Rhonaesk Limited

Chelsea Dental Clinic

Inspection report

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Date of inspection visit: 06 May 2022
Date of publication: 10/06/2022

Overall summary

We carried out this unannounced focused inspection on 6 May 2022 under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered practice was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a Care Quality Commission (CQC), inspector who was supported by a second inspector and a specialist dental adviser.

To get to the heart of patients' experiences of care and treatment, we usually ask five key questions. However, this inspection was in response to concerns received by the Commission and we focused on two key 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:

- Staff knew how to deal with medical emergencies. Appropriate medicines and life-saving equipment were available.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The practice appeared to be visibly clean and well-maintained. However, improvements were needed to ensure that the required cleaning equipment was available and stored appropriately.
- The practice had infection control procedures which broadly reflected published guidance. However, improvements were needed to ensure the effectiveness of the decontamination process.
- Risks to staff and patients from undertaking of regulated activities had not been suitably identified and mitigated.
- Clinical staff provided patients' care and treatment in line with current guidelines; however, improvements were needed to ensure that information related to patient care was suitably recorded within the dental care records.
- There was ineffective governance and leadership, and a lack of oversight of the day-to-day management of the service.

Summary of findings

- There were systems in place to ensure the dental equipment was serviced regularly. However, improvements were required to ensure that the premises were safe and radiography equipment were regularly serviced in line with the manufacturer`s guidance.
- The practice had staff recruitment procedures which broadly reflected current legislation. However, improvements were needed to ensure that documentation in relation to the persons employed was monitored and maintained adequately.
- There were ineffective systems to ensure that staff training was appropriately monitored.

Background

Chelsea Dental Clinic is in Fulham in the London Borough of Kensington and Chelsea and provides private dental care and treatment for adults and children.

The practice is located close to public transport links and car parking spaces are available nearby.

The dental team includes a principal dentist, five associate dentists, three qualified dental nurses, a trainee dental nurse, a compliance head nurse, one dental hygienist, three dental therapists, one receptionist, one head receptionist who also acts as treatment coordinator and a practice manager. The practice has three treatment rooms.

During the inspection we spoke in person with the trainee dental nurse, two qualified dental nurses, one dental therapist, the head receptionist and over the phone with the practice manager. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday to Friday 9am to 6pm.

Saturdays and Sundays by appointment only.

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.

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

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

Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the College of General Dentistry.

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?	**Requirements notice**

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 Action section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

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

The practice had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.

The practice had infection control procedures which broadly reflected published guidance. The practice had introduced additional procedures in relation to COVID-19 in accordance with published guidance. However, we found shortcomings in the effectiveness of the infection prevention and control procedures at the practice.

We observed that some sterilisation pouches were not stamped and there was an inconsistent use of the expiry and processing date on some of the sterilisation pouches.

We reviewed the practice Infection Prevention and Control Policy on the provider`s compliance portal. This did not meet the requirements of the Health and Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health and Social Care. The policy was a generic template and did not contain a clear decontamination process, including a written manual cleaning procedure staff could follow to ensure the risks arising from infections were sufficiently prevented and controlled.

The practice did not have procedures to reduce the risk of Legionella or other bacteria developing in water systems, in line with a risk assessment. There was no evidence that a risk assessment in respect of Legionella contamination had been carried out and reviewed by a person with the qualifications, skills, competence and experience to do so.

We saw no evidence that periodic temperature checks of the cold-water supply and hot water circulating systems had been carried out in accordance with the relevant guidance.

The practice had policies and procedures in place to ensure clinical waste was segregated in line with guidance. However, improvements were needed to ensure the appropriate storage of clinical waste before disposal. In one of the cabinets in surgery 1 we observed an overfilled and unlocked sharps bin.

We saw that the clinical areas within the practice were visibly clean. However, we noted that dental materials, including sterile surgical drapes, endodontic syringes and disposable gloves were stored in the basement and had dust build up on the packaging.

The practice had a recruitment policy and procedure to help them employ suitable staff and had checks in place for agency and locum staff. However, there was lack of appropriate systems in place to store and maintain recruitment documentation. The practice manager told us that recruitment checks had been completed upon commencement of staff's employment. On the day of the inspection, evidence of Disclosure and Barring Service (DBS) checks were missing for seven members of staff, professional registration details were not available for four members of staff, evidence of employment history was not available for five members of staff, details of qualification were missing for five members of staff and professional indemnity details were not on record for ten members of staff.

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

Are services safe?

The practice had ensured that dental equipment was maintained according to the manufacturers` instruction. We saw evidence of suction motor, compressor and dental chair servicing within the last 12 months.

The risks related to fire safety had not been assessed and mitigated and neither reviewed regularly by a person with the qualifications, competence and experience to do so. The fire risk assessment provided to us by the practice manager on 10 May 2022 did not contain a date and the name of the assessor and did not include all risks associated with fire. The assessment was a one-page document which listed electrical equipment and flammable materials as significant hazards and the control measures of these. It did not consider all fire risks within the practice such as combustibles, ongoing building work, and the laser units. The emergency routes and exits, fire detection systems, firefighting equipment, the removal and storage of dangerous substances, emergency fire evacuation, the needs of vulnerable people and staff training had not been assessed and documented.

