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Family Dental Care

Inspection report

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Overall summary

We carried out this unannounced focused inspection on 28 July 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 adviser.

To get to the heart of patients' experiences of care and treatment, we usually ask five key questions, however due to the ongoing COVID-19 pandemic and to reduce time spent on site, only the following three questions were asked:

- Is it safe?
- Is it effective?
- Is it well-led?

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

Our findings were:

- The dental clinic was visibly clean and well-maintained.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff provided preventive care and supported patients to ensure better oral health.
- Staff and patients were asked for feedback about the services provided.
- The practice did not have infection control procedures which reflected published guidance.
- The practice did not have effective arrangements for dealing with medical emergencies. Not all of the recommended medicines and life-saving equipment were available, and staff were unclear about emergency procedures.
- Effective safeguarding processes were not in place and staff were unclear as to their responsibilities for safeguarding vulnerable adults and children.
- The practice did not have staff recruitment procedures which reflected current legislation.

Summary of findings

- There were ineffective systems to support continuous improvement.
- Improvements were needed to the Information Governance policy to take account the General Data Protection Regulation (GDPR) 2018 requirements.
- There was ineffective leadership and a lack of oversight for the day-to-day management of the service.
- Staff generally worked as a team. Improvements were needed to ensure that they were supported and involved in the delivery of care and treatment.
- There were ineffective systems to ensure that staff were up to date with their training.
- The practice had some systems to help them assess and manage risk. There was scope to improve these in order to align them with current guidance and legislation.

Background

Family Dental Care is in the London borough of Kingston-upon-Thames and provides NHS and private dental care and treatment for adults and children.

There is level 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 dental team includes six dentists, one dental nurse, two dental hygienists, three trainee dental nurses, one practice manager and two receptionists. On the day of inspection, there was also a dental graduate present carrying out work experience prior to professional registration. The practice has four treatment rooms.

During the inspection we spoke with the two principal dentists, two trainee dental nurses and the receptionist who is also a qualified dental nurse. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday to Friday 9am to 6.30pm

Saturdays 9am to 1pm

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.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.
- Ensure persons employed in the provision of regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them carry out their duties.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.
- 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.

Summary of findings

There were areas where the provider could make improvements. They should:

- Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the College of General Dentistry.

The provider accepted the clinical and managerial issues raised and started to take action to address these.

Where evidence is sent that shows the relevant issues have been acted on, we have stated this in our report but we cannot say that the practice is compliant for that key question as this would not be an accurate reflection of what was found on the day of our inspection.

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 effective?	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 Enforcement Actions at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

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 and some staff were unaware of their responsibilities for safeguarding vulnerable adults and children.

The practice did not have information available to staff in relation to safeguarding vulnerable adults and children.

Not all staff had undertaken appropriate training in safeguarding vulnerable adults and children. Following our inspection, the provider took action to ensure the training was undertaken.

The practice did not have infection control procedures which reflected current published guidance. We observed the re-use of single use suction tips and we found visible debris remaining on sterilised instruments. Equipment used for the placement of dental implants was stored inappropriately on an open trolley within the waiting room. We also observed that local anaesthetic cartridges had been removed from their packaging and cotton wool rolls were not kept in closed containers.

The decontamination of instruments was not carried out in accordance with The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) guidance. Staff did not wear adequate personal protective equipment (PPE); in particular, disposable aprons and eye protection were not donned. Instruments were transported in boxes with lids that were not secured. The temperature of the water used for scrubbing contaminated instruments was not checked and staff did not know the correct quantity of detergent to use. The instruments were rinsed beneath running water, creating a risk of contaminated aerosol. Instruments were not examined to check for debris and dirt beneath a magnifying light. Sterilised instruments were left on bare work surfaces to dry and were not packaged and labelled before they were returned to the treatment rooms. We noted that two members of clinical staff had long varnished fingernails and wore jewellery below the elbow.

Three members of staff had not completed training in infection prevention and control. There was a lack of supervision, as there was no decontamination lead person in place.

Records were not available to demonstrate that the ultrasonic cleaner used by staff for cleaning instruments was validated and used in line with the manufacturers' guidance.

