Gregory G Lai & Associates

Mr G Lai & Associates - Willesden

Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 22 November 2022 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:

- Staff knew how to deal with medical emergencies. Appropriate medicines and life-saving equipment were available.
- Patients were treated with dignity and respect and staff took care to protect their privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.

Summary of findings

- Staff felt involved and supported and worked as a team.
- Complaints were dealt with positively and efficiently.
- The dental clinic had information governance arrangements.
- The clinical staff generally provided patients' care and treatment in line with current guidelines. Improvements were needed to their knowledge and understanding of the National of Institute of Excellence (NICE) guidelines and consent.
- There were some systems in place to support continuous improvement. However, there was ineffective leadership and a lack of oversight for the day-to-day management of the service.
- The dental clinic did not appear visibly clean and well-maintained.
- The practice did not have infection control procedures which reflected published guidance.
- There were ineffective processes in place to prevent abuse of vulnerable adults and children.
- Risks to staff and patients from undertaking of regulated activities had not been suitably identified and mitigated.
- The provider did not have suitable staff recruitment procedures to comply with current legislation.
- Improvements were needed to the systems and processes for seeking and learning from patient feedback.

Background

The provider Mr G Lai & Associates has three practices and this report is about Mr G Lai & Associates - Willesden.

Mr G Lai & Associates - Willesden is 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.

The practice is not fully accessible to people who use wheelchairs and those with pushchairs. The practice communicated this to new patients before booking and they signposted people with mobility issues to nearby practices.

The dental team includes the principal dentist, an associate dentist, a foundation dentist, a qualified dental nurse, a trainee dental nurse and a receptionist. The practice has 3 treatment rooms.

At the time of inspection there was no registered manager in post as required as a condition of the provider's registration with the Commission.

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

The practice is open:

Monday to Friday 9.30am to 6pm

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.

Summary of findings

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 the clinicians carry out patient assessments and ensure they are in compliance with current legislation and take into account relevant nationally recognised evidence-based guidance.
- Improve and develop staff awareness of the requirements of the Mental Capacity Act 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.
- Implement processes and systems for seeking and learning from patient feedback with a view to monitoring and improving the quality of the service.

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.

The impact of our concerns, in terms of the safety of clinical care, is minor for patients using the service. Once the shortcomings have been put right the likelihood of them occurring in the future is low.

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

The practice did not have effective safeguarding processes to prevent abuse of vulnerable adults and children. Internal safeguarding arrangements were not communicated effectively. One member of staff we spoke with was unaware of safeguarding arrangements within the practice. They told us they would direct patients to the complaints procedure if there was a safeguarding concern.

Safeguarding contact details made available to staff within the Safeguarding policy folder were for Hammersmith and Fulham safeguarding team, though the practice is in Brent, and for a Primary Care Trust (PCT) – an entity that no longer exists.

We noted that one clinical and one non-clinical staff member had not completed safeguarding training at a level appropriate to their role. Safeguarding training certificates for two other clinical members of staff, not available for review on the day of inspection, were provided to us after the inspection, and the principal dentist told us that safeguarding contact details for both adults and children had now been displayed in each surgery. Furthermore, they told us that the importance of safeguarding had been discussed and staff were now aware of how to raise safeguarding concerns.

The provider was failing to assess the risk of, and prevent and control the spread of, infections in accordance with the Department of Health publication 'Health and Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05).

The practice had cleaning schedules in place, however we observed a high level of dust in in the decontamination room that was also cluttered. We noted a kettle, that staff told us was used for making tea for patients and themselves, and a box of chewable vitamins in the dirty zone designated to receive contaminated dental instruments

The practice could not demonstrate that heavy-duty gloves and long handled brushes were replaced as per the manufacturers` recommended intervals.

The practice infection prevention and control policy did not include a detailed decontamination process that staff could refer to. The manual cleaning policy was a generic document that was not tailored to the service. Staff we spoke with gave us conflicting accounts about how used dental instruments were reprocessed. The principal dentist, who was also the infection control lead told us that instruments were scrubbed in the treatment rooms before transportation, while dental nurses told us they scrubbed the instruments in the decontamination area.

There was no evidence that weekly tests on the autoclave were being carried out in line with the manufacturers` guidance.

Following the inspection, the provider submitted photographic evidence that they had now cleaned and de-cluttered the decontamination area and removed the kettle and chewable vitamins from the dirty zone. In addition, the practice had implemented a log to monitor the use of heavy-duty gloves and long-handled brushes used to scrub dirty instruments. The principal dentist told us that moving forward they would ensure that weekly tests on the autoclave were carried out in line with the manufacturer`s recommendations and current national guidance.

Following the inspection, the provider submitted the updated infection prevention and control policy that had been signed by all members of staff. We noted that the updated policy reflected published guidance.

