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East Finchley Smiles

Inspection report

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Overall summary

We carried out this announced inspection on 22 April 2021 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 Care Quality Commission, (CQC), inspector who was supported by a specialist dental adviser.

To consider the concerns we received we asked the following questions.

• Is it safe?

• Is it well-led?

These questions form the framework for the areas we look at during the inspection.

Our findings were:

Are services safe?

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

Are services well-led?

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

Background

East Finchley Smile is in Barnet and provides NHS and private dental care and treatment for adults and children.

Summary of findings

The practice is owned by an individual. 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.

During the inspection we spoke with the Nominated Individual, one dentist, one dental nurse and the receptionist.

Our key findings were:

- The provider had safeguarding processes but not all staff had training for safeguarding vulnerable adults and children.
- The provider had infection control procedures which reflected published guidance including guidance related to the management of COVID-19. However, these were not being monitored to ensure that they were fully understood and adhered to.
- The provider had staff recruitment procedures which reflected current legislation. Improvements were needed to ensure that important checks were carried out to determine the suitability of all staff who worked at the practice.
- The provider had ineffective leadership to support a culture of openness and continuous improvement.
- There were ineffective governance systems to monitor the day-to-day running of the practice.
- The provider had ineffective arrangements to ensure that staff undertook important recommended training in relation to their roles within the practice.

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 is not meeting are at the end of this report.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**Enforcement action** 
Are services well-led?	**Enforcement action** 

Are services safe?

Our findings

We found this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement 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.

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

There were ineffective systems to keep patients and staff safe.

The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. However, not all staff had received appropriate safeguarding training.

The provider had an infection prevention and control policy and procedures in line with 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. However, these and specific procedures in relation to the provision of aerosol generating procedures (AGPs) were not being followed/monitored to ensure that systems were robust to keep patients and staff safe.

The provider told us that the fallow time (period allocated to allow aerosol to settle) was 20 minutes. We asked them how this time had been calculated based upon the guidelines within current standard operating procedures.

They were not able to provide assurance that these operating procedures had been followed to assess air changes within the treatment rooms upon which a suitable and safe fallow period had been determined.

We looked in two dental treatment rooms. We found that the work surfaces were cluttered with items and paperwork. This meant that the provider could not be assured that cleaning procedures employed were effective, including the cleaning of any aerosol matter generated during dental treatments.

There was several out of date materials found in both surgeries and the stock cupboard.

Two vias of out of date local anaesthetic was found in one of the surgeries draws.

An Infection prevention and control audit had been carried out in October 2020 to monitor infection control practices and procedures.

There were ineffective systems to ensure that equipment used at the practice to deliver care and treatment was maintained, tested and serviced to ensure its safe and proper working.

We asked to see records in relation to the installation and maintenance of the dental X-Ray equipment such as Critical Examination and Acceptance test and the yearly electrical and mechanical testing for the two Intra oral X-ray units. The provider was unable to provide these documents and not able to tell us when these tests were carried out.

The X-ray unit in surgery one had a clear tape around the arm of the unit. We observed that the tape was visibly dirty. We checked the practice Local rules. This document did not identify who, if any, was the appointed Radiation Protection Advisor or the Radiation Protection Supervisor.

The provider did not have appropriate recruitment procedures to help them employ suitable staff. We looked at 12 staff recruitment records. Not all references had been sought for clinical staff. Not all checks had been conducted for the newly appointed staff. Disclosure and Barring Service checks had not been carried out for all staff.

There were no records to indicate that staff completed an induction to familiarise themselves with the practice environment, policies or procedures. There were no records to show that COVID-19 related screening risk assessments had been carried out for staff. The Nominated Individual said that they were unaware of these having been carried out.

Are services safe?

We observed that clinical staff were qualified and registered with the General Dental Council; however not all nurses had professional indemnity cover.

Risks to patients

The provider did not have effective systems to assess, monitor and manage risks to patient safety.

We looked at the range of emergency medicines and equipment available at the practice. We observed that Diazepam 10mg for intravenous or rectal administration was available in the emergency medicines. The use of Diazepam in the treatment of epileptic seizures in a dental setting is contrary to the Resuscitation Council UK guidelines and General Dental Council standards.

We observed that the medicine used to manage blood sugars in an emergency situation was not stored in a refrigerator. Neither was the expiry date had not been reviewed and reduced in accordance with the manufacturer's guidance to ensure the effectiveness of this medicine.

There was no portable suction equipment available. Patient oxygen was delivered via an oxygen concentrator. The provider was not aware if or when any servicing or calibration tests had been carried out on the equipment.

We asked the provider to demonstrate how the oxygen concentrator equipment was operated in the event of a medical emergency. We observed the staff member that carried out the demonstration, they were. hesitant in operating this equipment. We could not be assured that staff know how to use this machine.

There were ineffective systems to assess and manage the risks of Legionella or other bacteria in the water systems. We noted there were some procedures to reduce the possibility of Legionella or other bacteria developing in the water systems. Staff told us that they disinfected the dental unit waterlines. We asked you if a Legionella risk assessment had been undertaken to assess and mitigate risks. Staff said they were not aware if a risk assessment had been carried out and there were no records available.

We observed that hot water was heated by individual electrical water heaters which were installed in each surgery. There were no records to demonstrate that these heating units were tested or serviced to ensure that they worked properly.

There were ineffective arrangements to mitigate the risk of fire at the practice. We noted that a fire risk assessment had been carried out in September 2020. A number of areas for action were documented within this fire risk assessment. These included replacing ceiling tiles due to their risk of combustion, ensuring that staff undertake fire safety training and that regular fire evacuation exercises are carried out. We asked the provider if these issues had been addressed and they could not tell us what if any actions had been taken. We observed that the ceiling tiles had not been replaced. We noted that staff did not have fire safety training and there were no records available in relation to fire evacuation exercises.

