Implant Expert DSO UK Ltd

Implant Expert Liverpool Street

Inspection report

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Overall summary

We carried out this announced inspection on 18 March 2021 under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to follow up on concerns we identified during a Transitional Regulatory monitoring call on 15 March 2021 and to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a Care Quality Commission (CQC) inspector who was supported by a CQC specialist dental adviser.

To consider the concerns we received we asked the following questions

• Is it safe?

• Is it well-led?

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

Our findings were:

Are services safe?

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

Are services well-led?

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

Background

Summary of findings

Implant Expert Liverpool Street is in the city of London and provides private dental care and treatment for adults and children.

The practice is owned by an organisation. At the time of inspection there was no registered manager in post as required as a condition of registration. A registered manager is legally responsible for the delivery of services for which the practice is registered.

During the inspection we spoke with the practice manager, one dentist, one dental nurse and two receptionists.

Our key findings were:

- The provider had ineffective infection control procedures to reduce the risk of infections.
- The provider had ineffective systems to help them manage risks to patients and staff. Risk assessments were not carried out, equipment was not tested or serviced as required.
- The provider had ineffective arrangements to ensure that the important checks were carried out when new staff are employed at the practice.
- The provider had ineffective arrangements to ensure that staff undertook important recommended training in relation to their roles within the practice.
- The provider had ineffective leadership to support a culture of openness and continuous improvement.
- There were ineffective governance systems to monitor the day to day running of the practice.

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

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

the fundamental standards of care.

- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.
- 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.

We are considering enforcement action in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

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

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**Enforcement action** 
Are services 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.

We are considering enforcement action in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

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

There were ineffective systems to keep patients and staff safe.

There were no policies and procedures available to staff in relation to safeguarding adults and children. One dentist had recently undertaken the role as safeguarding lead for the practice. Staff including the dental nurse told us that they did not have training in safeguarding adults and children. Staff told us they were unsure about safeguarding procedures.

Staff did not have access to an infection prevention and control policy. The practice manager told us that they had recently introduced procedures in relation to COVID-19 and these were being followed. The dental nurse was the infection control lead for the practice. They told us that they had not undertaken training in infection prevention and control.

Infection prevention and control audits were not carried out to monitor infection control practices and procedures in line with Guidance.

There were ineffective systems to ensure that equipment used at the practice to deliver care and treatment was maintained, tested and serviced to ensure its safe and proper working.

There were no records available to show that the practice had registered with the Health and Safety Executive (HSE), no records to show that a critical examination and acceptance test had been carried out for the dental X-ray equipment. There were no records to show that the required annual electrical and mechanical tests or three yearly radiological tests had been carried out. The practice manager could not tell us when these tests have been carried out.

There were no records available to demonstrate when the compressor had been serviced. The practice manager could not tell us when or if the compressor had been serviced.

The provider did not have suitable recruitment procedures to help them employ suitable staff. We looked at four staff recruitment records. No references had been sought for clinical staff. No checks had been conducted for the newly appointed practice manager. Disclosure and Barring Service checks had only been recently carried out for staff, within the previous two weeks.

We observed that clinical staff were qualified and registered with the General Dental Council and had professional indemnity cover.

Risks to patients

The provider did not have effective systems to assess, monitor and manage risks to patient safety.

There were ineffective procedures for dealing with a medical or other emergencies. Staff told us that they could not make calls to emergency numbers such as 999 or 101 from the practice telephone in the event of an emergency. The practice manager told us that this issue was identified when they had been subjected to a physical assault by a service user and staff had been unable to call the police via the practice telephone system. Staff told us that they would rely upon using their personal mobile telephones to make these calls. The practice manager and other members of staff present raised concerns that mobile telephone reception was not always reliable while in the practice.

Are services safe?

There were no health and safety policies and procedures available to staff. Health and safety risk assessments were not carried out to help manage potential risk.

There were ineffective systems to assess and manage the risks of Legionella or other bacteria in the water systems. A Legionella risk assessment was undertaken at the practice in July 2020.

