in place for staff to discuss their training needs at an appraisal. • The provider did not ensure that they had sufficient number of persons employed in the provision of regulated activities. Regulation 18 (2)

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. • There was no evidence that a fire risk assessment had been carried out and regularly reviewed by a person with the qualifications, skills and experience to do. • There were no records of periodic in-house testing of the fire safety equipment, including the fire alarm system and emergency lighting, and we saw no evidence of the servicing of these. • The fire extinguishers had not been serviced annually

This section is primarily information for the provider

Enforcement actions

- There was no evidence that fire drills had been carried out to demonstrate any issues or areas for improvement.
- The electrical 5-year fixed wiring safety certificate and records of portable appliance tests were not available.
- There were no systems in place to ensure that dental equipment were serviced regularly in line with manufacturers` guidance.
- Medical emergency equipment and drugs were not available as per relevant national guidance.
- Staff did not know how to deal with medical emergencies.
- The decontamination of used dental instruments was not carried out in accordance with the Department of Health publication 'Health and Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM 01-05).
- COSHH assessments had not been carried out for hazardous material used in the practice.
- There were no arrangements to ensure the safety of the X-ray equipment. The required radiation protection information was not available and there was no evidence that quality assurance tests were carried out in line with the regulations. An RPA had not been appointed.
- There was no evidence that X-Ray equipment validation, such as critical examination tests and three-yearly service, including calibration and dosage tests had been carried out.
- There was no evidence that the provider had registered the use of X-ray equipment with the Health and Safety Executive.
- Information about current safeguarding 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.
- There were ineffective systems to ensure that dental materials were disposed of beyond their use-by date.

Reg 12 (1)

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

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

There were no systems or processes that enabled 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:

- Risk assessments, including the sharps and general health and safety risk assessment, had not been carried out.

There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

- Radiography audit was not available.
- Infection prevention and control audit was not carried out bi-annually.
- A disability access audit had not been carried out.

There were no systems or processes that enabled the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular:

- The provider did not maintain accurate, complete and contemporaneous dental care records in relation to each service user.

Regulation 17 (1)