BRL Dentos Ltd

Diamond Dental and Medical Clinic

Inspection report

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Overall summary

We carried out this announced inspection on 19 August 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 CQC specialist dental advisor.

To get to the heart of patients' experiences of care and treatment, we usually ask five key questions, however due to the ongoing 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:

Are services safe?

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

Are services effective?

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

Summary of findings

Are services well-led?

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

Background

Diamond Dental and Medical Clinic is in the London Borough of Barnet and provides private dental care and treatment for adults and children.

The dental team includes the principal dentist, two associate dentists, one visiting dentist, two dental nurses and a receptionist. The practice has four treatment rooms.

The practice is owned by a company and as a condition of registration must have a person registered with the CQC as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at Diamond Dental and Medical Clinic is the principal dentist.

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

The practice opening times are:

10am – 10pm Mondays to Sundays

Our key findings were:

- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children. Improvements were needed so that all staff undertook training in safeguarding adults and children.
- 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.
- Infection prevention and control procedures were not followed in accordance with national guidance.
- The provider had ineffective arrangements to ensure that equipment was tested, serviced and maintained in accordance with relevant guidelines.
- Staff knew how to deal with emergencies. However, emergency equipment and medicines were not available in accordance with the Resuscitation Council UK 2021 guidelines.
- The provider had ineffective systems to help them manage risks to patients and staff.
- The provider had ineffective recruitment procedures.
- The provider had ineffective systems to monitor staff training and learning needs.
- 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.

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

- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

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 effective?	**No 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 and Requirement 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)

The provider did not have systems that were operated effectively to keep patients safe.

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. This information was easily accessible and discussed during practice meetings. The information included contact details for the local child and adult safeguarding teams.

Staff knew about the signs and symptoms of abuse and neglect and how to report concerns. Improvements were needed to the systems to monitor that staff undertake safeguarding training. There were no training records available for the principal dentist and one dental nurse.

The provider had a system to highlight vulnerable patients and patients who required other support such as with mobility or communication, within dental care records.

The provider had an infection prevention and control policy and procedures. Staff completed infection prevention and control training and received updates as required.

However, infection prevention and control procedures were not followed in accordance with the 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.

During the inspection we observed the practices for cleaning and sterilising dental instruments. There were ineffective procedures to check and test the ultrasonic bath equipment used to clean dental instruments. The ultrasonic bath had not been tested in accordance with the manufacturer's recommendations or quarterly in accordance with the HTM-01-05 guidance.

We noted that dirty instruments were stored in a dry box prior to cleaning, and single use metal polishing strips had been sterilised and were available in the treatment rooms for re-use. These practices are contrary to the HTM-01-05 guidance.

There were records available for the daily checks carried out on the autoclave. However, these records were not legible, and it was unclear what checks were performed.

We were shown cleaning schedules to ensure the practice was kept clean. When we inspected, we saw that most areas of practice looked visibly clean. However, some areas of the practice including dental surgery two and four and equipment in dental surgery one were visibly dirty

The principal dentist told us there were procedures in relation to COVID-19. Additional standard operating procedures had been implemented to protect patients and staff from Coronavirus. These included social distancing and screening measures which had been implemented. The principal dentist told us there were arrangements for fallow time (period of time allocated to allow aerosol to settle following treatments involving the use of aerosol generating procedures) and cleaning the treatment room following treatments using aerosol generating procedures (AGPs). However, they were unable to demonstrate that these were fully understood or adhered to. They were unable to tell us what fallow time was

observed following treatments involving the use of AGPs. We noted that there were no windows for ventilation in the treatment rooms where AGPs were carried out. There were air purifier equipment used in both treatment rooms. The principal dentist was unable to tell us how many changes per hour this equipment was delivered and so was unable to provide assurances that a safe and appropriate fallow time was employed.