The report identified that flushing and disinfecting dental unit waterlines to minimise growth of Legionella bacteria should be carried out. On the day of the inspection there were no records to demonstrate that these measures were being carried out. We saw some dental unit water bottles contained, what appeared to be, a disinfection product, while others did not. Staff were unable to tell us what method for disinfecting was used or how frequently disinfecting products should be replaced.

The Legionella risk assessment also identified that monitoring of hot and cold water temperatures within the practice to minimise the risk of Legionella bacteria growth was not being carried out. During the inspection staff told us that these temperature checks were being carried out. However, when we tested, we found that the temperatures for hot water did not reach the required temperature to minimise the risk of Legionella bacteria growth

We observed that hot water was heated by individual electrical water heaters which were installed in each surgery. There were no records to demonstrate that these heating units were tested or serviced to ensure that they worked properly. Staff present during the inspection were unaware of any checks which should be carried out for the water heaters or how often these should receive maintenance or service checks.

There were ineffective arrangements to mitigate the risk of fire at the practice. A fire safety risk assessment was carried out in July 2020. The assessment report identified areas where improvements were required. The report recommended that fire doors are fitted with three hinges and have suitable and serviceable intumescent strips and cold smoke seals. There were no records to demonstrate that these issues identified had been addressed. Staff present during the inspection were unclear as to the procedures in the event of a fire, including evacuation procedures. The practice manager told us that there was a central fire alarm for the building and that there was no separate, individual fire alarm for the practice. We observed an ‘’in case of fire break glass alarm’’ located by the front entrance. During the inspection visit the central fire alarm was tested. Staff present were unsure how to react.

There were no arrangements for checking or testing emergency lighting system and staff present during the inspection were not aware that this system was installed.

There were no records available at the practice to demonstrate that a five year electrical installation report had been completed.

There were no records available to demonstrate when the compressor had been serviced. The practice manager could not tell us when or if the compressor this had been carried out. The provider cannot be assured that this equipment is serviced in line with the manufacturers’ instructions to ensure that it is operating safely.

There were ineffective systems in relation to substances hazardous to health in accordance with Control of Substances Hazardous to Health (COSHH) Regulations 2002. Staff told us they did not have access to information in relation to the handling, storage, and disposal of hazardous materials. There were no policies or other information available to staff to help them manage an accidental exposure to hazardous materials used in the practice.

Information to deliver safe care and treatment

Staff did not have access to the information they needed to deliver safe care and treatment to patients. They did not have access to policies and procedures in relation to a number of areas including safeguarding, infection prevention and control and Legionella management.

Dental care records and a number of other records we saw were written in Romanian and we were unable to determine their completeness.

Are services safe?

The provider did not have systems for referring patients with suspected oral cancer under the national two-week wait arrangements. These arrangements were initiated by National Institute for Health and Care Excellence to help make sure patients could access specialist care quickly.

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.

We are considering enforcement action in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

Leadership capacity and capability

There was a lack of clear leadership and the systems for the day to day monitoring and management of the practice were not effective. The practice is owned by an organisation. The practice owner does not reside in the UK. The previous registered manager left the practice in January 2021. There was a lack of oversight for the day to day management of the service. Some members of staff told us that there were difficulties in accessing support from the practice owner. They told us that there were considerable delays when they asked for items such as testing materials for the ultrasonic bath.

There was a lack of clear accountability, specific roles and responsibilities in relation to the management of the service. Staff did not have access to policies or other information in relation to procedures such as infection control, dental radiography, Legionella management, the safe use and maintenance of equipment, health and safety and monitoring referrals. This meant that relevant legislation, guidelines and policies were not available, implemented or understood to ensure that the service was delivered in a safe way.

Staff were concerned at the lack of management and support systems at the practice. They were concerned at the lack of identified lead roles in relation to infection prevention and control, safeguarding and health and safety.

Staff told us that they believed the practice owner did not understand the legal requirements in relation to the management of the practice.

