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Elm Park Dental Clinic

Inspection Report

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Overall summary

We carried out this announced inspection on 29 October 2019 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 provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

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

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Elm Park Dental Clinic is in the London Borough of Havering. The practice provides private dental treatments to adults over 18 years.

The practice is located close to public transport services. The practice is located on the ground floor of a purpose adapted building and has two treatment rooms.

The dental team includes the principal dentist, one associate dentist and one dental nurse. The principal dentist is also the practice manager.

The practice is owned by an individual who is the principal dentist there. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

Summary of findings

We collected feedback from 12 patients who completed CQC comment cards.

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

The practice is open between:

10am and 7pm on Mondays to Saturdays.

Our key findings were:

- The practice appeared clean.
- The provider had suitable safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider had thorough staff recruitment procedures.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The appointment system took account of patients' needs.
- The provider dealt with complaints positively and efficiently.
- The provider had suitable information governance arrangements.
- Staff provided preventive care and supported patients to ensure better oral health and clinical staff provided patients' care and treatment in line with current guidelines. Improvements were needed so that detailed records in relation to assessment, care and treatment were maintained .
- The provider infection control procedures were not consistent with published guidance.
- Staff lacked knowledge of how to deal with medical emergencies and some emergency equipment was not set up ready for use. Some items of emergency equipment were not available on the day. These were ordered and procured promptly and were available for use.
- There were ineffective systems to manage risk to patients and staff.
- Improvements were needed to the arrangements for assessing and providing adjustments to meet the needs of people with disabilities.
- There was ineffective leadership and a lack of systems to support continuous improvement.

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:

- Take action to ensure dentists are aware of the guidelines issued by the British Endodontic Society for the use of dental dam for root canal treatment.
- Review the practice protocols regarding audits for prescribing of antibiotic medicines taking into account the guidance provided by the Faculty of General Dental Practice.
- Take action to ensure the clinicians take into account the guidance provided by the Faculty of General Dental Practice when completing dental care records.

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?	**Requirements notice** ✖
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 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 Requirement Notice 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)

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw evidence that all staff received safeguarding training to an appropriate level for their roles and responsibilities. The principal dentist was the safeguarding lead and they had undertaken additional training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC.

The provider had a whistleblowing policy. Staff felt confident they could raise concerns without fear of recrimination.

The principal dentist did not follow guidance from the British Endodontic Society when providing root canal treatment. They told us that they did not use dental dams and they did not record risks, or other methods used to protect patients' airways when carrying out treatments.

The provider had a business continuity plan to deal with events that could disrupt the normal running of the practice.

The provider had a recruitment policy and procedure to help them employ suitable staff. These reflected the relevant legislation. We looked at each of the three staff recruitment records. These showed the provider followed their recruitment procedure. Appropriate checks including Disclosure and Barring Service (DBS) checks (where required), proof of identity and proof of suitable conduct in previous employment were carried out.

We noted that clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover. There were systems to monitor this.

There were ineffective systems to ensure that equipment was maintained according to manufacturers' instructions.

There was a fire safety risk assessment, which was last carried out in November 2019. Evacuation procedures and fire safety posters were displayed throughout the premises.

There were no records to show that fire extinguishers were tested or serviced or that the fire alarm and emergency lighting systems were checked by staff. Following our inspection the principal dentist told us that safety and validation tests were booked for the fire extinguishers and that periodic checks were carried out for the fire alarms and emergency lighting.

There was a three year radiological test certificate for the dental X-ray equipment. However no annual electrical and mechanical tests had been carried out for the X-ray equipment and the principal dentist was unaware that these tests should be carried out. These tests were carried out shortly after our inspection and the principal dentist told us that they had implemented systems to ensure that they were conducted every year.

We noted that the dentists did not record the justification for taking dental radiographs, the grade of dental X-rays or report on their findings. There were no arrangements to audit the quality of dental radiographs following current guidance and legislation.

The principal dentists told us t they and the associate dentist completed continuing professional development (CPD) in respect of dental radiography. Records for this training were not available on the day of the inspection. Following this inspection the principal dentist told us training was booked for both dentists in November 2019.

Risks to patients

There were ineffective systems to assess, monitor and manage risks to patient safety.

The practice's health and safety policies, procedures and risk assessments were reviewed regularly and accessible to staff. However a number of procedures, guidelines and protocols were not embedded into practice or followed to help manage potential risk.

