Dr Monica Bijlani

Brilliant Dental Limited

Inspection Report

117a Harley St
London
W1G 6AT
Tel: 07802 349619
Website: Monicadental.co.uk

Date of inspection visit: 28 October 2019
Date of publication: 20/12/2019

Overall summary

We carried out this unannounced inspection on 28 October 2019 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 specialist dental adviser.

To get to the heart of patients' experiences of care and treatment, we always ask the following five 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:

Are services safe?

We found that this practice was not providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations.

Are services responsive?

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

Are services well-led?

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

Background

Brilliant Dental Limited is located in the City of Westminster in London and provides private treatment to adults and children.

Car parking spaces, including some for blue badge holders, are available near the practice.

The dental team includes a dentist and a dental nurse. The practice has two treatment rooms, one of which incorporates a decontamination area.

Summary of findings

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.

On the day of the inspection there were no patients to speak with. We reviewed patient feedback that patients had left about the provider.

During the inspection we spoke with the dentist. We looked at practice policies and procedures and other records about how the service is managed.

Our key findings were:

- Improvements were required in the appearance and cleanliness of the practice.
- The dentist generally provided patients' care and treatment in line with current guidelines.
- Staff were providing preventive care and supporting patients to ensure better oral health.
- The appointment system took account of patients' needs.
- The provider asked staff and patients for feedback about the services they provided.
- The dentist had some understanding of how to deal with medical emergencies. Some medicines and life-saving equipment were available on the premises.
- Improvements were required to the provider's infection control procedures.
- The practice had some systems in place to help them manage risk to patients and staff.
- The dentist was not up to date with key training such as safeguarding children and vulnerable adults and improvements were required to their safeguarding policy.
- The provider did not have a staff recruitment procedure in place to carry out all the required recruitment checks for staff employed
- The provider did not have systems in place to audit their non-clinical and clinical processes.

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 the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.
- 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:

- Take action to ensure the clinicians take into account the guidance provided by the Faculty of General Dental Practice when completing dental care records. In particular in regard to recording patients consent.
- Review the practice protocols regarding audits for prescribing of antibiotic medicines taking into account the guidance provided by the Faculty of General Dental Practice.
- Review the practice protocols regarding auditing patient dental care records to check that necessary information is recorded.
- Review its complaint handling procedures and establish an accessible system for identifying, receiving, recording, handling and responding to complaints by service users.

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?	**Enforcement action**

Are services safe?

Our findings

We found that 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 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 dentist knew some of their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. However, the practice did not have localised safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. They had some details of the local authorities safeguarding policy. The dentist and the nurse had not undertaken safeguarding training. We spoke with the dentist about this and following the inspection they confirmed they were enrolling on a course.

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

The provider did not have a staff recruitment procedure or a documented policy in place. The provider employed one member of staff. They had not undertaken the relevant employment checks such as references and checks on employment history or criminal records checks for this member of staff. We spoke with the provider about this and they told us they would ensure these checks were in place.

The landlord where the practice was based had undertaken an electrical installation condition test for the premises in September 2018. However, the test had assessed the wiring as unsatisfactory. We were advised that the works required to bring the wiring to a satisfactory standard had been carried out but a new test had not been commissioned.

The sterilisation equipment had been serviced in April 2019.

Records showed that fire detection equipment, such as smoke detectors and the firefighting equipment such as fire extinguishers were regularly tested. The landlord for the building had undertaken a fire risk assessment in July 2017.

The practice had some arrangements to ensure the safety of the X-ray equipment and some of the required information was available. This included details of the radiation protection advisor and radiation protection training. However, there were some gaps. For example, there were no details of local rules, there were no records to show that the dental X-ray units had a critical examination and acceptance test carried out when they were installed. The X-ray machine had not been serviced. The provider told us that the X-ray equipment was less than three years old and was only just due for a service. They said they would make arrangements for the servicing to be carried out.

The practice used a laser. The dentist had received training on how to use the laser.

We saw evidence that the dentist justified, graded and reported on the radiographs they took. However, there was no system for analysing the information collected to monitor or improve the quality of dental radiographs.

Risks to patients

We looked at the practice's arrangements for safe dental care and treatment.

The practice had some health and safety policies and procedures in place including a Control of Substances Hazardous to Health (COSHH) policy. However, the provider did not have data sheets in the COSHH file for all substances used in the practice. We spoke to the provider about this and they told us they would make improvements to the file.

We looked at the practice's arrangements for safe dental care and treatment. The staff generally followed relevant safety regulation when using needles and other sharp dental items. However, a sharps risk assessment had not been undertaken.

The provider did not have a system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus.

The practice had employer's liability insurance.