Culture

Staff stated they did not feel supported. Some staff told us that they were concerned to work in the practice because they did not feel that the owner understood their responsibilities and did not respond to their requests for assistance.

There were no systems to monitor staff learning and development needs or to ensure that all staff had undertaken training required to enable them to carry out their roles and duties. We reviewed training records for eight members of staff. Five members of staff did not have safeguarding training. Two of the four dentists had not completed training in dental radiography and six of the eight staff had not completed infection prevention and control training.

Staff did not feel that they could raise concerns or encouraged to do so. They did not have confidence that concerns raised would be addressed.

Governance and management

There was a lack of clear and effective processes for managing risks.

The practice infection control procedures were not in accordance with current guidance. There were no systems to ensure that staff were following these procedures.

There were no audits of dental radiographs to assess the quality of dental radiograph images taking into account the Ionising Radiation (Medical Exposure) Regulations 2017 and taking into account the guidance for Dental Practitioners on the Safe Use of X-ray Equipment.

There were ineffective systems to assess and manage risks in relation to areas including fire safety, infection prevention and control and Legionella management.

Are services well-led?

There were ineffective systems to ensure that equipment, including the compressor and the dental X-ray unit were maintained, tested and serviced in line with the manufacturer's instructions and relevant legislation and guidance.

The provider did not have systems in place to monitor or follow up on referrals to other dental / health providers where patients required urgent or specialist dental treatments, which the practice did not provide. There were no arrangements to ensure that patients would receive this treatment in a timely manner.

The provider did not have systems in place for receiving, managing and sharing safety alerts such as those reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies, such as Public Health England (PHE).

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person's recruitment procedures did not ensure that potential employees had the necessary qualifications, competence, skills and experience before starting work. In particular: There were no references available for the practice manager, four dentists and one dental nurse. Disclosure and Barring Service (DBS) were not carried out when staff were recruited to work at the practice as part of ensuring each person's fitness to help keep people who use the service. Checks in respect of current registration with the General Dental Council (GDC) were not carried out when dentists and dental nurses were employed to work at the practice. There were no induction records for any staff working at the practice. We spoke with the practice manager, one dentist and one dental nurse and they told us that they did not have a period of induction when they commenced work at the practice. 19 (1) (2)

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 a regulated activity

This section is primarily information for the provider

Enforcement actions

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:

There were no arrangements to assess staff learning and development needs or to ensure that staff undertook required training including continuing professional development (CPD) in accordance with the General Dental Councils *Standards for the Dental team* for clinical staff:

We checked staff files and found that there were no safeguarding training records for one dentist, one dental nurse and two receptionists. The dental nurse told us that they were unsure about safeguarding procedures or their responsibilities in relation to these.

There were no training records in relation to dental radiography in accordance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R 2000 for one dentist and the dental nurse.

There were no training records in relation to infection prevention and control in accordance with the guidelines issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, and having regard to The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance' for two dentists and one dental nurse.

There were no records available for any staff working at the practice in relation to:

Fire safety

Legionella management

18 (2)

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 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 provider did not have proper arrangements to deal with medical or other emergencies at the practice.

Staff could not make calls to emergency numbers such as 999 or 101 from the practice telephone in the event of an emergency.

The provider did not have effective radiation protection arrangements at the practice in accordance with relevant legislation and guidance – Ionising Radiation (Medical Exposure) Regulations 2000/2018 (IRMER 2000/2018) and Ionising Radiation Regulations 2017 (IRR 2017):

There were no records available to show when the dental X-ray equipment had been installed at the practice or that the practice had registered with the Health and Safety Executive (HSE).There were no records to show that a critical examination and acceptance test had been carried out for the dental X-ray equipment.

There were no records to show that annual electrical and mechanical tests or three yearly radiological tests had been carried out. Staff present during the inspection could not tell us when these tests had been carried out.

The provider did not have suitable infection prevention and control arrangements to monitor and minimise the risks of cross infection in accordance with the Department of Health publication “Health Technical Memorandum 01-05: Decontamination in primary care dental practices’’.