Further, the practice did not have procedures in place to mitigate risks associated with fire. There were no records of periodic in-house testing of the fire safety equipment, including the fire alarm system, smoke detection system and emergency lighting. The provider could not demonstrate that the smoke detectors, the emergency lighting equipment and fire alarm system were serviced regularly. There was no evidence that fire drills had been carried out. The provider could not demonstrate that members of staff appointed as fire marshals undertook fire awareness or fire marshal training.

The practice did not have arrangements to ensure the safety of the X-ray equipment. Critical examination tests and the 3-year safety checks had been carried out; however, the required radiation protection information was not available. There was no evidence that regular in-house quality assurance tests and periodic calibration and dosage tests of the X-ray equipment had been carried out in line with the manufacturers' guidance.

The practice did not have arrangements to ensure the safe use of dental laser equipment. The required laser protection information was not available on the day of the inspection. A Laser Protection Advisor (LPA) and a Laser Protection Supervisor (LPS) had not been appointed in line with the relevant guidance. The provider appointed an LPA two days after the inspection and a risk assessment in relation to the use of dental laser was undertaken and shared with us on 10 May 2022.

Risks to patients

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

On the day of the inspection, the provider had some information available in relation to the use and storage of hazardous substances as per Control of Substances Hazardous to health regulations 2002 (COSHH). However, improvements were needed to ensure that safety data information and risk assessment was available for all hazardous materials used in the practice. Improvements were also needed to ensure that information was organised and easily accessible to staff in case of an incident while using hazardous materials. In addition, we noted that the COSHH products were not stored securely.

Emergency equipment and medicines were available and checked in accordance with national guidance.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year. Immediate Life Support training with airway management for staff providing treatment to patients under sedation was also completed.

Information to deliver safe care and treatment

Dental care records we saw were legible and were kept securely and complied with General Data Protection Regulation requirements.

Safe and appropriate use of medicines

Are services safe?

The practice had kept a log of antimicrobial medication dispensed to patients. However, improvements were needed to ensure that there was an adequate stock control system of medicines which were held on site.

On the day of the inspection we found out of date materials in surgery 1. The provider did not have suitable or effective systems for ensuring dental materials were disposed of adequately once they were beyond their recommended use by date. For example; a permanent adhesive dental cement (exp. 03/2022) and a high fluoride content toothpaste (exp. 04/2022) were noted in a drawer in surgery 1 that was in use for patient care and treatment.

Track record on safety, and lessons learned and improvements

The practice had implemented systems for reviewing and investigating incidents and accidents. The practice had a system for receiving and acting on safety alerts.

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 section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

Leadership capacity and capability

We found that there was ineffective leadership which impacted on the practice`s ability to deliver safe, high quality care. Staff we spoke with commented that previous systems and processes for governance were ineffective. Whilst improvements had been made the new systems were in their infancy and still being implemented.

Improvements were required to ensure key information about systems and processes was communicated effectively across the organisation. On the day of the inspection staff told us they could not access key policies and health and safety documentation as they were uncertain of where these documents were kept.

The information and evidence presented during the inspection process was not always well documented and well maintained.

The practice manager contacted us after the inspection to let us know they had gathered some of the documentation that was not available at the time of the inspection visit and shared these with us on the 10 May 2022.

The documents included the Radiation Protection Advisor (RPA) details, fridge temperature log, electrical installation certificate, records of conscious sedation procedures, fire alarm modification certificate (dated 22 June 2019), antibiotic prescribing log, disability and discrimination audit, COSHH control checklist, fire extinguisher service certificate, ICO registration certificate, LPA appointment (dated 8 May 2022), Health and Safety Executive (HSE) registration certificate for the use of X-ray devices, waste control contract and consignment notes.

Improvements were required to ensure that records in relation to the management of regulated activities were readily available and accessible to all members of staff and those who would need to review them.

Culture

We found that dentists working at the practice had annual appraisal completed in January 2022. However, improvements were needed to ensure that all members of staff who worked at the practice including dental nurses and reception staff, also received an annual appraisal.

The practice manager told us that staff undertook training in line with the relevant guidance. However, improvements were needed to ensure that staff training records were adequately updated and monitored. We were given access to the practice's compliance portal that held the staff records. We found, on the day of the inspection that no training records were available for one dental nurse and one dentist. Other members of staff did not have all their training certificates on file; including safeguarding for one receptionist, basic life support for one dental nurse and infection control training details for one of the dentists.

Governance and management

The registered manager had overall responsibility for the management of the practice. Improvements were required to ensure that they were more involved in the day to day running of the service or to ensure that effective deputising arrangements were in place in their absence.

