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Churchfields Dental Clinic

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 20 January 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

We found that this practice was not providing caring services in accordance with the relevant regulations.

Are services responsive?

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

Are services well-led?

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

Background

Churchfields Dental Clinic is a private practice located in the London Borough of Bromley. The premises consist of one surgery, and a waiting and reception area.

The staff structure consists of one dentist and a receptionist. At the time of our inspection there was no dental nurse working in the practice and the provider was not using temporary agency staff.. At the time of our inspection the practice was only open on Tuesday and Wednesdays from 9.00am to 5.00pm.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Our key findings were:

- The practice did not have processes in place to reduce and minimise the risk of infection.
- The principal dentist was not up to date with their continuing professional development.
- The principal dentist's registration with their professional regulator-The General Dental Council (GDC) had expired and they were currently practicing without appropriate registration.

Summary of findings

- Patients' needs were not assessed and treatment was not planned and delivered in line with current guidance such as from the National Institute for Health and Care Excellence.
- The practice did not have appropriate equipment and medicines to respond to a medical emergency in line with Resuscitation Council (UK) and British National Formulary (BNF) guidance
- There was lack of effective processes in place to ensure patients were safeguarded from the risks of abuse.
- The practice did not have processes in place such as undertaking audits and obtaining staff feedback to assess and monitor the quality of the service.
- The practice did not have appropriate arrangements in place to ensure that X-rays were taken safely and in line with health and safety requirements.
- The practice was not carrying out risk assessments to ensure the health and safety of staff and patients.
- The premises where the regulated activities were being undertaken was not fit for purpose.

We identified regulations that were not being met and the provider must**:**

- Ensure that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way.
- Ensure that the practice has and implements, robust procedures and processes that make sure that people are protected from abuse.
- Ensure the practice's recruitment policy and procedures are suitable and the recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in order to meet the requirements of the regulations.
- Ensure the training, learning and development needs of individual staff members are reviewed at appropriate intervals and an effective process is established for the on-going assessment and supervision of all staff.
- Ensure audits of various aspects of the service, such as radiography, infection control and dental care records are undertaken at regular intervals to help improve the quality of service. The practice should also check all audits have documented learning points and the resulting improvements can be demonstrated.
- Ensure the practice establishes an effective system to assess, monitor and mitigate the various risks arising from undertaking of the regulated activities.
- Ensure the safety and suitability of all areas of the premises and the fixtures and fittings.
- Ensure staff training and availability of equipment and medicines to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Ensure the practice's infection control procedures and protocols give due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- Ensure that the practice is in compliance with its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000.
- Ensure that the registered person establishes and operates effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users.
- Ensure the practice's sharps handling procedures and protocols are in compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2014.

The principal dentist was made aware of our findings on the day of the inspection. On the subsequent day of our inspection (21 January 2016) the provider was formally notified of our concerns.

The provider responded by submitting an application to cancel their registration with the CQC. The provider's registration with the Care Quality Commission was cancelled on 22 January 2016 and they are no longer registered as a provider to undertake the regulated activities from this location.

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?

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

No staff had received recent safeguarding adults and child protection training to the appropriate levels and principal dentist we spoke with did not demonstrate appropriate knowledge of safeguarding. None of the staff in the practice were able to provide evidence of a Disclosure and Barring services check having been carried out.

There was lack of processes to ensure safe recruitment and selection of staff to the service.

Processes were not in place for staff to learn from incidents and accidents. The practice had not carried out any risk assessments. There was lack of adequate processes to ensure equipment and materials were well maintained and safe to use. There were no processes in place for the maintenance of the X-ray machine.

Recommended medicines and equipment were not available to manage a medical emergency. The practice did not have an automated external defibrillator (AED) in line with Resuscitation Council (UK) guidance. Medical oxygen was not available and the oxygen cylinder had mould and cob-webs on top of it.

Are services effective?

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

The provider was not assessing patients' needs and delivering care and treatment, in line with published guidance, such as from the National Institute for Health and Care Excellence.

Information was available to patients relating to health promotion and maintaining good oral health. The principal dentist told us they gave necessary advice to patients on oral health but this was not documented in dental care records. The dentist was not meeting their requirements for continuing professional development (CPD) in line with General Dental Council (GDC) guidelines. At the time of our inspection the dentist was not registered with the GDC.

