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Grove Dental Surgery

Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 3 October 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.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.
- 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.

Summary of findings

- The practice had information governance arrangements.
- The practice had infection control procedures which broadly reflected published guidance.
- Staff knew how to deal with medical emergencies. However, not all of the life-saving equipment and medication was available as per national guidelines.
- The practice had some systems to manage risks for patients, staff, equipment and the premises, however these were not documented effectively.
- The practice did not have staff recruitment procedures which reflected current legislation.
- The leadership, and oversight of the day-to-day management of the service needed improvements.
- Staff generally worked as a team. Improvements were needed to ensure that they were supported and involved in the delivery of care and treatment.
- Improvements were needed to ensure that clinical staff kept up to date with current guidelines, and information related to patient care was suitably recorded within the dental care records.
- There were ineffective systems to ensure that staff were up to date with their training.
- There were ineffective systems to support continuous improvement.

Background

Grove Dental Surgery is in the London Borough of Kensington and Chelsea and provides predominantly NHS dental care and treatment for adults and children.

There is step free access to the practice for people who use wheelchairs and those with pushchairs. Car parking spaces, including dedicated parking for disabled people, are available near the practice. The practice has made reasonable adjustments to support patients with access requirements.

The dental team includes the principal dentist, 7 associate dentists, 1 qualified dental nurse, 1 trainee dental nurse, 1 practice manager and 2 receptionists. The practice has 4 treatment rooms.

During the inspection we spoke with 1 dentist, the dental nurse, the trainee dental nurse, 1 receptionist and the practice manager. We also spoke with the principal dentist remotely. We looked at practice policies, procedures and other records to assess how the service is managed.

The practice is open:

Monday to Friday from 9.15 to 6pm.

We identified regulations 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.
- Ensure specified information is available regarding each person employed.

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:

Summary of findings

- Improve the practice’s infection control procedures and protocols taking into account the guidelines issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, and having regard to The Health and Social Care Act 2008: ‘Code of Practice about the prevention and control of infections and related guidance’.
- Improve the practice's protocols and procedures for the use of X-ray equipment in compliance with The Ionising Radiations Regulations 2017 and Ionising Radiation (Medical Exposure) Regulations 2017 and taking into account the guidance for Dental Practitioners on the Safe Use of X-ray Equipment.
- Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the College of General Dentistry.
- Improve the practice protocols regarding auditing patient dental care records to check that necessary information is recorded.

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 we were not assured that all staff had undertaken appropriate training in safeguarding vulnerable adults and children. Following the inspection the provider sent evidence that all members of staff had carried out training at a level appropriate to their role. Improvements were required to ensure up to date details of the local authority safeguarding teams were available to all staff.

The practice had infection control procedures which broadly reflected published guidance. Packaged, sterilised instruments were not always labelled to indicate the date by which they should be used by or which they should be subject to a further decontamination cycle in accordance with guidance with the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health. In addition, local anaesthetic cartridges were not stored in their blister packs up to the point of use to prevent contamination, and data from the autoclave logger was not stored securely after it was viewed.

The practice did not have adequate procedures to reduce the risk of legionella or other bacteria developing in water systems. Recommendations made in the legionella risk assessment from May 2023 and June 2020 had not been actioned. In particular, an annual inspection of the hot water storage vessel had not been carried out. The practice manager told us that hot and cold water outlets were temperature tested monthly but there were no records to demonstrate this. The latest risk assessment noted that there were 3 hot water outlets where the temperature did not reach the recommended threshold of 55 degrees Celsius. There was no written scheme of control as required by the Health and Safety Executive's Approved Code of Practice (ACOP) L8 "Legionnaires' disease: The control of legionella bacteria in water systems". Following our inspection, we were sent evidence that the provider had taken immediate action to implement the recommendations. On inspection we noticed an infrequently used water outlet within the internal waste cupboard. The practice manager told us this was not flushed weekly as recommended by ACOP L8. However, in mitigation, the risk assessor had not identified this outlet at their inspection in May 2023.

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 did not have a recruitment policy and procedure in accordance with relevant legislation. Recruitment checks had not been carried out, in accordance with relevant legislation to help them employ suitable staff. In particular, the provider had not obtained satisfactory evidence of conduct in previous employment for any staff members. On the day of inspection we looked at all staff records and found all to be missing parts of information required in respect of persons employed or appointed for the purposes of a regulated activity as per Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection, we received some documentary evidence of recruitment checks but were still missing 5 Disclosure and Barring Service (DBS) checks, 2 proofs of identity including a recent photograph, 5 employment histories and there was no evidence of immunity to Hepatitis B for 2 staff members.