The practice did not have effective systems and processes in place in relation to the management of the service. We noted that several essential requirements, including important safety checks (5-year fixed wire electrical check, fire safety

Are services well-led?

checks, PAT testing) had not been undertaken in the past and some services were only booked in response to the CQC inspection. For example, the practice did not have an LPA or LPS and one was only appointed after the inspection. Risk assessment for the use of dental laser was carried out on 10 May 2022. Colour coded mops and buckets were ordered on 9 May 2022.

The processes for managing risks were ineffective. The practice did not have adequate systems in place for identifying, assessing and mitigating risks in areas such as sharps, fire safety, legionella and general health and safety. Some risks assessments were generic and not reflective of the arrangements within the service and others were not available at all.

There was a lack of robust governance system and audit for the management of patients who receive treatment under conscious sedation. On the day of the inspection we asked staff for a list of patients who had treatment under conscious sedation. Staff was unable to provide such list or guide us to dental records of treatments involving sedation.

The practice did not maintain accurate and complete dental care records to reflect treatment provided to patients. Staff told us that sedation records were maintained by the visiting sedationist, who would send a copy of the records after the procedure to the practice. However, our check of documents and dental care records revealed that suitable pre-clinical assessment, discussion with the patient about options, written consent, peri-operative monitoring and post-operative care instructions were not documented suitably in the dental care record or elsewhere for all patients undergoing treatment under conscious sedation.

Appropriate and accurate information

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

We also found a staff folder containing confidential personal information lying unsecured in an unlocked kitchen cabinet.

Continuous improvement and innovation

The practice had some quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, disability access and radiographs.

However, improvements were needed to ensure that the infection prevention audit was completed bi-annually in line with the relevant guidance.

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 17 HSCA (RA) Regulations 2014 Good governance **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 17 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 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: • Risk assessments, including the sharps and general health and safety risk assessment, were not reflective of the arrangements within the service. • Infection prevention and control audits were not carried out in accordance with the relevant guidance. • Annual appraisals were not being carried out for all staff. • There was a lack of robust governance systems for the management of patients who receive dental care and treatment under conscious sedation. • Governance systems were ineffective as they did not include sufficient oversight, scrutiny and overall responsibility by the registered manager. The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to maintain securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activities. In particular:

This section is primarily information for the provider

Requirement notices

- The required recruitment documentation was not stored and maintained adequately.
- Not all staff training records were maintained and the processes to monitor staff training were ineffective.
- Confidential personal information in relation to staff was not stored securely.

The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular:

- Dental care records of treatments carried out under conscious sedation did not include details of pre-clinical assessment, discussion with the patient about options, written consent, peri-operative monitoring and post-operative care instructions.

Regulation 17 (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.

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 HSCA (RA) Regulations 2014 Regulation 12 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 fire risk assessment did not consider all risks associated with fire and it was not carried out and regularly reviewed by a person with the qualifications, skills, competence and experience to do so. • There were no records of periodic in-house testing of the fire safety equipment, including the fire alarm system, smoke detection system and emergency lighting. • The fire safety equipment had not been serviced regularly. • Fire drills had not been undertaken. • Members of staff appointed to act as fire marshals had not undertaken training in relation to fire safety. • The 5-year fixed wire safety test, portable appliance testing and gas safety checks were not completed. • Risks in relation to the use of substances and materials hazardous to health had not been carried out. • The material safety data sheets in the Control of Substances Hazardous to Health (COSHH) Regulations, 2002 folder were not organised or accessible to staff in case of an incident. • Hazardous cleaning materials were not stored securely. • There were no documented radiation protection arrangements, including local rules, and a maintenance and inspections schedule in line with the manufacturer`s recommendations to ensure the proper and safe operation of equipment.

This section is primarily information for the provider

Enforcement actions

- Regular in-house quality assurance and performance tests of radiography equipment had not been carried out.
- Regular electrical and mechanical servicing of the radiography equipment had not been carried out in line with the manufacturer`s recommendations.
- The required laser protection information was not available on the day of inspection.
- A Laser Protection Advisor (LPA) and that a Laser Protection Supervisor (LPS) had not been appointed.
- A risk assessment in respect of Legionella contamination had not been carried out and regularly reviewed by a person with the qualifications, skills, competence and experience to do so.
- Periodic testing of water temperature had not been carried out in line with the relevant guidance.
- Dental materials were not disposed beyond their use-by date.
- There were unstamped sterilisation pouches and there was inconsistency in the use of processing date and expiry date on the pouches of sterilised instruments.
- The Infection Control Policy did not include a written manual cleaning process staff could follow to ensure that risks arising from infections were sufficiently prevented and controlled.
- Equipment for environment cleaning such as buckets and mops were not available as per national guidance.
- Clinical waste was not stored appropriately prior to its disposal in line with the relevant guidance.
- There was lack of adequate stock control system of medicines which were held on site.

Regulation 12 (1)