Are services safe?

The provider had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The staff followed relevant safety regulation when using needles and other sharp dental items. Risks associated with the use and disposal of dental sharps were assessed and systems were in place to mitigate these.

Improvements were needed to the systems to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked. We noted that while all clinical staff had appropriate vaccination, two dental nurses did not have records to demonstrate their immune response or that they had sufficient immunity.

Staff had completed training in emergency resuscitation and basic life support (BLS). Improvements were needed to ensure that staff were confident and competent in using medical emergency equipment and medicines.

Staff did not carry out checks to ensure that emergency medicines and equipment were available as described in recognised guidance. There was insufficient oxygen available to be able to deliver the required 15 Litres per minute, as there were only three small oxygen cannisters available with a combined volume of 21 Litres. There were no oxygen tubing, oxygen masks and no self-inflating bag with reservoir. There was no portable suction equipment. The medicine used to treat seizures was not in the appropriate format. These items were ordered on the day of the inspection and were available at the practice shortly after our inspection visit.

The automated external defibrillator (AED) was not set up and ready for use. We noted that the AED battery pack was not inserted. These items were ordered on the day of the inspection and were available at the practice shortly after our inspection visit. The principal dentist told us that they were reviewing staff training needs and that a training update in basic life support was scheduled.

A dental nurse worked with the dentists when they treated patients in line with General Dental Council (GDC) Standards for the Dental Team.

There were suitable numbers of dental instruments available for the clinical staff and measures were in place to ensure they were decontaminated and sterilised appropriately.

The provider had a policy for handling and storing substances used that are hazardous to health. There were suitable risk assessments to minimise the risk that can be caused from exposure to these substances.

The provider had an infection prevention and control policy and procedures. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health and Social Care. Staff completed infection prevention and control training and received updates as required.

The provider had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. The records showed equipment used by staff for cleaning and sterilising instruments was checked daily. An annual validation and maintenance test for the sterilising equipment was carried out on the day of our inspection. We noted this test had not been carried out in 2018 in line with the manufacturer's guidance. The principal dentist told us they would implement measures to ensure these tests were carried out annually.

We found staff had systems in place to ensure that any work was disinfected prior to being sent to a dental laboratory and before treatment was completed.

The practice did not have suitable procedures to reduce the possibility of Legionella or other bacteria developing in the water systems. There was no Legionella risk assessment and there were ineffective arrangements for flushing or disinfecting the dental unit water lines. There were no arrangements to ensure that the electric hot water heater was tested and no monitoring hot and cold water temperatures. On the day of our inspection we checked the hot water temperature, and this was 36 degrees Celsius and below the recommended temperature of 50 degrees Celsius, which reduces the risk of Legionella or other bacterial growth.

We saw cleaning schedules for the premises. The practice was visibly clean when we inspected.

Are services safe?

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

The dental nurse carried out infection prevention and control audits, however, these were carried out annually and not twice a year as recommended in guidance. The audits we saw were incomplete and there were no action plans to show how and by when issues for improvement would be addressed.

Information to deliver safe care and treatment

The practice had arrangements to ensure that patients' personal information was kept securely, and the use and storage of this data complied with General Data Protection Regulation (GDPR) requirements.

Safe and appropriate use of medicines

Improvements were needed to the systems for appropriate and safe handling of medicines.

There were ineffective stock control systems to check medicines which were held on site to ensure that medicines did not pass their expiry date and enough medicines were available if required.

Improvements were needed so that antimicrobial prescribing audits were carried out taking into account the guidance provided by the Faculty of General Dental Practice.

Track record on safety and Lessons learned and improvements

The practice maintained a log of safety incidents. The principal dentist told us that safety incidents and learning arising from these would be discussed with the practice team during practice meetings.

There were policies and procedures for reviewing and investigating when things went wrong. These included arrangements to learn, share lessons and identify themes to improve safety in the practice. The principal dentist told us that there had been no safety incidents at the practice within the previous 12 months.

There were no systems for receiving and acting on safety alerts. The principal dentist was unaware of their responsibility to ensure that safety information such as external safety events as well as patient and medicine safety alerts are received, reviewed and acted on to monitor and where appropriate improve safety and reduce risks to patients and staff.

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 clinicians kept up to date with current evidence-based practice through training, and reviewing relevant guidance. The principal dentist told us they assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance. However dental care records which we sampled and reviewed with the dentist did not include detailed information in relation to the assessments carried out.

