

Mr. Christopher Parte

Christopher Parte - Queen Anne Street

Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 13 March 2023 under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

We planned the inspection to check whether the registered practice was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations.

The inspection was led by a Care Quality Commission (CQC) inspector who was supported by a specialist dental advisor.

To get to the heart of patients' experiences of care and treatment, we always ask the following 5 questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions form the framework for the areas we look at during the inspection.

Our findings were:

- The dental clinic appeared clean and well-maintained.
- The practice had infection control procedures which reflected published guidance.
- Clinical staff provided patients' care and treatment in line with current guidelines.
- Patients were treated with dignity and respect. Staff took care to protect patients' privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system worked efficiently to respond to patients' needs.

Summary of findings

- The frequency of appointments was agreed between the dentist and the patient, giving due regard to National Institute of Health and Care Excellence (NICE) guidelines.
- Patients feedback about the services provided was considered
- The practice did not have a complaints policy in place.
- The practice had information governance arrangements.
- Staff knew their responsibilities for safeguarding vulnerable adults and children although some shortfalls were identified.
- The provider did not have a recruitment policy in place. At the time of the inspection they used agency staff.
- Staff knew how to deal with emergencies. Most medicines and life-saving equipment were available; however, some items were not available on the day of the inspection, including buccal midazolam and some face masks.
- Improvements were required to the provider's systems to identify and manage risks associated with sharps, legionella to patients and staff.
- There were insufficient assurances that equipment used by staff had been serviced in line with the manufacturers' guidance.

Background

Christopher Part - Queen Anne Street is a dental practice in the City of Westminster and provides private dental care and treatment for adults and children.

The practice is located on the 1st floor of the building and is accessible for people who use wheelchairs and those with pushchairs via a lift. Car parking spaces, including dedicated parking for disabled people, are available near the practice.

The dental team includes a dentist and an agency dental nurse. The practice has 1 treatment room that includes a decontamination room.

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

The practice is open:

Monday, Wednesday & Thursday from 8.30am to 17.30pm

We identified regulation the provider was not complying with. They must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Full details of the regulation 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.

Summary of findings

- Take action to ensure audits of infection prevention and control are undertaken at regular intervals to improve the quality of the service. 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 always ask the following five questions of services.

Are services safe?	No action ✓
Are services effective?	No action ✓
Are services caring?	No action ✓
Are services responsive to people's needs?	No action ✓
Are services well-led?	Requirements notice ✗

Are services safe?

Our findings

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

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

The dentist knew their responsibilities for safeguarding vulnerable adults and children and had received safeguarding training. However, the practice did not have a safeguarding policy, or contact details for the local safeguarding team. We spoke to the provider about this and following the inspection the provider told us they had put a safeguarding policy in place.

The practice appeared clean and had infection control procedures which reflected published guidance.

The practice had procedures to reduce the risk of Legionella, or other bacteria, developing in water systems. This included, for example, ensuring water at the outlets was within the recommended temperature range and undertaking regular water temperature testing. However, they had not undertaken a legionella risk assessment.

Clinical waste was segregated and stored appropriately in line with guidance.

The practice did not have a recruitment policy, and the provider told us that they had not recruited any staff for a number of years. The dentist worked with an agency nurse and there was a procedure to help them employ suitable staff. However,

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

The practice had some systems in place to ensure the safe use of equipment. For example, they used indicator test *strips* after every sterilisation cycle for the autoclave. However, they could not give us assurance of when the autoclave, compressor or X-ray equipment were last serviced. They told us they would make arrangements for the servicing of the equipment to be carried out.

The practice ensured the premises were maintained in accordance with regulations.

A fire safety risk assessment was carried out in line with the legal requirements. The management of fire safety was effective.

The practice had some arrangements to ensure the safety of the X-ray equipment including having local rules. However, the practice had not appointed a Radiation Protection Advisor (RPA). We were also not assured of regular checks having been undertaken on the X-ray equipment.

Risks to patients

The dentist had an understanding of the risks associated with running a practice. However, they had not undertaken a health and safety or sharps risk assessment.

The dentist demonstrated sepsis awareness.

Not all emergency equipment and medicines were available and checked in accordance with national guidance. For example, buccal midazolam (a medicine used to manage prolonged seizures), clear masks sizes 1 and 2 and paediatric self-inflating bags were missing. Following the inspection, the provider told us they had ordered the missing items.

Both staff members knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year.

Are services safe?