This section is primarily information for the provider

Enforcement actions

There were no infection prevention and control policies available for staff to refer to. The dental nurse had been nominated as the infection control lead for the practice. They told us that they had not undertaken infection prevention and control training.

There were no infection prevention and control audits carried out to assess and monitor infection prevention measures at the practice.

A Legionella risk assessment was carried out at the practice on 7 July 2020. The assessment report identified areas where improvements were required including flushing and disinfecting dental unit waterlines to minimise growth of Legionella bacteria . There were no records to demonstrate that these measures were being carried out. Staff present were unable to tell us what method for disinfecting was used or how frequently disinfecting products should be replaced.

The Legionella risk assessment also identified that monitoring of hot and cold water temperatures within the practice to minimise the risk of Legionella bacteria growth were not being carried out.

On the day of the inspection staff told inspectors that these checks were carried out and that the hot and cold water temperatures were in line with guidelines

During the inspection visit we checked the hot water temperatures in surgery one, surgery three and surgery four.

We found that the temperatures for hot water did not reach the temperature required to minimise Legionella growth. There were no records to demonstrate that hot water heaters were tested or serviced to ensure that they worked properly. Staff present during the inspection were unaware of any checks which should be carried out for the water heaters or how often these should receive maintenance or service checks.

The provider could not be assured that infection prevention and control procedures including the procedures to reduce the risk of bacterial growth in the water systems were being carried out safely to minimise risks to service users.

This section is primarily information for the provider

Enforcement actions

The provider did not have suitable arrangements to monitor and mitigate the risks of fire at the practice.

A fire safety risk assessment was carried out in July 2020. The assessment report identified areas where improvements were required. There were no records to demonstrate that these identified issues had been addressed and staff present were unable to tell us if the issues had been addressed.

There were ineffective arrangements for evacuation procedures in the event of an outbreak of fire at the practice. Staff were unclear as to the procedures in the event of a fire, including evacuation procedures.

There were no arrangements for checking or testing emergency lighting system and staff present during the inspection were not aware that this system was installed.

The provider could not be assured that appropriate fire safety measure were carried out at the practice to minimise risks to service users and staff.

The provider does not have effective systems to monitor and maintain equipment and systems for the safe running of the practice:

There were no records available at the practice to demonstrate that a five year electrical installation condition report had been carried out.

There were no records available to demonstrate when the compressor had been serviced to ensure that it was operating effectively and safely

Staff told us they did not have access to information in relation to the handling, storage, and disposal of hazardous materials in accordance with Control of Substances Hazardous to Health (COSHH) Regulations 2002. There were no policies or other information available to staff to help them manage an accidental exposure to hazardous materials used in the practice.

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.

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:

There is a lack of managerial oversight for the practice since the registered manager left the practice in January 2021. The Nominated Individual and sole director of the organisation resides outside of the United Kingdom. A practice manager had been employed at the practice two weeks prior to our inspection visit.

Staff expressed concerns about the lack of support they received and the delay / lack of response to requests for assistance with the day to day management of the practice.

Staff told us that they had concerns that the provider does not understand the requirements to manage the dental practice.

There were ineffective governance systems to assess and manage risks in relation to the service.

We identified a number of failings which demonstrated a lack of management, governance and monitoring the service to maintain and improve standards, safety and quality:

Staff told us they did not have access to policies and procedures in relation to running and management of

Enforcement actions

the practice such as safeguarding children and adults, infection prevention and control, managing risks or fire safety. These policies were not available at the practice during our inspection.

The provider did not have systems in place to monitor or follow up on referrals to other dental / health providers where service users required urgent or specialist dental treatments which the practice did not provide. The provider could not be assured that service users would receive this treatment in a timely manner.

The provider did not have systems for effective monitoring and quality improvement of the services provided:

There were no audits of dental radiographs to assess the quality of dental radiograph images taking into account the Ionising Radiation (Medical Exposure) Regulations 2017 and taking into account the guidance for Dental Practitioners on the Safe Use of X-ray Equipment.

17 (1)