Chronos London Dental Clinic Limited

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Inspection report

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Date of inspection visit: 6 January 2023
Date of publication: 22/02/2023

Overall summary

We undertook a follow up focused inspection of Chronos London Dental Clinic on 6 January 2023. This inspection was carried out to review the actions taken by the registered provider to improve the quality of care and to confirm that the practice was now meeting legal requirements.

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

We had previously undertaken a comprehensive inspection of Chronos London Dental Clinic on 11 November 2022 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We found the registered provider was not providing safe and well-led care and was in breach of regulations 12,13,17 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can read our report of that inspection by selecting the 'all reports' link for Chronos London Dental Clinic dental practice on our website www.cqc.org.uk.

When 1 or more of the 5 questions are not met we require the service to make improvements and send us an action plan. We then inspect again after a reasonable interval, focusing on the areas where improvement was required.

As part of this inspection we asked:

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

Summary of findings

Due to the nature of concerns identified during the follow up inspection on 6 January 2023, we undertook immediate enforcement action and the provider's CQC registration to undertake the regulated activities was suspended for a period of 6 months.

Our findings were:

Are services safe?

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

The provider had made insufficient improvements to put right the shortfalls and had not responded to the regulatory breaches we found at our inspection on 11 November 2022. In addition, we identified new concerns during the follow up inspection on 6 January 2023.

Are services effective?

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

We identified new concerns during the follow up inspection on 6 January 2023.

Are services caring?

We found this practice was not providing caring services in accordance with the relevant regulations.

We identified new concerns during the follow up inspection on 6 January 2023.

Are services responsive?

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

We identified new concerns during the follow up inspection on 6 January 2023.

Are services well-led?

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

The provider had made insufficient improvements to put right the shortfalls and had not responded to the regulatory breaches we found at our inspection on 11 November 2022. In addition, we identified new concerns during the follow up inspection on 6 January 2023.

Background

Chronos London Dental Clinic is in Kensal Rise, in the London Borough of Brent, and provides NHS and 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.

Summary of findings

The dental team includes the principal dentist, 1 associate dentist, 1 qualified dental nurse, and 1 trainee dental nurse. The practice has 2 treatment rooms and a separate decontamination room.

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

The practice is open:

Monday, Tuesday, Wednesday, Friday 9am to 5pm.

The practice is closed for lunch between 1pm and 2pm.

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

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

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?	**Enforcement action**
Are services effective?	**Enforcement action**
Are services caring?	**Enforcement action**
Are services responsive to people's needs?	**Enforcement action**
Are services well-led?	**Enforcement action**

Are services safe?

Our findings

We found that this practice was not providing safe care and was not complying with the relevant regulations.

At the inspection on 6 January 2023 we found the practice had made the following improvements to comply with the regulations:

- The practice had updated their safeguarding policy, and this now included information about current procedures and guidance about raising concerns about abuse. The contact details of the Local Authority`s safeguarding board were displayed in the staff room. We saw evidence that staff had received safeguarding training at a level relevant and suitable level for their role.
- The practice infection control procedures reflected published guidance. The practice had implemented systems to monitor the temperature of water throughout the cleaning procedure to ensure the temperature of water was 450C or lower. Staff now ensured that long-handled brushes used to scrub instruments were replaced regularly.
- The practice had updated their infection prevention and control policy. We noted that this reflected published guidance, was tailored to the service and included a cleaning procedure for manual cleaning of used dental instruments. We were provided meeting minutes to demonstrate that the updated infection control policy had been discussed in a practice meeting on 24 November 2022.
- A Legionella risk assessment undertaken on 21 November 2022 was available for review on the day of inspection. This was carried out by a person who had the qualifications, skills, competence and experience to do so. We saw evidence that the recommendations within the risk assessment had been acted upon. Staff were carrying out water temperature checks on the hot and cold water taps and they recorded these checks.
- Staff told us that they would flush Dental Unit Waterlines (DUWLs) for 30 seconds between patients and for at least 2 minutes at the beginning and end of the day. This was in line with the national guidance.
- A sharps risk assessment had been carried out on 17 November 2022. This included various types of sharps used within the practice and practice specific control measures. The practice procured needle guards to reduce the risk of needle stick injury.
- Medical emergency drugs and equipment were available and checked regularly in line with the Resuscitation Council guidance (2020).
- Staff told us that they were aware how to access alerts issued by the Medicines and Healthcare products Regulatory Agency (MHRA).
- We observed that the clinical waste bin used to store clinical waste bags awaiting collection was locked and secure.
- The practice had implemented a cleaning checklist to monitor the effectiveness of cleaning.
- The practice had made improvements to ensure the equipment and premises were safe for use. We saw evidence that the autoclave and dental chairs had been serviced in November 2022. In addition, the practice had a new suction unit installed in November 2022. Gas safety checks had been undertaken on 12 November 2022. The electrical installation condition report dated 20 November 2022 stated that the installations within the premises were in good condition.
- The practice had made improvements to ensure risks related to fire had been assessed and mitigated. A fire risk assessment report dated 21 November 2022 was made available for our review. We saw evidence that the practice had

new smoke detectors and a fire alarm installed on 20 November 2022. The fire extinguishers were serviced on 20 November 2022. We were shown records that the practice undertook fire drills and members of staff completed fire awareness training. Staff told us that they carried out weekly tests on the fire detection equipment. Improvements were needed to ensure that periodic inhouse checks were recorded.