The dentist did not have systems to minimise the risk that could be caused from substances that are hazardous to health in line with Control of Substances Hazardous to Health Regulations 2002 (COSHH). Risk assessments had not been completed for dental or cleaning products used at the practice.

Information to deliver safe care and treatment

Patient care records were complete, legible, kept securely and complied with General Data Protection Regulation requirements.

The practice had systems for referring patients with suspected oral cancer under the national two-week wait arrangements.

Safe and appropriate use of medicines

The practice had systems for appropriate and safe handling of medicines.

Track record on safety, and lessons learned and improvements

The practice had systems to review and investigate incidents and accidents. The practice had a system for receiving and acting on safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

The practice had systems to keep dental professionals up to date with current evidence-based practice.

Helping patients to live healthier lives

The practice provided preventive care and supported patients to ensure better oral health.

Consent to care and treatment

Staff obtained patients' consent to care and treatment in line with legislation and guidance. They 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 kept detailed patient care records in line with recognised guidance.

We saw evidence the dentist justified, graded and reported on the radiographs they took.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

Newly appointed staff, including agency staff, had a documented induction and clinical staff completed continuing professional development required for their registration with the General Dental Council.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

The dentist confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide.

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff were aware of their responsibility to respect people's diversity and human rights.

We reviewed feedback from patients. Patients said the dentist was caring, informative and kind.

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

Privacy and dignity

Staff were aware of the importance of privacy and confidentiality.

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

Involving people in decisions about care and treatment

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

The practice's website provided patients with information about the range of treatments available at the practice.

The dentist explained the methods they used to help patients understand their treatment options. These included for example photographs, study models, videos and X-ray images.

Are services responsive to people's needs?

Our findings

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

Responding to and meeting people's needs

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

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

The practice had not carried out a disability access audit. The provider told us they would make arrangements for the audit to be carried out.

Timely access to services

Patients could access care and treatment from the practice within an acceptable timescale for their needs. The practice had an appointment system to respond to patients' needs. The frequency of appointments was agreed between the dentist and the patient, giving due regard to NICE guidelines. Patients had enough time during their appointment and did not feel rushed.

Patients needing emergency dental treatment had contact details of the dentist to contact them in the event of an emergency.

Patients who needed an urgent appointment were offered one in a timely manner. When the practice was unable to offer an urgent appointment, they worked with partner organisations to support urgent access for patients. Patients with the most urgent needs had their care and treatment prioritised.

Listening and learning from concerns and complaints

There had been no complaints from patients in the last twelve months. The dentist told us they dealt with complaints from patients appropriately. However, the practice did not have a complaints procedure. We spoke to the provider about this and they told us they would develop one.

Are services well-led?

Our findings

We found this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices). We will be following up on our concerns to ensure they have been put right by the provider.

Leadership capacity and capability

The provider did not demonstrate that there were effective systems for management including oversight, assessment and mitigation of risks, and implementation of systems to monitor and improve the service.

Culture

The practice had arrangements to ensure staff training was up-to-date and was reviewed at the required intervals. This included for agency staff.

Governance and management

We saw there were ineffective processes for managing risks, issues and performance. Risks to the health, safety and welfare of patients and staff were not assessed as part of an ongoing and robust system of governance and management in accordance with legislation and relevant guidelines.

The practice did not have recruitment, complaints, whistleblowing or consent policies in place.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

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

Engagement with patients, the public, staff and external partners

The provider used patient emails and verbal comments to obtain views from patients about the service.

Continuous improvement and innovation

The practice had some quality assurance processes to encourage learning and continuous improvement. For example, there were audits of radiographs. However, infection prevention and control, disability access and antimicrobial prescribing audits were not completed. The practice also needed to regularly analyse the findings of the radiography audits.

We spoke with the provider about this, and they told us that arrangements would be made for the auditing arrangements to be improved.

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 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 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. Regulation 17 Good governance The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • The provider had not carried out risk assessments for health and safety, and legionella. • There were no risk assessments for hazardous substances used at the practice. • There were items missing from the medical emergency kit including buccal midazolam and some sizes of face masks. • The Provider had not appointed a Radiation Protection Advisor (RPA) as required. 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 improve the quality and safety of the services being provided. In particular:

This section is primarily information for the provider

Requirement notices

1. There were no infection prevention and control or Disability Access audits. Radiography audits were not analysed to identify areas for improvement.
2. There were no recruitment, complaints, whistleblowing or consent policies in place.

Regulation 17 (1)