There were ineffective systems for cleaning treatment rooms following treatments involving AGPs. We noted that work surfaces, in both rooms where aerosol generating procedures were carried out, were cluttered with items such as boxes of disposable gloves making effective cleaning difficult to carry out.

The principal dentist told us that Personal Protective Equipment was in use and clinical staff had been fit tested for filtering facepiece masks (FFP). There were no records available to show that clinical staff had been fit tested.

Following our inspection, the principal dentist told us that all treatments involving the use of AGPs would be rescheduled pending a review of the ventilation arrangements at the practice. They provided us with records to show that clinical staff, with the exception of one dentist and one dental nurse, had been carried out

The staff had systems in place to ensure that patient-specific dental appliances were disinfected prior to being sent to a dental laboratory and before treatment was completed.

There were ineffective procedures to reduce the possibility of Legionella or other bacteria developing in the water systems. A Legionella risk assessment had been carried out in 2016 from which a number of recommendations had been made. The principal dentist could not assure us that the recommended improvements had been made to minimise risks. The principal dentist told us that water was heated by means of individual electric hot water heaters. There were no records available to show that these heaters had been tested or serviced and the principal dentist could not confirm that any tests had been carried out. On the day of inspection there was no hot water in either of the dental treatment rooms of the decontamination room. The principal dentist told us that the dental unit waterlines were disinfected. However, dental nurse who we spoke with told us they flushed these lines but did not use any disinfecting agent.

Improvements were needed to the procedures for the storage and disposal of clinical waste. We saw that sharps bins were not dated when opened for use and were not disposed of within three months in accordance with relevant guidance.

The provider had ineffective arrangements to monitor the infection prevention control procedures at the practice. Infection prevention and control audits were not carried out twice a year in accordance with published guidance. The latest audit was carried out 18 August 2021. No other audit records were available, and the principal dentist was unable to tell us when the previous adult had been carried out. The audit did not identify a number of areas where improvements were needed, which we identified during the inspection.

The principal dentist told us a dental dam was used in line with guidance from the British Endodontic Society when providing root canal treatment. When we checked we found that only a latex rubber dam was available. The provider could not principal dentist assurances that risks to patients with latex allergies had been considered or assessed. Following our inspection, we were provided with evidence that non latex rubber dental dams had been purchased.

The provider had a recruitment policy and procedure to help them employ suitable staff. However, these procedures were not followed so that staff were employed taking into account relevant legislation. We looked at staff recruitment records for each of the six members of staff. Improvements were needed to ensure that all of the required employment checks were carried out. There were no records of Disclosure and Barring Service (DBS) available for two dentists. There were no records in respect of conduct in previous employment (references) for the dentists or dental nurses. There were no records to prove identity for two dentists.

Improvements were needed to ensure that clinical staff were qualified and registered with the General Dental Council and had professional indemnity cover. These records were not available for two dentists and one dental nurse.

Are services safe?

There were ineffective procedures to ensure that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. There were no records to show that the compressor equipment had been serviced. There were no records to show that the suction equipment had been serviced and there was no amalgam separator. There were no records to show that the endodontic rotary motor, laser equipment or the cone beam computerised tomography scanner (CBCT) had been tested in accordance with the manufacturer's instructions and relevant guidance.

We saw that a portable electric test (PAT) was carried out on the day prior to the inspection. However, there were no records available to demonstrate that a test for the electrical installations was carried out since 2011.

There were ineffective systems to monitor and review dental materials used at the practice to ensure that these were disposed of once they passed the manufacturer's expiry date. We found a number of dental materials with no expiry date visible. There were also a number of materials which had expired in 2020.

There were ineffective systems for assessing and managing risks of fire at the practice.

The last fire risk assessment was carried out in January 2021. Fire exits were clearly identified and were kept clear. We saw there were fire extinguishers located throughout the building and that these had been installed in May 2021. The principal dentist told us that these were due to be tested in August 2021. However, there were no records available to show that fire safety equipment such as fire and smoke alarms were tested.