Are services safe?

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

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

The practice recruitment policy and procedures did not reflect the relevant legislation. Disclosure and Barring Service (DBS) checks had not been undertaken at the time of employment for a recently employed member of non-clinical staff and there was no evidence that the risks around this had been considered. In addition, records were not available to show that satisfactory evidence of conduct in previous employment had been sought for all members of staff.

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

The practice had some systems in place to ensure equipment was safe to use, maintained and serviced according to manufacturers' instructions. Portable appliance testing had been undertaken on 18 November 2022. We saw evidence that the autoclave in use had been serviced on 13 April 2022. The practice had another autoclave that the provider told us was out of order. The most recent servicing certificate for this autoclave was dated 6 May 2016. We discussed with the provider that equipment not used for a long period of time and not serviced and maintained as per manufacturer's guidance should be removed from the premises to avoid accidental use.

The annual gas safety checks and the electrical installation condition tests had been carried out in November 2022.

The risks related to fire safety had not been effectively assessed and mitigated. We were provided a fire risk assessment dated 27 April 2022. We noted that it had made a number of recommendations requiring immediate action. This included the installation of suitable fire detectors and alarm system, inspecting all structural fire protection and elements of fire compartmentation, ensuring that all portable fire extinguishers were inspected by a competent contractor annually, keeping a fire safety log and undertaking fire drills. The report stated that the high risk concerns required immediate action as they could result in an increase in the likelihood of fire.

A fire safety log had not been implemented and there was no evidence of periodic in-house testing of the fire safety equipment. A fire drill had been undertaken on 18 November 2022- the first one since the recommendation made in the assessment of April 2022.

A new fire alarm system and smoke detectors had been installed on 18 November 2022.

The fire extinguishers were serviced on 13 June 2022. The fire extinguisher service report recommended that a 20-year-old water extinguisher and the two 10-year-old carbon dioxide extinguishers should be replaced. The provider could not demonstrate that these recommendations had been acted upon. We were provided with an invoice quoting 3 water, 1 powder and 1 carbon monoxide extinguishers, however there was no evidence that these had been delivered and installed at the premises. Following the inspection, the provider told us that they had arranged the out of date fire extinguishers to be replaced on 30 November 2022.

We observed that 2 out of the 4 fire exits were obstructed and cluttered. Following the inspection, the provider submitted photographic evidence that these had now been cleared and the obstructions removed.

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 2000/2018 [IRMER 2000/2018] and The Ionising Radiations Regulations 2017 [IRR 2017].

We saw evidence that the provider had appointed a Radiation Protection Advisor (RPA). The routine survey report for the orthopantomography (OPG) unit dated 16 June 2022 confirmed that the tests were satisfactory. The routine survey results for the intraoral units in Surgery 1 and Surgery 3 stated that the local dose levels 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) to determine a suitable reduction in exposure settings. There was no evidence that the

Are services safe?

provider had acted upon this recommendation. Tests results of the operation and condition of the safety and warning systems, equipment performance, patient entrance dose and operating parameters were not available for the intraoral unit in Surgery 2. This meant that there was no evidence that the intraoral unit in surgery 2 was safe to use. Following the inspection, the provider submitted evidence that they had now booked the 3-year quality assurance survey on the intraoral unit in surgery 2.

Furthermore, there was no evidence of daily, weekly and monthly quality assurance processes for wet-film processing.

Risks to patients

Emergency equipment and medicines were available and checked in accordance with national guidance

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

The provider could not demonstrate that they carried out risk assessments for hazardous materials used within the practice as per Control of Substances Hazardous to Health regulations 2002 (COSHH).

Information to deliver safe care and treatment

Dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation requirements.

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

Safe and appropriate use of medicines

The provider did not have an effective tracking system or log for NHS prescriptions. We noted that only 1 out of the 3 clinicians logged their prescriptions. Following the inspection, the provider submitted evidence that they had implemented an updated prescription log that now included the details of antibiotics prescribed by all clinicians.

The practice had systems for appropriate and safe handling of medicines. Antimicrobial prescribing audits were carried out.

Track record on safety, and lessons learned and improvements

The provider informed us that in the previous 12 months there had been no safety incidents. The provider told us they had systems in place to review any safety alerts, though staff we spoke with told us they were unaware how they could access alerts issued by the Medicines and Healthcare products Regulatory Agency (MHRA). Following the inspection, the provider confirmed that they had created an MHRA alerts folder and going forward they would discuss any relevant safety alerts with 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 practice had some systems to keep dental professionals up to date with current evidence-based practice. Improvements were needed to ensure all clinicians were up to date with their knowledge and understanding of the National Institute of Clinical Excellence (NICE) guidance in relation to wisdom tooth extractions and antimicrobial prescribing. Following the inspection, the provider told us that clinicians were committed to continuously improve their knowledge. They had now printed the NICE guidelines, and these have been read and signed by all clinicians.