Staff had not received Mental Capacity Act (MCA) 2005 training and did not demonstrate an awareness of their responsibilities under the Act.

Are services caring?

We found that this practice was not providing caring services in accordance with the relevant regulations.

There were no patients attending for appointments on the day of our inspection; hence we were unable to speak with any patients.

The provider had not taken reasonable steps to ensure patient confidentiality was protected. Dental care records were kept in an unsecure area and the filing cabinet could not be locked. Records were held unsecure.

Are services responsive to people's needs?

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

Information was made available to patients through leaflet available at the reception area. Urgent on the day appointment slots were available during opening hours however this was difficult to accommodate since the provider had reduced the number of days they were open. Information about opening times was not displayed in the practice and there was no practice website. Patients had to rely on calling or turning up at the practice to get information about opening times. There was lack of suitable systems in place for patients to make a complaint about the service.

Summary of findings

Are services well-led?

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

Policies and procedures were not effective to ensure the smooth running of the service. Most policies were out of date and had not been updated for a number of years. Practice meetings were not being held and there were no mechanisms in place to update staff or support staff. There were no processes in place for staff development, no appraisals and no evidence of how staff were supported. Audits were not being completed and there were no mechanisms in place for obtaining and monitoring feedback for continuous improvements.

Churchfields Dental Clinic

Detailed findings

Background to this inspection

The inspection took place on the 20 January 2016 and was undertaken by a CQC inspector and a dental specialist adviser. The inspection was undertaken because we received information of concern about the service. To mitigate the risks to patients we arranged the inspection and gave short notice to the provider. As a result we were unable to send the provider comment cards ahead of the inspection for patients to complete.

The methods used to carry out this inspection included speaking with staff and reviewing policies records and documents. There were no patients booked for appointments on the day of the inspection; we were therefore unable to speak with any patients.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There were no systems in place to receive safety alerts. The dentist was unaware of what safety alerts were or which organisations they could be received from. At the time of our inspection there had not been any accidents or incidents recorded in at least over 10 years. We were unsure whether this was due to a lack of understanding of what should be reported or whether there were no actual incidents. There were no processes in place for learning from incidents to be shared with staff.

The practice had not had any RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) incidences. The dentist was aware of RIDDOR reporting requirements.

Reliable safety systems and processes (including safeguarding)

The provider did not have systems in place to ensure people were safeguarded from abuse. The provider did not have an up to date safeguarding policy or procedure in place. Staff did not know the details of the local safeguarding authority to report actual or suspected concerns to.

No staff were able to evidence recent safeguarding training and the dentist who was the lead for safeguarding, did not demonstrate appropriate knowledge of safeguarding issues.

The dentist told us that the practice was following guidance from the British Endodontic Society relating to the use of rubber dam for root canal treatment. However we examined the rubber dam kit and it had expired in 2013. [A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth].

Medical emergencies

The provider had emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice however all the medicines were expired. The expiry dates ranged from 2008 to 2010. The dentist confirmed that regular checks were not carried out on medicines to monitor expiry.

Medical oxygen was not available in the practice in line with Resuscitation Council (UK) guidance and the General Dental Council (GDC) standards for the dental team. There was an oxygen cylinder however it was empty and had cobwebs and mould on the case indicating that it had not been checked or services in some time. The practice did not have access to an automated external defibrillator (AED) [An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm].

The receptionist confirmed that they had never completed medical emergencies training and the dentist was unsure when they had last completed it.

Staff recruitment

There was lack of sufficient numbers of staff to provide the service. The staff team consisted of one dentist and a receptionist. We were told that the dental nurse left in October 2015. The dentist told us that he was planning to retire soon and as a result had not employed another nurse. The dentist was aware of the requirement not to treat patients without a nurse or other suitably qualified person present but had continued to treat patients alone.

At the time of the inspection the dentist did not have current registration with the General Dental Council. We asked the dentist for evidence of proof of registration and we were advised that they were unsure if they had a registration certificate and would have to check if it was at home. They did not provide us with evidence of their registration. Our checks with the General Dental Council revealed that the provider was not on their register since January 2016.

The dentist and receptionist had both worked in the practice for over 10 years. We did not see any evidence of pre-employment checks carried out; however we were told that interviews had taken place at the time of employment. Criminal records check had not been carried out for the receptionist. The dentist told us that they had one but evidence of the check having been undertaken was not available for us to verify on the day of the inspection.