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 in place to ensure clinical waste was segregated and stored appropriately in line with guidance. We noted that the practice did not follow these policies and we observed that procedures were carried out incorrectly. In particular, we observed that used surgical gloves had been placed into domestic waste and one sack of clinical waste was stored in an insecure area. Sharps bins were not labelled according to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 and some were situated on the floor and balanced over the edge of a sink, increasing the risk of accidental spillage.

We saw the practice was visibly clean and there was an effective cleaning schedule to ensure the practice was kept clean.

Are services safe?

The practice had a recruitment policy to help them employ suitable staff and had checks in place for agency and locum staff. We noted that the policy was not always adhered to. We saw that recruitment checks had not been carried out in accordance with relevant legislation to help the practice to employ suitable staff. In particular, there was no evidence of immunity to hepatitis B or Disclosure and Barring Service (DBS) checks for six members of staff.

One clinician did not provide us with evidence of adequate professional indemnity cover.

The practice ensured equipment was safe to use and maintained and serviced according to manufacturers' instructions. The practice ensured the facilities were maintained in accordance with regulations.

A fire risk assessment was carried out in line with the legal requirements, but improvements could be made regarding the management of fire safety. In particular, not all staff had received training and there were no records of the monthly testing of equipment or fire drills.

The practice had arrangements to ensure the safety of the X-ray equipment and we saw the required radiation protection information was available including handheld X-ray equipment.

Risks to patients

The practice had implemented some systems to assess, monitor and manage risks to patient and staff safety. This included lone working. We observed that safer sharps were not used where practicable, and no needle guards were evident, contrary to the sharps risk assessment.

Three members of staff had not completed sepsis awareness training. Sepsis prompts to assist the staff to triage appointments and patient information posters were not displayed within the practice.

Not all emergency equipment and medicines were available and checked in accordance with national guidance. In particular, there was only one adrenaline autoinjector available to treat anaphylaxis in an adult. This meant there was not the capacity to treat a child or to administer repeat doses if necessary. The provider took immediate action following the inspection and acquired an appropriate quantity of adrenaline. The adhesive pads for the automated external defibrillator (AED) had expired in 2018. The provider recognised this in April 2022 but supply issues had meant that this item was still outstanding at the time of inspection. The AED was not equipped with scissors or a razor. The glucagon (a medicine to treat low blood sugar) was stored in a fridge that was not temperature monitored. This meant that the medicines effectiveness could not be assured.

Two qualified staff members did not know how to respond to a medical emergency and the newer members of staff had not completed training in emergency resuscitation and basic life support. Immediate life support training for staff providing treatment to patients under sedation had not been completed. We observed that members of staff were not confident in operating the emergency oxygen.

The practice did not have adequate systems to minimise the risk that could be caused from substances that are hazardous to health. In particular, there were minimal risk assessments

in relation to the safe storage and handling of substances hazardous to health and staff did not know where the information could be accessed in the event of an emergency.

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. Improvements were required to records involving sedation and implants. For example, the discharge observations and instructions were not recorded for a patient who had received sedation and we noted that the consent and the type of local anaesthetic used was not recorded for one patient who had implants placed.

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

The practice did not have systems for appropriate and safe handling of medicines.

Antimicrobial prescribing audits were not carried out.

We saw prescriptions were not stored securely or monitored as described in current guidance.

The practice did not have an adequate stock control system of medicines which were held on site, in particular, we found expired local anaesthetic in one treatment room.

Track record on safety, and lessons learned and improvements

The practice had implemented systems for reviewing and investigating incidents and accidents. The practice had a system for receiving and acting on safety alerts.

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 to keep dental professionals up to date with current evidence-based practice.

The practice offered conscious sedation for patients. We found the practice did not have systems to do this safely. For example, there was limited evidence that the practice carried out relevant patient checks before and after treatment.

There was limited evidence staff had the relevant training in relation to the provision of conscious sedation.

We saw the provision of dental implants was in accordance with national guidance.

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.

Staff 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

The practice kept detailed dental care records in line with recognised guidance, although we identified issues in two sets of patient records as described above.

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. Improvements could be made to the radiography audits to ensure they are following current guidance and legislation, in particular, by carrying out the audits at six-monthly intervals.