Helping patients to live healthier lives

The principal dentist told us the practice was providing preventive care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The principal dentist told us that they prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for patients based on an assessment of the risk of tooth decay. They told us, where applicable, they discussed smoking, alcohol consumption and diet with patients during appointments.

The principal dentist described to us the procedures they used to improve the outcomes for patients with gum disease, such as providing patients with preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition. They told us that patients with more severe gum disease were recalled at more frequent intervals for review and to reinforce home care preventative advice. However, dental records which we sampled and reviewed with the dentist showed there were no records made of the assessments as described by the principal dentist, discussions with patients about promoting and maintaining oral health or details of frequent reviews to monitor patients with advanced gum disease.

The practice provided health promotion leaflets to help patients with their oral health.

Consent to care and treatment

The practice team understood the importance of, obtained and recorded patients' consent to treatment in line with current legislation and guidance.

The practice's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who might not be able to make informed decisions.

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

Improvements were needed so that the dentists kept detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories.

Effective staffing

The dentists had personal development plans which included details of current and planned training and learning. Improvements were needed so that there were systems to ensure that all staff undertook appropriate training and training updates in areas such as basic life support and dental radiography.

Co-ordinating care and treatment

The principal dentist could not demonstrate they had a good understanding in relation to systems for referring patients to a range of specialists in primary and secondary care if they needed routine or urgent treatment the practice did not provide.

There were no procedures or protocols to identify, manage and where required refer patients for specialist care when presenting with dental infections.

There were no systems for referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist.

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

The practice had procedures and staff were aware of their responsibility to respect people's diversity and human rights.

Patients commented positively that staff were welcoming, helpful, considerate and caring.

They said that the clinical team were excellent, professional and that the care and treatment they received was outstanding and first class. We saw that staff treated patients respectfully and were helpful and welcoming towards patients at the reception desk and over the telephone.

Privacy and dignity

Staff respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting was open plan in design. The staff team were mindful of this when dealing with patients in person or on the telephone so as to maintain privacy. If a patient asked for more privacy, staff would take them into another room.

The reception computer screens were not visible to patients and staff did not leave patients' personal information where other patients might see it.

Staff stored paper records securely.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care and were aware of

the requirements under the Equality Act to ensure that patients understood their care and treatment. The practice provides private dental treatment to adults over 18 years old, the majority of who are of Eastern European or Russian origin, who may experience difficulties accessing services. Information could be made available in large fonts if needed.

Staff gave patients clear information to help them make informed choices about their treatment. The dentists described the conversations they had with patients to satisfy themselves they understood their treatment options.

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

The principal dentist described to us the methods they used to help patients understand treatment options discussed. These included for example, photographs, models and X-ray images.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We found that 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. It took account of patient needs and preferences.

Staff were clear on the importance of emotional support needed by patients when delivering care.

Staff understood the needs of more vulnerable members of society such as adults and children with a learning difficulty and people living with dementia.

Patients described high levels of satisfaction with the responsive service provided by the practice. They commented that they could access appointments in a timely way and that the practice met their needs.

Improvements were needed so that a disability access audit is completed to ensure the service takes into account so far as practicable, the needs of patients with disabilities and to give consideration to the provision of equipment to assist patients with visual or hearing impairment. There was step free access to two dental treatment rooms on the ground floor. The size and layout of the building did not afford the provision of disabled access toilet facilities and patients were informed of this where required.

Timely access to services

Patients could access care and treatment from the practice within an acceptable timescale for their needs.

The practice displayed its opening hours on the practice website.

The practice had an appointment system to respond to patients' needs. Patients who requested an urgent appointment were, where possible, seen on the same day. Patients commented that they had enough time during their appointment and did not feel rushed.

The practice's answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open.

Listening and learning from concerns and complaints

The provider had policies providing guidance to staff on how to handle a complaint and information for patients which explained how to make a complaint.

The principal dentist was responsible for dealing with these. Staff told us they would tell the principal dentist about any formal or informal comments or concerns straight away so patients received a quick response.

The practice aimed to settle complaints in-house and would invite patients to speak with them in person to discuss these. Information was available about organisations patients could contact if not satisfied with the way their concerns had been dealt with.

Staff told us that there had been no complaints made within the previous 12 months.