Clinical staff were qualified, registered with the General Dental Council (GDC) and had professional indemnity cover. However, documentary evidence of GDC registration was unavailable for 3 clinical members of staff.

Are services safe?

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. Evidence of Portable Appliance Testing (PAT) was unavailable on the day of inspection, but the inspection team were shown messages from the electrician who had carried out the tests and agreed to return to the location to provide the necessary documentation.

We were shown evidence that the fire alarms, emergency lighting and fire-fighting equipment were maintained in line with legal requirements, however the provider did not have effective fire safety management processes in place. In particular, there was no evidence to demonstrate that the fire risk assessment had been carried out by a person who had the qualification, skills, competence and experience to do so. We were told that the fire detection system and emergency lighting were regularly tested, however there were no records to demonstrate this. In addition, there were no records to demonstrate that fire drills had been carried out. There was only 1 person who had received fire safety training at the time of inspection.

The practice had arrangements to ensure the safety of the X-ray equipment. On the day of inspection, some of the required radiation protection information was not available. In particular there was no evidence of registration with the Health and Safety Executive (HSE) for working with ionising radiation. Since the inspection, the practice completed the registration process. Rectangular collimators had not been fitted as recommended within national guidance, and highlighted in the three-yearly X-ray performance testing reports on three of the intra-oral X-ray units. Following the inspection, we were sent evidence that the collimators had been fitted and staff were to be instructed in the importance of their use to reduce the amount of radiation patients are exposed to during x-ray procedures.

Risks to patients

The practice had implemented some systems to assess, monitor and manage risks to patient and staff safety, this included sharps safety. Staff told us that a contracted cleaner worked alone outside surgery opening hours. Following the inspection, we were sent lone-working guidance written by the contractor, but a site-specific policy had not been considered by the provider to identify and mitigate the possible risks arising from working alone.

Staff had not completed sepsis awareness training. Sepsis prompts to assist the staff to triage appointments and patient information posters were not available within the practice. We discussed the advantages of staff undertaking sepsis awareness training to ensure they were able to triage patients with sepsis symptoms correctly. Following the inspection all staff members carried out appropriate training.

Not all emergency equipment and medicines were available. There was no glucagon, a medicine used to treat low blood sugar and there were no oropharyngeal airways or portable suction. In addition, there was no paediatric oxygen mask. The provider did not effectively use the monitoring system in place to check emergency drugs and equipment. The checks were only carried out monthly. National guidance states that the frequency of checks depend on local circumstances but should be at least weekly. Following our inspection, the provider obtained glucagon.

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 some risk assessments to minimise the risk that could be caused from substances that are hazardous to health. However we were not assured that these were regularly reviewed or easily accessible to all staff.

Information to deliver safe care and treatment

Patient care records were legible, kept securely and complied with General Data Protection Regulation requirements. We noted that records were not always complete. In particular justification and reporting of radiographs was not always recorded and discussions not always documented. Templates were available to ensure detailed records were written but we noted that these were not populated effectively to include important information such as risk assessments or social histories. In addition, treatment options were not always recorded.

Are services safe?

The practice had systems for referring patients with suspected oral cancer under the national two-week wait arrangements.

Safe and appropriate use of medicines

Improvements were required to the current system for appropriate and safe handling of medicines. We saw prescriptions were not monitored as described in current guidance produced by NHS Counter Fraud Authority to prevent fraudulent misuse. Antimicrobial prescribing audits were not carried out. We observed that current antimicrobial prescribing guidance from the College of General Dentistry (CGDent) was not being followed. In particular we saw that 7-day courses of antibiotics were routinely given without justification.

Track record on safety, and lessons learned and improvements

The practice had a system for receiving and acting on safety alerts but on the day of inspection, the practice manager could not demonstrate how these were recorded or actioned. The practice had a system to review and investigate incidents and accidents although there were no recent records to view.

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 which required improvement to keep dental professionals up to date with current evidence-based practice. Current guidance from the British Society of Periodontology had not been implemented. In particular patients were not diagnosed according to current staging and grading and Basic Periodontal Examinations were not always carried out upon children over the age of 7.

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

Improvements were needed to ensure all clinicians kept detailed dental care records in line with recognised guidance. In particular, we noted that radiographs were not always justified or reported on and some records omitted details of discussions. Dental care record audits were not carried out.

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.

Evidence was not available to demonstrate the dentists justified, and reported on the radiographs they took. The practice had not carried out radiography audits six-monthly following current guidance and legislation. We saw that radiographs were graded but improvements were required to ensure the current radiographic grading system was used.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. However we saw limited evidence that inductions were carried out for newly appointed staff. The practice did not have systems in place to ensure clinical staff had completed continuing professional development (CPD) as required for their registration with the General Dental Council. In particular, there were no training logs available for any staff and on the day of inspection, a large proportion of recent training certificates were not available for review. Following the inspection, the provider submitted training certificates. The provider was not aware that all healthcare employees should receive autism and learning disability awareness training according to the Health and Care Act 2022. Following the inspection, we received evidence that training appropriate to their roles had been undertaken.