Staff told us they carried out periodic evacuation exercises. However, these were not recorded. The practice had fire safety procedures. However, these had not been reviewed since 2015.

The practice did not have effective arrangements to ensure the safety of the X-ray equipment. We saw invoices for annual mechanical and electrical checks and three yearly radiological tests carried out for the dental X-ray equipment which were carried out on the day prior to the inspection. There were no records to demonstrate that previous tests had been carried out.

We saw evidence the dentists justified, graded and reported on the radiographs they took. There were ineffective systems to monitor and improve the quality of dental radiographs. Audits of dental radiographs were not carried out taking into account current guidance and legislation. The results from the most recent audit showed that the provider has systems to monitor and improve the quality of the dental radiographs they took.

Improvements were needed to ensure clinical staff completed continuing professional development in respect of dental radiography. There were no training records available in respect of dental radiography for two dentists. There were no records in respect of training for use of the CBCT equipment.

Risks to patients

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

The practice's health and safety policies, procedures and risk assessments were reviewed regularly. The provider had current employer's liability insurance. However, risk assessments were not carried out to help minimise risks.

We looked at the practice's arrangements for safe dental care and treatment. There were procedures for the safe handling and disposal of needles and other sharp dental items. A sharps risk assessment had been undertaken.

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including vaccination to protect them against the Hepatitis B virus. Records were available to show that clinical staff had receive vaccination against Hepatitis B virus and blood result to confirm the effectiveness of the vaccine.

We looked at the arrangements for dealing with medical emergencies. Improvements were needed to ensure that staff undertook training in emergency resuscitation and basic life support every year. There were no records available for the principal dentist.

Are services safe?

Emergency equipment and medicines were not available as described in accordance with the Resuscitation Council UK 2021 guidelines. The medicine used to treat seizures (Midazolam) was not in the recommended format. We found one of the medicines use to treat low blood glucose (Glucagon injection) was stored at room temperature and the expiry date had not been adjusted in accordance with the manufacturer's instructions. We found only one dose of medicine to treat anaphylaxis (EpiPen 0.3mg) was available. There was no adrenaline injection for subsequent administration to treat anaphylaxis in the event of a medical emergency.

We checked the emergency equipment including the automated external defibrillator, oxygen masks and tubing. This equipment was available for use in the event of a medical emergency.

Following our inspection, the principal dentist told us that all patient appointments were rescheduled until such time as these emergency medicines were available and we were provided with photograph evidence once these medicines were available for use at the practice.

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

The provider had risk assessments to minimise the risk that can be caused from substances that are hazardous to health. On the day of the inspection we noted that information in relation to the handling and disposal of hazardous materials was disorganised and not easily accessible to staff. Following our inspection, we were provided with evidence to show that staff had access to information in relation to the handling, disposal and action to take in the event of accidental exposure to hazardous materials.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at dental care records with clinicians to confirm our findings and observed that individual records were typed and managed in a way that kept patients safe. Dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation requirements.

The provider had ineffective systems 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 were seen quickly by a specialist. There were no systems for logging or following up on urgent referrals.

Safe and appropriate use of medicines

The dentist were aware of current guidance with regards to prescribing medicines. Prescriptions were printed at the point of issue and records of medicines prescribed were maintained in patients dental care records.

Track record on safety, and lessons learned and improvements

The principal dentist told us they had systems for reviewing and investigating when things went wrong. However, improvements were needed to ensure that risks are assessments in relation to safety issues. There were no systems for monitoring and reviewing incidents as part of an effective risk management system.

The provider had a system for receiving and acting on safety alerts. Staff learned from external safety events as well as patient and medicine safety alerts. The principal dentist told us they were responsible for receiving, reviewing and sharing relevant patient safety information.

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. We saw clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

Helping patients to live healthier lives

The practice provided preventive care and supported patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentists prescribed high concentration fluoride products if a patient's risk of tooth decay indicated this would help them.

