East Finchley Smiles Limited

East Finchley Smiles

Inspection report

144 High Road
London
N2 9ED
Tel: 02084443436
www.eastfinchleysmiles.co.uk

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Overall summary

We undertook a follow up focused inspection of East Finchley Smiles on 15 September 2023. This inspection was carried out to review the actions taken by the registered provider to improve the quality of care and to confirm that the practice was now meeting legal requirements.

The inspection was led by a CQC inspector who was supported by a specialist dental advisor.

We had previously undertaken a comprehensive inspection of East Finchley Smiles on 14 July 2023 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We found the registered provider was not providing safe and well-led care and was in breach of regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can read our report of that inspection by selecting the 'all reports' link for East Finchley Smiles dental practice on our website www.cqc.org.uk.

As part of this inspection we asked:

- Is it safe?
- Is it well-led?

Our findings were:

Are services safe?

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

The provider had made insufficient improvements to put right the shortfalls and had not responded to the regulatory breaches we found at our inspection on 14 July 2023.

Summary of findings

Are services well-led?

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

The provider had made insufficient improvements to put right the shortfalls and had not responded to the regulatory breaches we found at our inspection on 14 July 2023.

Background

East Finchley Smiles is in the London Borough of Barnet 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 are available near the practice. The practice has made reasonable adjustments to support patients with access requirements.

The dental team includes the principal dentist, 3 associate dentists, 2 qualified dental nurses, 1 trainee dental nurse, 1 dental hygienist, 1 practice manager and 2 receptionists. The practice has 2 treatment rooms.

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

The practice is open:

Monday to Friday 9am to 5pm

We identified regulations the provider was not meeting. They must:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

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

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

- 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.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

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

Are services safe?

Our findings

We found this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement Actions section at the end of this report).

At the inspection on 15 September 2023 we found the practice had made the following improvements to comply with the regulations:

- The practice had made improvements to ensure the separation of instrument decontamination from other activities by physical and temporal means.
- We saw evidence that periodic safety checks, such as daily automatic control tests and weekly air leakage tests were carried out on the autoclave in line with the relevant guidance.
- The free-standing fans had been removed from both surgeries.
- Checks had been carried out to ensure portable appliances were safe to use.
- We saw evidence that a fire risk assessment had been carried out by a competent person.
- The emergency lighting systems and fire alarm system had been serviced in line with the manufacturer`s guidance.
- The practice had implemented a system to monitor prescription pads to ensure missing prescriptions can be identified. We noted that NHS prescription pads were stored securely.

However, we found that in the following areas the practice was not complying with the relevant regulation. In particular:

- The practice infection control procedures did not reflect the guidance set out in the Department of Health publication 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05).
- The decontamination process demonstrated by staff did not reflect the guidance set out in HTM 01-05;
- The enzymatic solution which was diluted with water and used to disinfect instruments was not measured to ensure the dilution recommended by the manufacturer was achieved.
- There were no systems and processes to monitor the use of heavy-duty gloves.
- The water temperature was not monitored throughout the cleaning process to ensure it was 45C or lower.
- Staff did not wash their hands before and after undertaking decontamination of used dental instruments. Following the inspection, the provider told us that concerns around infection prevention and control had been relayed to staff and further training had been provided.
- Systems and processes in place to control the storage time of instruments were ineffective. We noted that there was an inconsistent use of processing and expiry dates on the pouches of sterilised instruments. Following the inspection, the provider told us that they would implement the use of stamps to ensure consistency.
- Work surfaces in the decontamination room were visibly dirty, and we saw cobwebs on the vent opening and the light sockets, and dead insects on the emergency lights.
- Surfaces in the clinical area were not impervious or easily cleanable and the flooring in the decontamination room was not sealed. Following the inspection, the provider told us that they had obtained quotes for new cabinetry, and flooring would be replaced as part of the refurbishment.

Are services safe?