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.

Improvements were needed to ensure all staff were aware of their responsibilities under the Mental Capacity Act 2005.

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

The practice kept detailed dental care records in line with recognised guidance.

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

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

Effective staffing

Clinical staff had the skills, knowledge and experience to carry out their roles. Improvements were needed to ensure that all staff undertook appropriate training, including safeguarding training at a level appropriate to their role.

Clinical staff completed continuing professional development required for their registration with the General Dental Council. Improvements could be made to ensure training certificates were maintained and monitored to identify individual development and training needs.

We noted that there were no arrangements for staff new to the practice to have a structured induction programme.

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. However, improvements were needed for monitoring referrals made, including urgent referrals where oral cancer was suspected. Following the inspection, the provider told us that they had now implemented a referral log to monitor the status of external referrals.

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff were aware of their responsibility to respect people's diversity and human rights.

Privacy and dignity

Staff were aware of the importance of privacy and confidentiality.

Staff password protected patients' electronic care records and backed these up to secure storage. They stored paper records securely.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care.

Staff gave patients clear information to help them make informed choices about their treatment.

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

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

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. It took account of patient needs and preferences.

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

The practice had made reasonable adjustments for patients with disabilities. Staff had carried out a disability access audit and had formulated an action plan to continually improve access for patients.

Timely access to services

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.

Listening and learning from concerns and complaints

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

Are services well-led?

Our findings

We found this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices 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.

At the time of inspection there was no registered manager in post as required as a condition of registration. A registered manager is legally responsible for the management of services for which the practice is registered.

Leadership capacity and capability

We found that there was ineffective leadership which impacted on the practice`s ability to deliver safe, high quality care. The principal dentist could not assure us that they understood risks pertaining to the management of the service and the delivery of care.

We found that staff members worked well together. However, improvements were needed to ensure information about systems and processes were communicated effectively across the practice.

The information and evidence required during the inspection process was not suitably documented. Improvements were needed to ensure that records in relation to the management of regulated activities were readily available and easily accessible to all members of staff and those who would need to review them.

Culture

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

We saw evidence that annual appraisals had been undertaken. However, improvements were needed to ensure there were systems in place to monitor continuing professional development and other training requirements relevant for staff in carrying out their roles.

Governance and management

The practice did not have effective governance and management arrangements in place. We noted that the Health and Safety risk assessment document dated 25 October 2022 contained inaccurate information. For example, it stated that fire exits were clearly identifiable, fire escape routes and corridors were kept clear of obstruction. None of these statements were substantiated in our findings on the day of inspection.

The processes for managing risks were ineffective. The practice did not have adequate systems in place for identifying, assessing and mitigating risks in areas such fire safety and the use of substances hazardous to health.

Appropriate and accurate information

The practice had information governance arrangements 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 gathered feedback through the Friends and Family Test feedback forms under their NHS contractual requirements. However, we saw no evidence that patient responses had been reviewed and analysed to drive improvement nor had feedback been gathered from private patients.

The practice gathered feedback from staff through meetings, and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

Continuous improvement and innovation

Are services well-led?

The practice had systems and processes for learning, continuous improvement and innovation.

The practice had quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, disability access, radiographs and infection prevention and control.

Staff kept records of the results of these audits and the resulting action plans and improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 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: • Fire safety risks had not been effectively assessed and mitigated. • Risk assessments in relation to the use of substances and materials hazardous to health had not been carried out. • Heavy-duty gloves and long handled brushes were not replaced as per the manufacturers` recommended intervals. • The manual cleaning policy was a generic document that was not tailored to the service. • Weekly tests on the autoclave were not being carried out in line with the manufacturers` guidance. • The decontamination room had high level of dust and was also cluttered. • Adequate radiation protection arrangements were not in place. • There was no evidence of daily, weekly and monthly QA process for wet film processing • Information about current procedures, and guidance about raising concerns about abuse were not accessible to staff and people who use the service. 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.

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:

- There were no systems in place to track and monitor referrals.
- The log of NHS prescriptions was inconsistently maintained.
- Systems and processes to monitor staff training were ineffective.

The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:

- The Health and Safety risk assessment was ineffective in identifying issues and was not reflective of the shortcomings noted on the day of the inspection.
- MHRA alerts were not shared with staff.

The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to maintain 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 recruitment process was not in line with the regulations and the practice recruitment policy.

There was additional evidence of poor governance. In particular:

- Governance systems were ineffective as they did not include sufficient oversight, scrutiny and overall responsibility by the principal dentist.

This section is primarily information for the provider

Requirement notices

Regulation 17 (1)