Care Quality Commission

Totteridge Dental Studio Limited

Totteridge Dental Studio - Totteridge Lane

Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 14 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 broadly reflected published guidance. Improvements were needed to ensure that contaminated instruments were safely transported to the decontamination area.
- Staff knew how to deal with medical emergencies. Appropriate medicines and life-saving equipment were available.

Summary of findings

- The practice had some systems to manage risks for patients, staff, equipment and the premises. Improvements were needed to the systems for assessing, monitoring and mitigating risks associated with fire, radiation safety and the use of sharps.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The practice had staff recruitment procedures which reflected current legislation.
- 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.
- 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.
- Staff felt involved, supported and worked as a team.
- Staff and patients were asked for feedback about the services provided.
- Complaints were dealt with positively and efficiently.
- The practice had information governance arrangements.

Background

Totteridge Dental Studio - Totteridge Lane is in the London Borough of Barnet and provides private dental care and treatment for adults and children.

The main entrance into the practice has steps; however, there is a second entrance with step free access for people who use wheelchairs and those with pushchairs. Limited car parking spaces are available for patients. The practice does not have an accessible toilet and they have systems in place to communicate this to patients prior to their appointments.

The dental team includes the principal dentist, 1 associate dentist, 1 dental therapist, 1 trainee dental nurse and 1 qualified dental nurse who also undertakes practice management duties. They are supported by an administrator. The practice has 2 treatment rooms.

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

The practice is open:

Monday from 9am to 5pm.

Tuesday from 9am to 4pm

Wednesday to Friday from 8.30am to 5pm.

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.

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 practice had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children. On the day of inspection, the provider could not demonstrate that the trainee dental nurse had completed safeguarding training at a level appropriate to their role. Following the inspection, we received evidence that the trainee dental nurse had now completed the relevant safeguarding training.

The practice had infection control procedures which broadly reflected published guidance.

The practice however, did not have adequate systems in place for the safe transportation of contaminated items from the treatment rooms to the adjoining decontamination area. Used instruments, including sharps were transported on open trays putting staff at an increased risk of sharps injury. Following the inspection, the provider submitted evidence that they had now implemented the use of rigid and leak-proof transportation containers.

We observed that not all surfaces in the treatment room were suitable to aid successful cleaning and hygiene. The computer keyboard, telephone and printer in Surgery 2, located in close proximity of the dental chair, were not covered with a protective cover and there was no evidence that consideration had been given to the cleanability of these surfaces. Following the inspection, we received photographic evidence that these surfaces had now been covered with a disposable protective layer.

The practice had procedures to reduce the risk of Legionella, or other bacteria, developing in water systems, in line with a risk assessment.

The practice had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance.

The practice appeared clean and there was an effective schedule in place to ensure it was kept clean.

The practice had a recruitment policy and procedure to help them employ suitable staff, including for agency or locum staff. These reflected the relevant legislation.

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

The practice ensured equipment was safe to use, maintained and serviced according to manufacturers' instructions. The practice ensured the facilities were maintained in accordance with regulations.

Not all recommendations made in the fire risk assessment dated 6 July 2018 had been acted upon. Outstanding actions included fixing self-closers on all fire doors, fitting British Standard compliant hinges on the kitchen door, installation of emergency lighting as per BS-5266 and testing them as mentioned in the relevant guidance, fixing the fire blanket on the kitchen wall, installing a fire alarm system or at least mains power supplied interlinked smoke detectors with back-up power supply and maintaining a fire-log book so that all information regarding fire safety features were stored in one place. In addition, there was no evidence that the fire risk assessment had been regularly reviewed. The practice had a new fire risk assessment undertaken on 13 March 2023, and at the time of the inspection they were awaiting the report of that assessment.

Following the inspection, we received photographic evidence that the self-closers on the fire doors and hinges on the kitchen door had been fitted. The provider further submitted a copy of a quote from their electrician for the fitting of emergency lighting and fire alarm system. We also received evidence that the fire blanket had been fixed to the wall, and copies of a fire logbook the provider had implemented since the inspection.

Are services safe?

We further noted that while the fire extinguishers had been serviced on 7 March 2023, there was no record of annual servicing since 18 November 2020. The provider submitted an email from the contractor that due to a computer error, annual servicing had not been carried out between the above dates.

The practice had some arrangements to ensure the safety of the X-ray equipment, and the required radiation protection information was available. We saw evidence that the 3-yearly performance checks on the two intraoral units had been carried out on 20 October 2022. However, improvements were needed to ensure that the local rules displayed in Surgery 2 were up to date and included the main working instructions intended to restrict any exposures arising from work in the controlled area. The local rules document that was on display was a generic document, referred to types of radiography equipment the practice did not have and included the name of an operator who no longer worked at the practice. In addition, it did not include location specific control measures to reduce exposure to staff working in the adjoining decontamination room while the intraoral unit in Surgery 2 was in use.