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.

On the day of inspection, patients told us that it was easy to book appointments and they were treated with kindness and care.

Patients said staff were compassionate and understanding when they were in pain, distress or discomfort.

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.

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. Improvements were required to ensure translation services were made available when deemed necessary.

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

The dentist explained the methods they used to help patients understand their treatment options. These included for example photographs, study models, X-ray images and an intra-oral 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 a ramp and wheelchair accessible toilet for patients with access requirements. A disabled parking bay is located at the side of the building. 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 and patient information leaflet.

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

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. Improvements were required to ensure complaints were documented effectively to assess trends and shared with the wider team.

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 noted that all staff members worked well together. Improvements were needed to improve oversight at the practice which had suffered recently due to staff turnover, and to ensure information about systems and processes was readily available and embedded in the day to day running of the practice. The inspection highlighted some issues and omissions such as relating to medical emergency equipment, the management of Legionella, recruitment procedures and governance. Following our inspection feedback, the provider agreed to provide assistance to the practice manager through extra staffing and personal support.

The information and evidence presented during the inspection process was poorly organised and much documentation was unavailable. Following the inspection, we requested the missing evidence and were sent a significant number of documents.

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.

There were no recent records to demonstrate that individual training needs had been discussed. The practice manager told us that staff appraisals had not taken place due to time constraints. We received evidence that staff training was up-to date but some of it had been completed in the days after our inspection. Systems were required to ensure that staff training remains up-to-date in the future.

Governance and management

The practice's management and governance structure required improvements. The practice policies and procedures were not reviewed or monitored effectively to ensure that they reflected current guidance and legislation. For example, there was no recruitment or whistleblowing policy. The infection prevention and control policy stated that Hepatitis B immunity records were maintained securely, but this was not evident on inspection. We were not assured that staff had access to policies and protocols. The practice had some processes for managing risks but improvements were required.

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.

Feedback from staff was obtained through meetings and informal discussions. The content of practice meetings was not documented to ensure decisions were actioned and reflective learning was applied. 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

Are services well-led?

The practice had some systems and processes for learning, quality assurance, continuous improvement. These included audits of disability access, and infection prevention and control. Staff kept records of the results of these audits and the resulting action plans and improvements. Radiographic audits had not been carried out by the time of the inspection but following the inspection, 2 clinicians submitted radiographic audits which required improvements as only 10 radiographs were sampled. Guidance states that 100 radiographs should be sampled unless the radiographic workload is too low to support this number.

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 Transport services, triage and medical advice provided remotely	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: • The practice policies and procedures were not reviewed or monitored effectively to ensure that they reflected current guidance and legislation. • There were ineffective systems to monitor staff training and to ensure that staff undertook periodic training updates in accordance with relevant legislation and guidelines. • Audits of radiographs were not carried out in accordance with current guidance and legislation. • There were ineffective systems in place for reviewing alerts and complaints. 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.

This section is primarily information for the provider

Requirement notices

- The risks associated with water systems were not effectively reviewed and mitigated.
- The fire risk assessment had not been carried out by a person competent to do so.
- Not all staff had received fire safety training.
- There was no evidence of in-house fire safety equipment checks or drills.
- There were ineffective systems for monitoring the medicines and equipment used for the treatment of medical emergencies taking into account relevant guidance. The checks failed to identify that medicines and equipment needed in the event of a medical emergency were missing.
- There was no system to track and monitor NHS prescriptions.
- The governance in relation to radiation safety had not been fully considered, in particular, the provider could not demonstrate evidence of registration with the Health and Safety Executive for the use of ionising radiation.

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:

- The recording of the justification and reporting of radiographs was not always present.
- There was a lack of consistency and detail in the information recorded in the dental care records.

Regulation 17 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 19 Fit and Proper Persons Employed**

This section is primarily information for the provider

Requirement notices

The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed. In particular:

- There were no records in respect of conduct in previous employment (references) for any members of staff.
- There was no record to prove the identity for 2 members of staff.
- Evidence of hepatitis B immunity was unavailable for 2 members of staff.
- A full employment history, together with a satisfactory written explanation of any gaps in employment was not available for 5 staff members.
- Disclosure and Barring Service (DBS) checks had not been carried out for 5 members of staff.
- There was no evidence of professional registration for 3 clinicians.

Regulation 19 (3)