- Basins in the decontamination room and the surgeries had overflows – this was not in line with current national guidance. The walls were damaged and there were no splash backs behind the basins in the decontamination room. Following the inspection the provider told us that they had obtained quotes for new basins.
- The 'Practice Infection Prevention Policy' displayed in the decontamination room was dated 2014 (seven years before the provider registered with CQC) and the provider could not demonstrate that it had been reviewed regularly. We were not satisfied that the policy contained an adequate infection control procedure staff could follow to ensure the risks arising from infections were sufficiently prevented and controlled. In particular, the policy stated that 'used instruments must be cleaned using an ultrasonic cleaner'. We noted that the practice did not have an ultrasonic cleaner, and they relied on manual cleaning of dirty instruments. In addition, the policy referred to the previous provider`s registered manager who no longer worked at the practice. Following the inspection, the provider submitted an updated Infection Prevention and Control Policy, We noted that this was reflective of the arrangements within the service and included a manual cleaning procedure.
- Systems and processes in place to reduce the risk of Legionella and other bacteria developing in the water system were not effective:
- A legionella risk assessment dated 29 April 2021 was made available for review. This made a number of recommendations, including the nomination of a duty holder or responsible person in writing, training in Legionella management for all staff involved in Legionella management, ensuring that the dead leg pipework is cut back and descaling of scaled fittings. The provider could not demonstrate that all recommendations made in the Legionella risk assessment had been acted upon.
- When we asked about the management of Dental Unit Water Lines (DUWLs) within the practice, Staff A told us that they did not flush the DUWLs in Surgery 2. This was not in line with the guidance set out in HTM01-05 which states that DUWLs 'should be flushed for at least two minutes at the beginning and end of the day. In addition, they should be flushed for at least 20-30 seconds between patients'.
- We observed heavy scale deposits on the outlets in the decontamination room, the service user's toilet and in Surgery 2.
- The provider did not ensure that clinical waste was managed in line with the current guidance. We noted that the amalgam separator was not connected to the suction unit in Surgery 2. This meant amalgam particles were not removed from the wastewater to reduce the amalgam entering the sewage system. After the inspection, the provider told us that the installation of an amalgam separator had been arranged for 22 September 2023.
- The provider did not have the required colour coded buckets and mops to reduce cross contamination between the clinical area, bathrooms and waiting area. In addition, we noted that the use of existing mops was inconsistent with the colour coding scheme displayed in the practice. The cleaning schedule was not completed to ensure the effectiveness of cleaning. In their response to our inspection feedback, the provider told us that colour coded mops and buckets had been ordered and the cleaner had been instructed on completing environmental cleaning checks.
- Systems and processes in place to reduce the risk of fire were not effective:
- A fire risk assessment undertaken on 19 July 2023 was made available for review. This made a number of recommendations, including regular user checks and recording these in the fire logbook, fire doors to the decontamination room and for the surgery and staff room to have self-closure hinges and heat and smoke seals. The provider could not demonstrate that all recommendations made in the fire risk assessment had been acted upon and completed by the date indicated in the fire risk assessment.
- There were no systems in place to ensure the fire log book was maintained and periodic in-house checks of the fire safety equipment, including the fire alarm system and the emergency lighting had been carried out.

Are services safe?