The dentist had a general understanding of how to respond to a medical emergency. However, neither the dentist or

Are services safe?

their nurse had completed training in emergency resuscitation and basic life support (BLS). We spoke to the provider about this and they told us they would make arrangements for training to be carried out.

There were emergency equipment and medicines. These were shared with other providers in the building the practice was based in and were maintained by the landlord who owned the building. The emergency equipment and medicines were available as described in recognised guidance. However, there were some gaps. We found no medicines to relieve symptoms of asthma. There was also no Midazolam (buccal), there were no paediatric pads for use with the AED and some clear facemasks for self-inflating bags were missing. We were advised that arrangements would be made for the missing items to be replaced.

A dental nurse worked with the dentist when they treated patients, in line with GDC's Standards for the Dental Team.

The practice had an infection prevention and control policy and procedures. They had some understanding of guidance in regards to the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health and Social Care. However, some improvements were required. For example, decontamination was carried out in one of the surgeries and the dirty and clean zones could be better demarcated. and there was clutter on the worktop surfaces. There was missing personal protective equipment (PPE) including heavy duty gloves and visors. There was out of date materials and local anaesthetic. We spoke to the provider about these deficiencies and they told us they would make improvements to the process.

The practice had systems in place to ensure that dental work was 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 line with a risk assessment. The practice had checked for the presence of legionella in August 2018.

Information to deliver safe care and treatment

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We checked a sample of dental care records. The practice held electronic records. We noted that individual records were written and managed in a way that kept patients safe. Dental care records we saw were, kept securely, and complied with General Data Protection Regulation requirements.

Patient referrals to other service providers contained specific information which allowed appropriate and timely referrals in line with practice protocols and current guidance.

Safe and appropriate use of medicines

The provider had some systems for appropriate and safe handling of medicines.

The dentist was aware of and following guidance in relation to prescribing medicines. Improvements were needed in regards to tracking medicines dispensed and ensuring that antimicrobial prescribing audits were carried out annually to demonstrate that the dentist was following current guidelines.

Track record on safety, lessons learned and improvements

There were adequate systems for reviewing and investigating when things went wrong. There had been no incidents recorded in the last twelve months.

There was a system for receiving and acting on safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The dentist assessed patients' needs and delivered dental 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 was providing preventive care and supporting patients to ensure better oral health.

The dentist, where applicable, discussed smoking, alcohol consumption and diet with patients during appointments.

The dentist described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition. Patients with more severe gum disease were recalled at more frequent intervals for review and to reinforce home care preventative advice; they could also be referred to a specialist if needed.

Consent to care and treatment

The practice 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. However, some improvements were required. The provider did not have records of consent forms that they said they had completed with patients. We spoke with the provider about this and they told us they would record consent appropriately in the future.

The dentist had a general understanding of their responsibilities under the Mental Capacity Act when treating adults who may not be able to make informed decisions. Similarly, they had a general understanding of the circumstances by which a child under the age of 16 years of age may give consent for themselves and were aware of the need to consider this when treating them. However, some improvements were required in regard to the understanding of the Mental Capacity Act 2005. For example, they did not have an understanding of the need to have best interest in certain circumstances. The provider told us they would familiarise themselves with the act.

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 dentist assessed patients' treatment needs in line with recognised guidance.

The practice carried out conscious sedation for patients who were nervous. This was carried out by a visiting sedationist. This included people who were very nervous of dental treatment and those who needed complex or lengthy treatment. The practice had systems to help them do this safely. These were in accordance with guidelines published by the Royal College of Surgeons and Royal College of Anaesthetists in 2015.

The practice's systems included checks before and after treatment, emergency equipment requirements, medicines management, sedation equipment checks, and staff availability and training. They also included patient checks and information such as consent, monitoring during treatment, discharge and post-operative instructions. However, improvements were required. We found that the dentist and nurse who assisted the dentist had not undertaken immediate life support (ILS) training. We spoke with the provider about this and they told us they would not undertake sedation until the appropriate arrangements were in place.

Effective staffing

The dentist and their nurse had completed some training in regards to their continuing professional development required for their registration with the General Dental Council. For example, in regards to infection control and Radiography. However, there were some gaps in regards to safeguarding, BLS, ILS and Mental Capacity Act, 2005 training.

The dentist told us they discussed training needs with their nurse in meetings. We found there were no formal appraisals completed.

Co-ordinating care and treatment

Are services effective?

(for example, treatment is effective)

The practice had systems to identify, manage, follow up and where required refer patients for specialist care when presenting with dental infections.

The practice also had systems for referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by the National Institute for Health and Care Excellence in 2005 to help make sure patients were seen quickly by a specialist.

The practice could strengthen arrangements for monitoring all outgoing referrals such as by implementing a referral tracker.

Are services caring?