Effective staffing

Staff had some level of skills, knowledge and experience to carry out their roles. From the basis of our findings on the day, we could not be assured all staff had a thorough understanding of important subjects such as infection control, safeguarding, medical emergencies and basic life support.

The practice carried out an induction for newly appointed staff, but improvements were required as the provider could not demonstrate that there was a system and plan in place for the supervision and support of trainee staff.

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 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

There was a lack of leadership and oversight at the practice.

Systems and processes were not embedded among staff. For example, staff were unaware of the processes in relation to infection control, safeguarding and dealing with medical emergencies. The provider has sent evidence that some training has been undertaken since the day of inspection.

The information and evidence presented during the inspection process was not presented in an organised manner, but this was largely due to the nature of the unannounced approach of the inspection. We received plentiful evidence following the on-site visit.

We saw the practice had ineffective processes to support and develop staff with additional roles and responsibilities. For example, no supervision or help was offered to the trainee staff by the qualified staff.

Culture

Staff we spoke with stated they enjoyed working at the practice.

The practice did not have arrangements for staff to discuss their training needs during clinical supervision.

The practice had arrangements to ensure staff training was up to date, but this was reviewed ineffectively.

Governance and management

The practice had an ineffective clinical governance system in place. For example, the governance system included policies, protocols and procedures however we were not assured these were accessible to all members of staff. In particular, there were no records of the fire safety checks or drills and evacuation instructions were not evident.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

The practice had ineffective information governance arrangements. In particular, staff did not demonstrate an awareness of the importance of these in protecting patients' personal information. For example, the practice had installed closed-circuit television (CCTV) throughout the practice, including private treatment rooms. The staff did not know whether recording took place and patients were not informed that consultations were recorded. There was no privacy impact statement and there was inadequate signage within the practice. Staff were not familiar with the system and how to review and extract footage if required. This is contrary to the General Data Protection Regulation.

Engagement with patients, the public, staff and external partners

Staff gathered feedback from patients, the public and external partners and a demonstrated commitment to acting on feedback.

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

Continuous improvement and innovation

Are services well-led?

The practice had systems and processes for learning, continuous improvement and innovation, however these were not effectively implemented.

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. We noted that there were several inaccuracies within the infection prevention and control audits. For example, the latest audit stated that sharps bins were stored and labelled correctly; safer sharps were used; packed instruments were dated; instruments were inspected beneath a magnifying light; scrubbing water was temperature checked; lint-free cloths were used in the decontamination packing area; all clinical staff have short nails, free from nail varnish and stoned rings not worn; aspirator tips were identified as single-use; waste was stored safely and single use aprons and eye protection were worn during the decontamination process. On the day of inspection, our findings did not reflect these statements.

Improvements were required to ensure the radiography audits were completed every six months in line with guidance.

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 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 The registered person's recruitment procedures did not ensure that only persons of good character were employed. In particular: • Disclosure and Barring Service (DBS) checks had not been carried out for six members of staff. 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: • Evidence of hepatitis B immunity was unavailable for six members of staff. • There were no records in respect of conduct in previous employment (references) for the most recently recruited members of staff. • There were no records to prove the identity for six members of staff. Regulation 19(1)(2) & (3)

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

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 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 use of closed-circuit television (CCTV):

- There was no privacy impact assessment.
- Privacy notices were not provided to persons liable to be recorded.
- There was no evidence of discussions held with people who use the services about the implementation of recording equipment.
- There was no documented consent for the use of recording within private areas.
- There was no evidence that the provider has consulted with the Information Commissioner's Office (ICO) regarding recording within private areas.
- There was a lack of appropriate signage.

Fire safety arrangements:

- Fire evacuation instructions were not displayed.
- There was no evidence of fire safety equipment checks or drills.

There was limited information available to staff about substances hazardous to health. This was not in accordance with the Control of Substances Hazardous to Health (COSHH) Regulations 2002:

- There was an incomplete log of products used or risk assessments for COSHH products.
- There was no evidence that COSHH documentation was reviewed or organised in a way to be accessible to staff if required.

Requirement notices

The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to ensure that accurate, complete and contemporaneous records were being maintained in respect of each service user. In particular:

- Dental care records for sedation procedures we reviewed did not adequately document the discharge arrangements.
- The dental care record for an implant procedure omitted the type of local anaesthetic used and consent was not recorded.