- Fire drills were not carried out. Following the inspection, the provider told us that moving forward they would ensure that in-house periodic checks and fire drills were carried out.
- The sharps risk assessment which we were shown, was a blank template and did not identify the hazards and the practice specific control measures. Needle guards were not available in Surgery 2.
- Systems in place to manage medical emergencies were not effective.
- The practice staff did not check the medical emergency drugs and equipment at least weekly as set out in the relevant guidance published by the Resuscitation Council (UK).
- Glucagon (the emergency medicine used to treat severe low blood sugar) was stored in the freezer section of the fridge. We saw ice build-up at the bottom of the compartment, indicating that the temperature was below 0C. This is not in line with the manufacturer's instructions, which states Glucagon should be stored at a temperature of 2-8C. In response to our inspection feedback, the provider told us that new Glucagon had been ordered and they would ensure that it was stored in line with the manufacturer`s guidance.
- Staff A was not aware where the medical emergency equipment was kept within the practice. When asked, they said the medical emergency equipment was stored behind the reception. We noted that this was not the case as the practice kept the medical emergency equipment in Surgery 1.
- The provider could not demonstrate that all clinical staff completed regular training in the management of medical emergencies. The 1-hour online training completed by some members of staff did not include cardiopulmonary resuscitation (CPR) and training in the use of an Automated External Defibrillator (AED). Medical emergency scenarios were not discussed in practice meetings. The provider informed us that in-person medical emergency training had been arranged for the whole dental team for 28 September 2023.
- The provider could not demonstrate that the electrical installation condition checks had been carried out in line with the relevant regulations. Following the inspection, the provider told us that the electrical installation condition checks had been carried out on 19 September 2023.
- We were shown an engineer report for the compressor dated 18 July 2023. It highlighted a number of issues with the compressor and stated that 'The pressure switch has no screw to secure it, making the on/off switch useless. There is no pressure regulator – full pressure is going to the chairs. The motor fan cover is not secure. Also the breathing air filter is an old one which will be difficult to get filters for. It is not a dental compressor. Due to its age and condition, recommend replacing it ASAP.' We asked that practice manager if any action had been taken to replace the compressor as soon as possible, as per the engineer`s report. They replied 'No'. Following the inspection, the provider submitted evidence of a quote for a new compressor and they told us that arrangements had been made for its installation.

Are services well-led?

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).

At the inspection on 15 September 2023 we found the practice had made the following improvements to comply with the regulations:

- The practice had appointed a Radiation Protection Advisor (RPA).
- We were shown evidence that all members of staff had the required level of Disclosure and Barring Service (DBS) checks on record.
- The safeguarding flowchart had been updated and it included the details of the Local Authority safeguarding board and other location specific information about raising concerns. Staff were aware of the internal safeguarding processes.

However, we found that in the following areas the practice was not complying with the relevant regulation. In particular:

- There was ineffective leadership which impacted the practice`s ability to deliver safe and effective care. The principal dentist could not assure us that they understood the risks pertaining to the lack of oversight. In response to our inspection feedback, the principal dentist assured us of their commitment to become compliant with the legal requirements.
- The principal dentist was responsible for compliance with the regulations, including fire safety, Legionella, radiation safety and infection prevention and control. They spent one day a week at the practice, and we were not assured that there were sufficient deputising arrangements in place to ensure that systems and processes were operated in line with the regulations in their absence. After the inspection, the principal dentist told us that in the future, they would be more involved in the day-to-day management of the service.
- The practice manager told us that the practice had one meeting following our previous inspection on 14 July 2023. There were no records of further practice meetings available for review. We were told that the practice had implemented changes in response to our previous findings. We were not assured that there were effective systems in place to review practice policies and disseminate changes to staff to ensure that the quality and safety of the services provided were assessed, monitored and improved.
- Systems and processes to ensure the safe use of radiography equipment were not effective.
- Following the inspection on 14 July 2023, the practice appointed a Radiation Protection Advisor (RPA). In an email dated 8 August 2023 they asked the service to complete the Management of Radiation Safety, Personnel, X-ray Equipment, Risk assessment and Local Rules sections in the online portal. The provider did not demonstrate that they had completed these actions. In response to our inspection feedback, the provider told us that the documents had now been submitted to the RPA and the recommendations would be incorporated in the updated local rules.
- The provider did not have adequate and up-to-date local rules, communicating the main working instructions intended to restrict any exposures arising from work in the controlled area. The local rules displayed in Surgery 1 and 2 referred to operators who no longer worked at the practice and they did not consider location specific arrangements. For example, the local rules displayed in Surgery 2 did not consider that those working in the decontamination room might be within the controlled zone or in close proximity to the intraoral unit in Surgery 2.
- The provider had not undertaken a radiation risk assessment identifying the procedural controls required to restrict exposure.