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

- We were not assured that staff we spoke with were confident using equipment and oxygen in case of a medical emergency.
- The provider was unable to show us evidence of radiation protection arrangements to ensure that dental radiography was carried out safely in accordance with Ionising Radiation (Medical Exposure) Regulations 2017 [IR(ME)R 2017] and The Ionising Radiations Regulations 2017 [IRR 2017]. The practice had appointed a Radiation Protection Advisor (RPA) on 8 November 2022 but there was no evidence that they had been consulted regarding the layout of the dental radiography facilities, including required structural protection, safety and warning devices and the required control measures in line with a risk assessment.
- The Equipment Performance Report dated 21 July 2022 for the intraoral unit in Surgery 1 and the Critical Examination and Acceptance Test Report dated 27 July 2021 for the intraoral unit in Surgery 2 stated that the patient entrance and doses for adult and child exposures were greater than the national diagnostic levels and should be reduced. It stated that the provider should seek advice from their Medical Physics Expert (MPE) on the appropriate exposure setting to use. There was no evidence that the provider had acted upon this recommendation.

During the follow up inspection we identified new concerns:

- We observed a dental nurse providing treatment without chairside support, and when asked, they confirmed to us that they were carrying out a dental hygiene treatment. The General Dental Council (GDC), in the Scope of Practice document, sets out the clinical activity registered dental nurses can undertake following training. This does not include supragingival and subgingival scaling and root surface debridement using manual or powered instruments. The GDC states that 'dental nurses **do not** diagnose disease or treatment plan. All other skills are reserved to one or more of the other registrant groups.'
- We noted from the digital appointment book on the computer in surgery 2 that on various days the dental nurse had appointments booked that included activities such as undertaking radiographs. The dental nurse confirmed to us they did not have the necessary qualifications and/or the experience to undertake such activities.
- At or around 12.15pm a patient arrived, saying that - they had received an appointment confirmation via a social media app. The patient stated that they required treatment for a broken front tooth. It was evident this patient had been booked as an emergency to be seen by the dental nurse as no dentist was scheduled to work at the practice after 10.45am that day.
- Based on the evidence we gathered on the day, the dental nurse was working outside the scope of their qualifications, competence, skills and experience, and prescribed care and treatment, including medicines without being registered with the GDC to do so.
- When we arrived at the practice, we observed a member of staff working at the reception with access to the appointment book and patient care records. The provider told us that this staff member was a friend and they were in the practice only that day and they helped out at the reception. However, the appointment book indicated that they were also present in the practice on 4 and 5 January 2023. The provider could not demonstrate that appropriate recruitment checks, including proof of identity, criminal record checks and satisfactory evidence of conduct in previous employment, had been undertaken for this staff member.

Are services effective?

(for example, treatment is effective)

Our findings

We found that this practice was not providing effective services and was not complying with the relevant regulations.

At the inspection on 6 January 2023 we found the practice was not complying with the relevant regulations.