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:

- Audits of infection prevention and control did not reflect the systems and processes within the practice and had failed to identify issues.
- Radiographic audits were not completed at the recommended intervals.

Regulation 17 (1)

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulation 18 Staffing

The registered person had failed to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed in order to meet the requirements of fundamental standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In particular:

- There were no suitably experienced members of staff available to supervise the newly recruited trainee staff. This directly caused the evident shortcomings regarding cross-infection control.

Requirement notices

The service provider had failed to ensure that persons employed in the provision of regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular:

- There were inadequate arrangements to assess staff learning and development needs.
- There were ineffective arrangements for induction for new staff and lack of adequate systems to support and supervise trainee staff.
- Not all staff had completed training as per recommended national guidance for safeguarding, infection control, fire safety awareness, sepsis awareness and medical emergencies.
- Basic life support training with airway management and sedation related continuous professional development (CPD) for

staff supporting the sedationist had not been completed.

Regulation 18 (1) & (2)

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 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: Emergency medicines and equipment were not available in accordance with Resuscitation Council UK Guidelines 2021 • There was only one adrenaline autoinjector which meant there was no provision to administer the correct dosage of adrenaline to treat anaphylaxis to a child or infant or to administer repeat doses if required. The adhesive pads for the automated external defibrillator (AED) had expired in 2018 and replacements were only ordered in April 2022. This item was still outstanding at the time of inspection. • The AED kit was not equipped with scissors, a razor or gloves. • The fridge where the glucagon (a medicine used to treat low blood sugar) was stored was not temperature monitored. • Systems and processes were not in place to mitigate risks associated with medical emergencies. The checks that staff carried out on emergency medicines were not effective and had not been recorded since 7 June 2022. Staff were not confident that they could respond effectively to any medical emergency. Some staff did not know how to operate the portable oxygen cylinder.

Enforcement actions

Risks in relation to the control and spread of infections had not been assessed and mitigated, in accordance with the Department of Health publication "Health Technical Memorandum 01-05: Decontamination in primary care dental practices"

- There was no decontamination lead to oversee infection prevention and control.
- Disposable aprons and eye protection were not worn during the decontamination of the used dental instruments.
- Instruments were transported in appropriately labelled boxes, but the lids were not secured.
- The temperature of the water used for the scrubbing of used dental instruments was not checked and staff did not know how much detergent should be used. The instruments were rinsed beneath running water, creating a risk of contaminated aerosol.
- Instruments were not inspected beneath a magnifying light.
- The sterilized instruments were placed directly on the work surface to dry. Non-linting cloths were not used.
- Instruments were not pouched before storage in the surgeries. We observed several un-pouched instruments in drawers, and visible debris, such as dental cement, was evident on a selection of these.
- Single use suction tips which were visibly soiled and scratched were being re-used.
- Implant equipment was stored inappropriately on an open trolley within the waiting room directly beneath a staircase. The trolley housed the implant motor and undated packaged instruments.
- Some staff had long varnished fingernails and wore jewellery below the elbow.
- There were no quarterly checks carried out on the ultrasonic bath.
- Local anaesthetic cartridges had been removed from their packaging leaving them vulnerable to contamination and cotton wool rolls were not kept in closed containers.

Handling of sharps was not in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

- Safer sharps were not in use and no needle guards were seen despite the risk assessment in place.

Enforcement actions

- Sharps bins were not dated and stored inappropriately. One sharps bin was on the floor and another was balanced on the edge of a sink increasing the risk of spillage of contaminated sharps.

Clinical waste was not stored securely in accordance with the Department of Health publication “Health Technical Memorandum 07-01 safe management of healthcare waste”, (HTM07-01) and used surgical gloves had been disposed of into household waste bins.

A book of NHS prescription forms was not stored securely and there was no evidence of tracking or monitoring prescriptions to prevent misuse or fraud as per guidance published by the NHS Counter Fraud Authority.

There was no stock control log for dispensed medicines, and they were not suitably labelled as required by The Human Medicines Regulation 2012.

Regulation 12 (1)