Monitoring health & safety and responding to risks

The practice did not have a health and safety policy that outlined staff responsibilities towards health and safety, accidents, fire safety and manual handling. The practice

had not carried out any form of risk assessment. This included no fire, legionella or premises risk assessments. On the day of the inspection there were visible signs of disrepair to the property. Walls in the reception and patient waiting area were damp and when touched paint/ plaster fell off. We asked the dentist told us that builders had visited to assess the work. However we did not see any evidence of the visit or any quotes provided by the builders as a result of the visit. We were told there was a residential flat above the property. We have contacted and shared our concerns about the lack of safety of the premises with Bromley local authority

Infection control

The practice had an infection control policy which had not been updated since 2009 and was not in line with guidance issued by the Department of Health, namely 'Health Technical Memorandum 01-05 -Decontamination in primary care dental practices (HTM 01-05). The dentist was the infection control lead.

There was no separate decontamination room; instead instruments were cleaned in the surgery. There was no clear zoning for dirty to clean areas. There were two sinks in the surgery, one for hand washing and one was used for cleaning dental instruments and a separate bowl was used for rinsing. The dentist gave a demonstration of the decontamination process which was not in line with HTM 01-05 guidance. This included not using a long handled brush for cleaning;not checking the temperature of water before decontamination; not using rubber gloves and not using disposable aprons while cleaning the instruments. During the demonstration we also saw that the dentist was putting single use instruments through the decontamination process. This indicated that these items were being reused. We discussed this with the dentist and they confirmed that single use items were being reused.

There was one autoclave and an ultrasonic cleaner. The dentist was not carrying out the recommended daily, weekly and quarterly checks to the autoclave and ultrasonic bath to ensure they were working effectively. The last such check to the autoclave was carried out on 7 October 2015 before the dental nurse left the practice. No further checks had been recorded after this date. There was no record of checks to the ultrasonic bath.

The dentist was immunised against blood borne viruses and we saw evidence of when they had received their vaccinations. Sharps bins were assembled but not labelled correctly. The sharps bin was stored on the floor which is not in line with guidance. The dentist was not aware of the up to date Health and Safety (Sharp Instruments in Healthcare) Regulations 2014. There was absence of appropriate clinical waste bins. Instead there was a general waste bin which was not foot controlled. Clinical waste stored externally was not stored securely. The door to the cupboard where it was stored did not close and was not secure. Instead the small sharps bins were piled inside the cupboard. The dentist told us clinical waste was collected approximately every six weeks. The dentist was only able to provide invoices to confirm collections in September 2015 and January 2016.

There was no stock of personal protective equipment such as disposable aprons for both staff and patients, although there was a good stock of gloves. There were enough cleaning materials for the practice. There was only one mop which looked very worn and dirty. Hand towels and gel were available but not wall mounted.

The surgery was visibly dirty, untidy and cluttered on the day of the inspection. There was dust and dirt on the work surfaces in the surgery; the draws and work surfaces were dusty and cluttered; infection control equipment was dusty and one of the sinks was corroded around the base. The dentist told us that the cleaning of the practice was carried out by the staff. The dentist told us that they were responsible for cleaning all surfaces and the dental chair in the surgery in-between patients and at the beginning and end of each session of the practice in the mornings/ evenings.

The practice did not have a Legionella risk assessment. We asked the dentist and they said they did not realise that one was required. [Legionella is a bacterium found in the environment which can contaminate water systems in buildings]. Purified water was used in dental lines and managed with a purifying solution. Taps were flushed daily in line with recommendations.

The dentist was unable to provide a record of when the last infection control audit was conducted.

Equipment and medicines

The practice had appropriate annual maintenance and service contracts in place for the autoclave. We saw that equipment had been serviced in May 2015 and the

Are services safe?

pressure vessel certificate was dated May 2015.The dentist confirmed that portable appliances had not been tested in many years. There was therefore no certification to confirm they were safe to use.

Radiography (X-rays)

The practice did not have appropriate systems in place for radiation protection and was not in in compliance with its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000. The practice did not have an appointed radiation protection file to confirm the maintenance of the X-ray machine. The last contract for maintenance of equipment had expired in July 2013.There was no appointed external radiation protection adviser. The dentist was the radiation protection supervisor. There was no evidence of Health and Safety Executive notification and there were no maintenance logs in place. These are all requirements for practices carrying out radiography on site. Local rules relating to the equipment were in place but they were out of date.