Are services well-led?

- The service could not demonstrate that electro-mechanical testing was carried out annually or in line with the manufacturer`s guidance on the intraoral units.
- 3-yearly performance test reports were not available for all intraoral units.
- We looked at the general health and safety risk management protocols within the practice. A 'Health & Risk Assessment' (undated) was made available for review. We noted that the findings of this documents were not reflective of the arrangements within the practice. In particular, it stated that 'biological agents are covered by COSHH' assessment, 'fire drills are held twice yearly', 'practice manager to make regular inspections to ensure that fire precautions are followed', 'arrangements for dealing with accidental and unintended dose are contained in the Local Rules' and 'needles are only re-sheathed using a device'. These statements were not substantiated by our findings on the day of the inspection. Following the inspection the provider told us that they would complete a new Health and Safety risk assessment.
- The provider could not demonstrate that they carried out risk assessments for hazardous materials used within the practice as per Control of Substances Hazardous to Health regulations 2002 (COSHH).
- The practice did not have an accident book or effective systems and processes to report and learn from accidents and incidents. Following the inspection, the provider told us that they had ordered an accident book.
- There were no systems in place to ensure recalls and rapid response reports relevant to the service issued by the Medicines and Healthcare products Regulatory Agency (MHRA) were reviewed. The practice manager was not aware of the recent recalls and alerts relevant to primary dental practices. After the inspection the provider told us that in the future MHRA alerts would be shared with staff.
- Six-monthly radiography audits had not been carried out in line with the relevant national guidance.
- Infection prevention and control audits had not been carried out bi-annually or at all, in line with the relevant guidance.
- The provider could not demonstrate that they were actively seeking the views of service users about their experience. We asked if the practice had systems in place to gather feedback from service users. The practice manager told us that service users were encouraged to leave Google reviews, however they could not demonstrate that the practice actively sought feedback from service users, including those who did not have access to the internet.
- Supervision and monitoring of staff working in the service were not effective, in that the provider did not identify the gaps in staff`s knowledge in the areas of the management of medical emergencies and infection prevention and control.
- Systems and processes in place to monitor staff training was ineffective. Training certificates were stored in various places, including emails, the practice Google drive and in a compliance portal. The system in place was not effective to identify when a staff member was not up to date with their required training. In response to our inspection feedback, the provider told us that training certificates had been uploaded to the compliance portal.
- The provider did not have effective communication systems to ensure that people working within the service received up to date information about policies, procedures and results of reviews about the quality and safety of the service and any actions required following the review. For example, Staff A did not know where the medical emergency equipment was kept. The sharps injury policy did not include details of the local Accident and Emergency Department staff could refer to in case of a sharps injury. In addition, the practice manager told us that the practice currently did not have regular staff meetings.
- The practice did not have internal Closed-Circuit Television (CCTV) signage to inform people about the presence of CCTV cameras.

Are services well-led?

- The CCTV Policy we were shown on the day of the inspection was a blank template and did not reflect the arrangements within the service. In particular, it referred to external and internal signage and a practice leaflet. The policy was not reflective of the arrangements within the practice as they did not have internal CCTV signage and there was no patient leaflet. In addition, the policy stated that 'the system has / has not an automatic back up'. Based on the policy it was not clear if you had an automatic back up. Following the inspection, the provider submitted an updated CCTV policy.
- During the inspection on 14 July 2023, we identified concerns around safeguarding, infection prevention and control, fire safety, Legionella safety, risk management, COSHH, the management of medical emergencies, recruitment, premises and equipment safety, radiation safety, medicines management, training, and a lack of processes to support continuous improvement.

In response to our inspection feedback, the provider submitted a reply setting out the immediate actions they took and a list of further actions they intended to take to address the concerns identified.