Our findings

Kindness, respect and compassion

The dentist understood the responsibility to respect people's diversity and human rights.

We saw the provider had received generally positive feedback from patients. They commented positively about the dentist.

Patients commented that staff made them feel at ease and were kind to them when they visited the practice.

Patients described the service as being great.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity and were aware of the importance of patient confidentiality.

The dentist told us If a patient asked for more privacy they would take them into another room.

The dentist told us they 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

The dentist helped patients to be involved in decisions about their care and were aware of the requirements of the Equality Act.

The provider told us that although they had never needed to in the past, they could arrange interpretation services for patients who did not speak or understand English as a first language. Staff communicated with patients in a way that they could understand.

The practice provided patients with information about the range of treatments available at the practice. The dentist described the conversations they had with patients to satisfy themselves they understood their treatment options. The provider gave patients clear information to help them make informed choices about their treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The provider organised and delivered services to meet patients' needs and preferences. They were clear on the importance of emotional support needed by patients when delivering care.

The practice was not accessible to people with mobility issues. The dentist told patients this prior to them making appointments to the service and referred them to accessible practices if applicable.

The practice, however had not undertaken a Disability Access audit.

Timely access to services

Patients could access care and treatment from the practice within an acceptable timescale for their needs.

The provider displayed the opening hours in the premises and included it on their website.

The provider had an appointment system to respond to patients' needs. They told us patients who requested an urgent appointment were seen the same day.

The practice provided telephone numbers at the practice's entrance and on their answer phone for patients needing emergency dental treatment during the working day and when the practice was not open.

Listening and learning from concerns and complaints

The practice told us they had a written complaints policy providing guidance to staff on how to handle a complaint. However, the policy presented to us was from another organisation. There was no information available to patients about how to make a complaint.

The dentist said they were responsible for dealing with complaints. They aimed to settle complaints in-house. We spoke to the provider about these deficiencies and they told us they would ensure that a complaints procedure was put in place.

Are services well-led?

Our findings

We found that 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

The principal dentist had overall responsibility for the management and clinical leadership of the practice. They also undertook responsibility for the day-to-day running of the service and worked closely with the dental nurse.

Culture

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

Governance and management

The provider had not established clear and effective processes for assessing, monitoring and managing risks, issues and performance in relation to the day to day running of the practice. In particular they had no details of the servicing of equipment used, they were not aware of the requirements to report Reporting of Injuries, Diseases and Dangerous Occurrences Regulations(RIDDOR) incidents, there were no systems to check for out of date medicines and materials, they were not aware of when some of their policies had last been updated, the provider did not have adequate oversight over their recruitment process.

Appropriate and accurate information

The provider had appropriate information governance arrangements and staff were aware of the importance of these in protecting patients' personal information.

Engagement with patients, the public, staff and external partners

The provider used verbal and social media comments to obtain views from patients about the service.

Continuous improvement and innovation

The practice did not have quality assurance processes to encourage learning and continuous improvement. For example, there were no audits of radiographs and infection prevention and control and improvements were required to the auditing of radiography. We spoke with the provider about this and they told us that arrangements would be made for the auditing arrangements to be improved.

The dentist had not completed all the 'highly recommended' training as per General Dental Council professional standards including for example safeguarding and BLS.

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 **How the regulation was breached** 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: • There was dust and clutter on work surfaces of both treatment rooms • There was clutter in the corridor • Missing medication from medical emergency kit (e.g. Midazolam and Salbutamol) • Unsatisfactory electrical installation condition report • No evidence of Hepatitis B checks • No sharps risk assessment • No evidence of critical examination for the x-ray unit • Improvements were required in regards to the practice COSHH file **Regulation 12 (1)**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was breached** The service provider had failed to ensure that persons employed in the provision of a regulated activity

This section is primarily information for the provider

Requirement notices

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:

- The dentist and nurse had not undertaken safeguarding training.
- No evidence of BLS or ILS training for dentist or nurse
- The dentist had not undertaken infection control training.

Regulation 18(1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was breached** The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed. In particular: • Recruitment procedures were not established to ensure persons employed for carrying out a regulated activity met with Schedule 3 requirements. For example, there were no employment check record for the nurse • inadequate oversight of the recruitment process. **Regulation 19(1)**

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
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 breached** 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: • There is a lack of clinical and managerial oversight for the service including: • No details of the servicing of equipment were available on the day of the inspection. • The dentist was not aware of the requirements to report Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) incidents. • There were no systems to check for out of date medicines and materials. • The dentist was not aware of when some policies had last been updated. • No appropriate safeguarding policy in place. • N**o Disability access**, radiography and infection control audits had been undertaken

This section is primarily information for the provider

Enforcement actions

Regulation 17 (1)