- The practice did not have systems to keep dental professionals up to date with current evidence-based practice. We found that antimicrobial prescribing was not in line with the relevant guidance (https://cgdent.uk/wp-content/uploads/2021/08/Antimicrobial-Prescribing-in-Dentistry-2020-online-version.pdf) . We found that on 21 December 2022 a patient was prescribed Amoxicillin 500 mg for 7 days to treat acute necrotising ulcerative gingivitis (ANUG). The antimicrobial of choice according to the guidance is Metronidazole 400mg for up to 5 days.
- We found that on 21 December 2022 Amoxicillin 500 mg was prescribed to another patient to 'prevent dry socket'. The guidance states that in the case of an acute periapical infection, antibiotics should only be prescribed as an adjunct to definitive treatment when there is elevated temperature or a diffuse swelling, evidence of systematic involvement and local lymph node involvement. Prevention is not mentioned as a possible justification for antimicrobial prescribing as per guidance.
- Prior to the inspection the practice submitted an antimicrobial audit undertaken on 17 November 2022. According to the audit, the associate dentist had prescribed antibiotics to 17 out of 20 patients for treatment of pain, without additional swelling, temperature or lymph node involvement. Similarly, according to the audit, the principal dentist had prescribed antibiotics to 18 out of 20 patients for treatment of pain, without additional swelling, temperature or lymph node involvement. As per the audit, antimicrobial prescribing was not in line with current guidance, which states that antimicrobials are only recommended as an adjunct to definitive treatment where there is elevated temperature, evidence of systemic spread or local lymph node involvement.
- Staff did not obtain patients' consent to care and treatment in line with legislation and guidance. We reviewed clinical records of two patients who had submitted social media reviews and had received dental hygiene treatment at the practice. The clinical records we checked at the practice on the day of inspection indicated that these patients had received treatment from the dental nurse on 10 December 2022 and 21 April 2022. It is clear from the publicly available reviews that both patients were under the impression that they were treated by a dental hygienist. Based on the evidence, it was obvious that the patients were not aware that they were receiving treatment not from a dental hygienist but from a dental nurse, who was not acting within their professional scope of practice.
- The practice did not keep detailed patient care records in line with recognised guidance. We noted that there were no clinical records of treatment carried out for a patient booked in with the dental nurse on 9 December 2022 and for another patient on 10 December 2022. Furthermore, there were no clinical records of treatment for a patient seen by the principal dentist on 21 December 2022.

Are services caring?

Our findings

We found that this practice was not providing caring services and was not complying with the relevant regulations.

At the inspection on 6 January 2023 we found the practice was not complying with the relevant regulations.

- Staff did not help patients to be involved in decisions about their care. Patients were not given clear information to help them make informed choices about their treatment.
- When being treated by the dental nurse, patients were receiving treatment from a person without the necessary knowledge and understanding of the care and treatment.
- Patients were not given clear information about the dental nurse`s registration status with the GDC and their lack of necessary skills, competence and qualifications.

Are services responsive to people's needs?

Our findings

We found that this practice was not providing responsive care and was not complying with the relevant regulations.

At the inspection on 6 January 2023 we found the practice was not complying with the relevant regulations.

- The practice did not organise and deliver services to meet patients` needs and preferences. The dental nurse, with the knowledge of the principal dentist, provided treatment including dental hygiene treatment, issued prescriptions, and undertook examinations and dental radiographs that were clearly outside the scope of their professional practice as set out by the GDC.

Are services well-led?

Our findings

We found that this practice was not providing well-led care and was not complying with the relevant regulations.

At the inspection on 6 January 2023 we found the practice was not complying with the relevant regulations.

The practice staff did not demonstrate a transparent and open culture in relation to people's safety.

- Our discussions with staff, and their actions, including the principal dentist's actions revealed that the practice was not open and transparent with the people using the service. The appointment book on the computer screen, showing the dental nurse's appointments was deactivated by the principal dentist during the inspection. This was re-instated after the inspection team's request.
- The practice did not have adequate systems in place for recognising, assessing and mitigating risks arising from the staff member acting outside their scope of practice.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. Not all of the people providing care and treatment had the qualifications, competence, skills and experience to do so safely. In particular: • We observed a dental nurse providing treatment outside her professional scope of practice as set out by the GDC. • The dental nurse provided dental care and treatment, including dental hygiene treatment, issued prescriptions, and undertook examinations and dental radiographs without being registered to do so. • There were no clinical notes for several appointments undertaken by the dental nurse. • A patient had been booked to receive emergency dental treatment at a time when otherwise no dentist was scheduled to work at the practice. It was evident that the patient was booked in to be seen by the dental nurse. **Regulation 12 (1)**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Patients were not given clear information to help them make informed choices about their treatment.

This section is primarily information for the provider

Enforcement actions

Regulation 11 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There were no systems or processes that enabled 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 practice did not have adequate systems in place for recognising, assessing and mitigating risks arising from the staff member acting outside their scope of practice. There were no systems or processes that enabled the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular: • We noted that there were no clinical records of treatment carried out for a patient booked in with the dental nurse on 9 December 2022 and for another patient on 10 December 2022. Further, there were no clinical records of treatment for a patient seen by the principal dentist on 21 December 2022. There were no systems or processes that ensured the registered person had maintained securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity or activities. In particular: The provider could not demonstrate that appropriate recruitment checks, including proof of identity, criminal record checks and satisfactory evidence of conduct in previous employment, had been undertaken for all staff. There was additional evidence of poor governance. In particular:

This section is primarily information for the provider

Enforcement actions

The practice did not organise and deliver services to meet patients` needs and preferences. The dental nurse, with the knowledge of the principal dentist, provided treatment including dental hygiene treatment, issued prescriptions, and undertook examinations and dental radiographs that were clearly outside the scope of her professional practice as set out by the GDC.

Regulation 17 (1)