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 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 decontamination process demonstrated by staff did not reflect the Department of Health publication 'Health Technical Memorandum 01-05: Decontamination in primary dental practices' (HTM01-05). • Systems and processes in place to control the storage time of sterilised instruments were ineffective. • Work surfaces in the decontamination room were visibly dirty. • Basins in the surgeries and decontamination room had overflows. • Surfaces in the clinical area were not impervious and not easily cleanable. • The infection prevention and control policy did not contain an adequate infection control procedure staff could follow to ensure the risks arising from infections were sufficiently prevented and controlled. • Systems and processes in place to reduce the risk of Legionella and other bacteria developing in the water system were not effective. • Clinical waste was not managed in line with the current guidance.

This section is primarily information for the provider

Enforcement actions

- The practice did not have colour coded buckets and mops to reduce cross contamination between the clinical area, toilets and the waiting area.
- An electrical installation condition report had not yet been carried out.
- The provider could not demonstrate that they took steps to act upon the recommendations in the most recent compressor servicing report.
- Systems and processes in place to reduce the risk of fire were not effective.
- Recommendations made in the fire risk assessment dated 19 July 2023 had not been acted upon.
- There was no evidence that fire drills were carried out.
- Periodic in-house checks of the fire safety equipment were not carried out.
- Glucagon was not stored in line with the manufacturer`s guidance.
- Staff A did not know where the medical emergency equipment was kept.
- The practice did not check the medical emergency drugs and equipment at least weekly as set out in the relevant guidance published by the Resuscitation Council (UK).
- The provider could not demonstrate that all clinical staff completed regular training in the management of medical emergencies. Medical emergency scenarios were not discussed in practice meetings.
- Risks from sharps injuries were not adequately assessed and the provider did not have appropriate control measures in place.

Regulation 12 (1)

This section is primarily information for the provider

Enforcement actions

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

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

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:

- Systems and professes to ensure the safe use of radiography were ineffective.
- The practice had not undertaken a radiation risk assessment, identifying the procedural controls required to restrict exposure.
- The provider could not demonstrate that they had completed the actions requested by their RPA.
- The provider failed to assess, monitor and mitigate the risks relating to staff working alone.
- The health and safety risk assessment was not reflective of the arrangement within the service, and it was not suitable to identify hazards and appropriate control measures.
- The provider could not demonstrate that they carried out risk assessments for all hazardous materials used within the practice as per Control of Substances Hazardous to Health Regulations 2002 (COSHH).
- The practice did not have adequate systems in place for identifying, assessing and mitigating risks in areas such as Legionella, fire safety, infection control and medical emergencies.

This section is primarily information for the provider

Enforcement actions

- The provider had no systems in place to report on accidents and incidents internally, to ensure information about these were shared with staff to promote learning.
- Staff were not aware of the most recent recalls and rapid response reports relevant to the service issued by the Medicines and Healthcare products Regulatory Agency (MHRA).

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 had not been undertaken.
- Infection prevention and control audits had not been carried out.
- The practice could not demonstrate that they were actively seeking the views of people who used the service about their experience.
- Systems and processes in place to monitor staff training were ineffective.
- The supervision and monitoring of staff working in the service were not effective in that the provider did not identify the gaps in staff`s knowledge.
- The provider did not have effective communication systems to ensure that people working within the service received up to date information about policies, procedures and results of reviews about the quality and safety of the service and any actions required following the review.

The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to maintain securely such records as are necessary to be kept in relation to the management of the regulated activity or activities. In particular:

This section is primarily information for the provider

Enforcement actions

- The practice did not have Closed Circuit Television (CCTV) signage to inform people about the presence of CCTV cameras.
- The CCTV Policy was a blank template and did not reflect the arrangements within the service.

There was additional evidence of poor governance. In particular:

- There was ineffective leadership which impacted the practice`s ability to deliver safe and effective care.
- There were insufficient deputising arrangements in place to ensure that systems and processes were operated in line with the regulations in the principal dentist`s absence.
- The practice did not comply with the Warning Notices we issued after the comprehensive inspection on 14 July 2023.

Regulation 17 (1)