The dentists discussed smoking, alcohol consumption and diet with patients during appointments.

The associate dentist described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients with preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition.

Records showed patients with severe gum disease were recalled at more frequent intervals for review and to reinforce home care preventative advice.

Consent to care and treatment

Staff obtained consent to care and treatment in line with legislation and guidance.

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentist gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions. We saw this documented in patients' records.

The practice's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who might not be able to make informed decisions and staff undertook training in relation to mental capacity issues. The policy also referred to Gillick competence, by which a child under the age of 16 years of age may give consent for themselves in certain circumstances. Staff were aware of the need to consider this when treating young people under 16 years of age.

Monitoring care and treatment

The practice kept detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dental care records which we viewed showed the dentist assessed patients' treatment needs in line with recognised guidance.

The provider did not have effective quality assurance processes to encourage learning and continuous improvement. Audits of dental care records were not carried out to ensure that dental care records were maintained in accordance with relevant guidance.

Effective staffing

Improvements were needed to ensure that staff had the skills, knowledge and experience to carry out their roles.

Are services effective?

(for example, treatment is effective)

The principal dentist told us that staff new to the practice had an induction programme. No records were available in respect of the induction processes. We looked at records to determine that clinical staff completed the continuing professional development (CPD) required for their registration with the General Dental Council (GDC). We noted there were no records available for the one dentist. There were no systems to monitor and ensure that clinical staff undertook CPD training updated periodically in accordance with the GDC requirements.

Co-ordinating care and treatment

The principal dentist confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide. There were ineffective arrangements to ensure that referrals were monitored so that patients received treatment in a timely way. Records were not maintained when patients were referred to other specialists, for example to provide dental implants.

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 and Requirement 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 oversight arrangements for the day-to-day management the practice. The principal dentist had overall accountability for leadership and the day-to-day management of the service. The provider made improvements in a reactive manner rather than as part of an ongoing system for monitoring and improving quality and safety. This was demonstrated in a number of assessments carried out and staff training undertaken following the inspection being announced and following the inspection visit

Staff had access to policies and procedures, and these were reviewed periodically by the practice team and discussed at practice meetings. However, there was a lack of overall leadership to ensure that the practice procedures in relation to issues such as infection prevention and control, dealing with medical emergencies and Legionella management were understood and followed.

Following our inspection, the provider took steps to address the issues of concern we identified. These included rescheduling patient appointments until such time as emergency medicines were obtained and employing a compliance consultant to assess and assist in rectifying the issues identified.

Culture

The principal dentist was aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

There was a lack of culture to support learning and improvement at the practice. There were ineffective arrangements to monitor staff training and development needs. There were some arrangements for annual performance appraisal for staff. However, these were inconsistent. We saw incomplete appraisal documents for the dental nurses. These did not identify learning and development needs or include how staff would be supported to achieve their development goals.

Governance and management

There were ineffective processes for governance and managing risks.

There were ineffective arrangements for assessing and minimising risks to patients and staff. This relates to the lack of monitoring infection prevention and control procedures, fire safety risk assessments and failure to monitor the arrangements for maintaining equipment and dealing with medical emergencies.

There were ineffective systems for monitoring staff recruitment, training and supervision.

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 18 HSCA (RA) Regulations 2014 Staffing **The registered person had failed to take such action as is necessary and proportionate to ensure that persons employed continued to have the qualifications, competence, skills and experience necessary for the work to be performed by them. In particular:** **The provider has failed to establish an effective system to monitor staff training.** • There were no training records available for the one dentist. • There were no records in respect of safeguarding adults and children for the principal dentist and one dental nurse • There were training records in respect of basic life support for the principal dentist. • There were no training records available in respect of dental radiography for two dentists. • There were no training records available in respect of use of CBCT or laser equipment for the principal dentist or other staff • There were no arrangements to monitor staff development and training needs. **Regulation 18 (2)**

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

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:

In particular:

- There were no records of Disclosure and Barring Service (DBS) available for two dentists.
- There were no records in respect of conduct in previous employment (references) for the dentists or dental nurses.
- There were no records to prove identity for two dentists.
- There were no records to confirm registration with the General Dental Council for two dentists and one dental nurse.
- There were no records of professional indemnity for two dentists and one dental nurse.