Risks to patients

The practice had implemented some systems to assess and manage risks to patients and staff. Improvements were needed to the processes to assess and mitigate risks related to the handling and disposal of dental sharps. A risk assessment was in place. This stated that *"needles and sharps should be disposed of safely in sharps bins by the clinician … easily accessible in the surgery close to the source of use".* We found that the sharps risk assessment was not consistently followed. On the day of inspection sharps boxes were not available in the treatment rooms and the principal dentist told us that they transported sharps on open trays to the decontamination room where the sharps box was located. The provider did not consider the additional risks arising from the transportation of contaminated sharps from one room to another. In addition, the most recent sharps risk assessment did not consider all types of sharps used and the practice specific control measures. Following the inspection, the provider submitted photographic evidence that sharps boxes had now been wall mounted in the treatment rooms. We also had sight of the sharps risk assessment dated 14 March 2023 which was now reflective of the arrangements within the practice and included all types of sharps and the relevant control measures.

Emergency equipment and medicines were available and checked in accordance with national guidance. Improvements could be made to ensure that the temperature of the medical fridge where Glucagon (a medicine to treat low blood glucose) was stored was monitored daily instead of weekly to ensure it was stored according to manufacturer's instructions. Following the inspection, the provider submitted an updated log that now included record of daily checks.

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

The practice had risk assessments to minimise the risk that could be caused from substances that are hazardous to health.

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. Antimicrobial prescribing audits were carried out.

Track record on safety, and lessons learned and improvements

Are services safe?

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.

Staff 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.

Staff conveyed an understanding of supporting more vulnerable members of society such as patients living with dementia or adults and children with a learning disability.

We saw evidence the dentists justified, graded and reported on the radiographs they took. The practice carried out radiography audits six-monthly following current guidance.

Effective staffing

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

Newly appointed staff had a structured 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 dentists 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.

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 dentists explained the methods they used to help patients understand their treatment options. These included for example photographs, X-ray images, animated patient guidance and an intraoral scanner.

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 made reasonable adjustments, including step-free access for patients with access requirements. Staff had carried out a disability access audit and had formulated an action plan to continually improve access for patients.

Timely access to services

The practice displayed its opening hours and provided information on their website.

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.

The practice's website leaflet and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open. Staff took part in an emergency on-call arrangement with other local practices in Barnet and patients were directed to the appropriate out of hours service.

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

The practice responded to concerns and complaints appropriately. Staff discussed outcomes to share learning and improve the service.

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 practice staff demonstrated a transparent and open culture in relation to people's safety.

We found that the provider had the capacity, values and commitment to deliver high quality sustainable services. However, the lack of effective risk management impacted the day to day management of the service.

Systems and processes were embedded, and staff worked together in such a way that where the inspection identified areas for improvement, these were acted on immediately.

The information and evidence presented during the inspection process was clear and well documented.

We saw the practice had effective processes to support and develop staff with additional roles and responsibilities.

Culture

Staff could show how they ensured high-quality sustainable services and demonstrated improvements over time.

Staff stated they felt respected, supported and valued. They were proud to work in the practice.

Staff discussed their training needs during annual appraisals and informal 1 to 1 meetings. They also discussed learning needs, general wellbeing and aims for future professional development.

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

Governance and management

The practice had a governance system which included policies, protocols and procedures that were accessible to all members of staff and were reviewed on a regular basis.

Staff did have clear roles and responsibilities, and there was a system of accountability. However, the practice governance and management arrangements needed improvement to be effective.

The practice did not have adequate systems in place for identifying, assessing, and mitigating risks in areas such as sharps, fire and radiation safety.

During the inspection we were provided a copy of the practice risk assessment dated January 2019. This was a one-page document and referred to hazards including, loose wire in main entrance, sharps box off the wall, latex soft tissue retractor and bleach inside the cupboard in the toilet. We were not assured that this risk assessment was suitable and sufficient to show that proper checks had been made, and the provider had considered who might be affected and the level of risk assessed.

Following the inspection, the provider submitted another risk assessment. We noted that this document reviewed on 12 January 2023 contained inaccurate information. It stated that fire extinguishers were situated for easy access on the ground, 1st and 2nd floors, although the practice only occupied the ground floor of the premises. It further stated that the fire extinguishers were regularly serviced. This statement was not substantiated in our findings on the day of inspection as we identified a gap in the annual servicing of the fire extinguishers; at the time of the review of the above document the fire extinguisher servicing had been overdue for over 2 years.

Are services well-led?

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

Staff gathered feedback from patients, the public and external partners and demonstrated a commitment to acting on feedback.

Feedback from staff was obtained through meetings, surveys, and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on where appropriate.

Continuous improvement and innovation

The practice had systems and processes for learning, quality assurance and continuous improvement. These included audits of patient care records, disability access, radiographs, antimicrobial prescribing, and infection prevention and control. Staff kept records of the results of these audits and the resulting action plans and improvements.

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 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: • Contaminated items from the treatment rooms to the adjoining decontamination area were not transported safely. • Recommendations in the fire risk assessment had not been acted upon within the given timeframes. • The X-ray local rules did not include the main working instructions intended to restrict any exposures arising from work in the controlled area. • Control measures identified in the sharps risk assessment were not consistently followed. • The practice risk assessment dated 12 January 2023 was not an accurate reflection of the systems and processes at the practice. Regulation 17 (1)