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 Enforcement Actions 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

The practice comprised of the principal dentist, one associate dentist and one dental nurse. The principal dentist was lead for the majority of clinical and non-clinical responsibilities within the practice. We found there was a lack of systems and leadership which impacted on the principal dentists' capacity to deliver high-quality, sustainable care. There were ineffective arrangements for continuous review and to make improvements as required.

Culture

The practice had a culture to support the delivery of patient focused care and treatment, in particular to patients of Eastern European origin who may experience difficulties in accessing services due language barriers.

The practice had arrangements to support staff to deliver these objectives.

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

The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour. Openness, honesty and transparency were demonstrated in conversations we had with the staff team and the procedures in place to respond to incidents and complaints.

Staff could raise concerns and were encouraged to do so, and they had confidence that these would be addressed.

Governance and management

There were clear staff responsibilities, roles and accountability identified. The principal dentist was responsible for the clinical leadership and the day-to-day running of the practice and this had impacted on their ability to manage in some areas.

There were policies, protocols and procedures which were reviewed and accessible to staff. However, some key policies were not fully understood or embedded into practice. This resulted in ineffective processes for assessing and managing risks and ensuring that some guidance and legislation was adhered to.

Appropriate and accurate information

The provider had information governance arrangements. Staff undertook training and staff were aware of the importance of these in protecting patients' personal information.

Engagement with patients, the public, staff and external partners

The practice had arrangements to include the views of patients and staff to support patient focused services. Patients who used the service were encouraged to give feedback on their level of satisfaction with the care and treatment they received.

The provider gathered feedback from staff through informal discussions and meetings.

Continuous improvement and innovation

There were ineffective systems and processes to support learning and continuous improvement.

The provider did not have suitable arrangements to audit areas such as dental radiography or infection prevention and control procedures as part of a system to assess and improve the safety and quality of services provided.

Documented guidelines and protocols were not fully understood or followed in relation to maintaining accurate and detailed dental care records or ensuring safe and appropriate patient referrals for urgent and routine treatments.

There was a lack of oversight to ensure that staff completed the 'highly recommended' training as per General Dental Council professional standards. The provider did not have systems to ensure that staff undertook suitable training in dealing with medical emergencies and basic life support, or that relevant staff were up to date with training in dental radiography.

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 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: • There were ineffective systems to deal with medical emergencies and ensure that staff were skilled, competent and had access to the recommended medicines and equipment to manage medical emergencies safely. • There were ineffective arrangements to safely manage medicines and no protocols for dispensing and prescribing medicines. • There were ineffective systems to assess and manage risk of Legionella. There was no risk assessment or effective water management systems. • There were ineffective arrangements for referring patients to other specialists or professionals for urgent and routine treatment. Regulation 12 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

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 were ineffective arrangements to ensure ongoing fire safety management. The fire extinguishers were old and had not been tested or validated. There were no arrangements to regularly test the fire alarm or the emergency lighting systems.

- There were ineffective arrangements and systems for checking and monitoring equipment taking into account relevant guidance and ensure that all equipment is well maintained. In particular there were no annual electrical and mechanical tests carried out for the dental X-ray equipment and there were no tests carried out for the hot water heaters.

- There were ineffective systems for assessing and monitoring the safety and quality of services provided. In particular;

  There were no audits of dental radiographs to assess and improve the quality and to ensure compliance with current guidance.

  Infection prevention and control audits were not carried out every six months. Audits where carried out were not complete, did not identify present risks and there were no action plans to address areas where improvements were needed.

This section is primarily information for the provider

Requirement notices

- There were ineffective arrangements to ensure that staff undertook suitable training, relevant to their roles and responsibilities. In particular;

  Staff did not have practical training in dealing with medical emergencies and could not demonstrate that they were confident in using emergency medicines and equipment

  The dentists did not have up to date training in dental radiography.

- There were ineffective arrangements to ensure that all clinical staff have adequate immunity for vaccine preventable infectious diseases.

- There were ineffective systems for receiving and responding to patient safety alerts, recalls and rapid response reports issued by the Medicines and Healthcare products Regulatory Agency, the Central Alerting System and other relevant bodies, such as Public Health England.

- There were no arrangements to assess and make reasonable adjustments for people with disabilities and the provider was unaware of their responsibilities in regard to this and the provision of the Equality Act 2010.

Regulation 17 (1)