Regulation 19 (3)

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 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:** **Emergency medicines and equipment were not available in accordance with Resuscitation Council UK Guidelines 2021.** • One of the medicines use to treat low blood glucose (Glucagon injection) was not stored in accordance with the manufacturer's instructions. • The medicine used to treat seizures was not available in the appropriate format in accordance with the Resuscitation Council UK 2021 guidelines. • There were insufficient doses of the medicine used to treat anaphylaxis. **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''.** • Dirty instruments were stored in a dry box prior to cleaning, single use metal polishing strips had been sterilised and were available in the treatment rooms for re-use. These practices are contrary to the Department of Health publication "Health Technical Memorandum 01-05: Decontamination in primary care dental practices". • The equipment used to clean dental instruments (ultrasonic bath) had not been tested in accordance

Enforcement actions

with the manufacturer's recommendations or quarterly in accordance with the Department of Health publication "Health Technical Memorandum 01-05: Decontamination in primary care dental practices".

- There were ineffective arrangements to minimise the spread of COVID-19 virus when treating patients. The principal dentist could not demonstrate that they were aware of the safe and appropriate fallow time employed.
- Air extraction units were available. The provider was unable to provide assurances that this equipment provided sufficient air changes to support fallow times observed.
- The provider was unable to demonstrate the appropriate or effective cleaning was carried out. We noted that work surfaces, in both rooms where aerosol generating procedures were carried out, were cluttered with items such as boxes of disposable gloves making effective cleaning difficult to carry out.

The provider is failing to ensure that risks of fire are assessed and mitigated.

- There were no records to demonstrate that fire safety equipment was periodically tested to ensure effective working.

The provider is failing to assess and mitigate risks in relation to Legionella.

- The provider could not provide assurances that the areas for improvement identified in the Legionella risk assessment carried out in 2016 had been addressed.
- There was no hot water in the treatment rooms or the decontamination room. The principal dentist told us that hot water was heated by means of individual electric water heaters. There were no records to determine that the heaters had been serviced and maintained in accordance with the manufacturer's instructions

Regulation 12 (1)

This section is primarily information for the provider

Enforcement actions

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

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 is failing to monitor and ensure systems in relation to the management of dental materials used at the practice.

- A number of dental materials which had no visible manufacturer's expiry date.
- Other dental materials which were beyond the manufacturer's expiry date with some having expired in July 2020

The provider is failing to monitor and ensure systems in relation to the maintenance of equipment used at the practice.

- We observed a number of pieces of equipment for which there were no records to demonstrate that this equipment was tested, serviced and maintained in accordance with the manufacturer's recommendations. These were:

Compressor

• Implant motor

• Endodontic rotary motor

• Laser equipment

• Cone beam computerised tomography scanner

- There was no non-latex dental rubber dam and the provider had not considered the risk of latex allergy where a dental rubber dam was used when treating patients.

This section is primarily information for the provider

Enforcement actions

The provider is failing to assess, monitor and improve quality in respect of dental radiography in accordance with The Ionising Radiations Regulations 2017 (IRR17) and Ionising Radiation (Medical Exposure) Regulations 2017 IR(ME)R 2017:

- There were no records of audits carried out to monitor the quality of dental radiographs taken.

The provider is failing to ensure that there is system for making and monitoring referrals where patients are referred to specialists in primary and secondary care for treatment the practice did not provide.

- There were no records in respect of urgent or routine referrals made or the systems for monitoring referrals to patients received timely care and treatment.

Regulation 17 (1)