There was one record available to demonstrate that the compressor had been serviced in March 2020. The Nominated Individual could not tell us when or if the compressor was due to be serviced again.

There were ineffective systems in relation to substances hazardous to health in accordance with Control of Substances Hazardous to Health (COSHH) Regulations 2002. There were no risk assessments available to staff to help them manage an accidental exposure to hazardous materials used in the practice.

There was ineffective system in place to ensure clinical staff had received appropriate vaccinations, including vaccination to protect them against the Hepatitis B virus and to check that the effectiveness of the vaccination.

Information to deliver safe care and treatment

The provider did not have a robust system for referring patients with suspected oral cancer under the national two-week wait arrangements. These arrangements were initiated by National Institute for Health and Care Excellence to help make sure patients could access specialist care quickly.

Are services safe?

Track record on safety and Lessons learned and improvements

Improvements were needed to the practice systems for receiving and acting on safety alerts such as those issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies, such as Public Health England (PHE).

The nominated individual could not demonstrate that relevant alerts were reviewed or that there were suitable arrangements in place to share and learn from these.

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

There was a lack of clear leadership and the systems for the day to day monitoring and management of the practice were not effective.

The nominated individual could not demonstrate that they understood their responsibility to lead and manage the dental team.

Culture

There were no systems to monitor staff learning and development needs or to ensure that all staff had undertaken training required to enable them to carry out their roles and duties. We reviewed training records for 12 members of staff. eight members of staff did not have safeguarding training. one of the dentists had not completed training in dental radiography and six of the 12 staff had not completed infection prevention and control training.

Governance and management

There was a lack of clear and effective processes for managing risks.

The practice infection control procedures were not in accordance with current guidance. There were no systems to ensure that staff were following these procedures.

There were ineffective systems to assess and manage risks in relation to areas including fire safety, infection prevention and control and Legionella management.

There were ineffective systems to ensure that equipment, including the compressor and the dental X-ray unit were maintained, tested and serviced in line with the manufacturer's instructions and relevant legislation and guidance.

Th provider did not have systems in place to monitor or follow up on referrals to other dental / health providers where patients required urgent or specialist dental treatments, which the practice did not provide. There were no arrangements to ensure that patients would receive this treatment in a timely manner.

The provider did not have systems in place for receiving, managing and sharing safety alerts such as those reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies, such as Public Health England (PHE).

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. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 17** **Good governance** Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 was a lack of leadership within the practice and the systems to assess and monitor day to day management were not carried out: • There were ineffective governance systems to assess and manage risks in relation to the service. • We identified a number of failings which demonstrated a lack of management, governance and monitoring the service to maintain and improve standards, safety and quality: • The provider did not have systems in place to monitor or follow up on referrals to other dental / health providers where service users required urgent or specialist dental treatments which the practice did not provide. The provider could not be assured that service users would receive this treatment in a timely manner. • The provider did not have systems for effective monitoring and quality improvement of the services provided:

This section is primarily information for the provider

Enforcement actions

- There were no arrangements to assess staff learning and development needs or to ensure that staff undertook required training including continuing professional development (CPD) in accordance with the General Dental Councils *Standards for the Dental team* for clinical staff:

17 (1)

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 **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 12** **Safe care and treatment** The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: • The provider did not have proper arrangements to deal with medical or other emergencies at the practice. • The provider did not have effective radiation protection arrangements at the practice in accordance with relevant legislation and guidance – Ionising Radiation (Medical Exposure) Regulations 2000/2018 (IRMER 2000/2018) and Ionising Radiation Regulations 2017 (IRR 2017): • There were no records to show that a critical examination and acceptance test had been carried out for the dental X-ray equipment. • There was no system in place to ensure infection prevention and control audits are carried out every six months to assess and monitor infection prevention measures at the practice. • A Legionella risk assessment had not been carried out at the practice.

This section is primarily information for the provider

Enforcement actions

- During the inspection visit we checked the hot water temperatures in one surgery. We found that the temperatures for hot water did not reach the temperature required to minimise Legionella growth. There were no records to demonstrate that hot water heaters were tested or serviced to ensure that they worked properly.
- The provider did not have suitable arrangements to monitor and mitigate the risks of fire at the practice.
- A fire risk assessment had been carried out in September 2020. A number of areas for action were documented within this fire risk assessment. These included replacing ceiling tiles due to their risk of combustion, ensuring that staff undertake fire safety training and that regular fire evacuation exercises are carried out.
- Not all staff had completed appropriate fire safety training and there was no evidence to demonstrate that fire evacuation drills had taken place.

The provider does not have effective systems to monitor and maintain equipment and systems for the safe running of the practice:

- There was one record available to demonstrate that the compressor had been serviced in March 2020. The Nominated Individual could not tell us when or if the compressor was due to be serviced again.
- Staff told us they did not have access to information in relation to the handling, storage, and disposal of hazardous materials in accordance with Control of Substances Hazardous to Health (COSHH) Regulations 2002. There were no policies or other information available to staff to help them manage an accidental exposure to hazardous materials used in the practice.

There were ineffective arrangements to assess and minimise risks to patients and staff:

- There were ineffective arrangements to assess and manage risks in relation to COVID-19:
- The provider had ineffective arrangements to ensure that the important checks were carried out when new staff are employed at the practice.

This section is primarily information for the provider

Enforcement actions

- There were ineffective systems to assess and manage risks to staff exposure to Hepatitis B in the absence of confirmation of the effectiveness of vaccination.

12 (1)