The dentist had not completed Ionising Radiation (Medical Exposure) Regulation 2000 (IRMER) training. The practice was not carrying out radiography audits. The dentist advised that the last audit was carried out approximately 5-10 years ago.

We discussed with the principal dentist our serious concerns around the lack of appropriate arrangements in place for ensuring that the X-ray equipment was maintained appropriately. The dentist agreed that they could offer no justification for the lack of maintenance and appropriate systems not being in place.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Patients' needs were not assessed, and care and treatment was not delivered in line with current legislation such as National Institute for Health and Care Excellence (NICE) guidance and the Faculty of General Dental Practice (FGDP). For example, NICE recall guidance was not being followed and risk assessments for caries and periodontal diseases were not being carried out

During the course of our inspection we checked dental care records to confirm the findings. We saw evidence of poor assessments and incomplete treatment plans. Dental care records did not contain details about materials used, evidence of risk assessments, details of the examination including condition of teeth, gums and soft tissues and an assessment of periodontal tissues using basic periodontal examination (BPE) screening tool. (The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums.)

We noted that medical histories were obtained from patients but some patients' medical history were not always updated appropriately.

Health promotion & prevention

There was some oral health and prevention information available to patients in the waiting area. Staff told us that oral health information was given to patients during consultations; however it was not always clearly documented in the records we reviewed.

There were no patients to speak with during the inspection. We were therefore unable to obtain any further, direct information from patients relating to this area.

Staffing

The dentist was the only clinical member of staff. We carried out checks to confirm their professional registration with the General Dental Council and were unable to find their details on the GDC register. We discussed this with the dentist and were advised that they had a certificate of registration but it was not at the location. They were unable to remember their registration number and told us they would have to check their paperwork which was not in the surgery. (All dental professionals practicing in the UK are required to be registered with the GDC).

Working with other services

We asked for evidence of how the provider worked with other services and health cand social care professionals. The dentist was unable to give any example of how they worked with other services. They did not have systems in place where they recorded referrals made and tracked them. The dentist told us they had not made any patient referrals to other health care professionals or specialists.

Consent to care and treatment

The dentist told us that consent was taken verbally from patients but confirmed that they did not always record this in patient's dental care records. Some of the records that we checked did not have consent documented.

The dentist had not completed Mental Capacity Act 2005 awareness training and did not demonstrate awareness of mental capacity issues. The dentist was unable to give examples of how they identified patients and the steps they would take if they suspected the patient lacked capacity to make such decisions for themselves. The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for them.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

This inspection was carried out on short notice in response to concerns raised about the practice. Therefore we were unable to send comment cards ahead of the inspection for patients to complete. There were no patients available during the inspection so we were unable to speak with patients.

We spoke with staff in the practice and they advised us that patients were treated with respect and dignity. This included closing doors when treatment was being given.

Dental care records were not stored securely. The records were kept in filing cabinets in an unsecure area. The cabinets had a lock however we were told that the key was lost.

Involvement in decisions about care and treatment

We saw no evidence to confirm that patients were involved in decisions about their care and treatment. We were unable to speak with patients on the day of the inspection and because the inspection was announced on short notice we were unable to distribute patient comment cards.

We reviewed dental care records and saw no evidence of how patients were involved in decisions about their care or treatment. There was no recording of discussions with patients, no completed treatment plans and no recording of discussing treatment options.

The dentist told us that treatment options were discussed with patients so that they had a clear understanding. However this was not evidenced in dental care records we checked.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The dentist was unable to give us any examples of how they responded to meeting patients' needs. We saw no examples of the service being planned to meet the needs of patients, no examples of reasonable adjustments made to ensure patients received appropriate care and no evidence of gathering views in the planning and delivery of services.

Tackling inequity and promoting equality

Staff told us that the patient population was fairly diverse although they had a high concentration of patients of Chinese origin. The dentist spoke Mandarin and Cantonese so was able to communicate effectively with patients who spoke these languages. Staff told us they did not have access to any other translation services.

The practice was set out on the ground level and access to the building was step free with wheelchair access for all areas except for the toilet facilities.

Access to the service

The practice we were told used to be open Monday to Fridays from 9.00am to 5.00pm; however the dentist had recently reduced this to two days a week; Tuesdays and Wednesdays from 9.00am to 5.00pm. Opening times were not advertised, instead patients had to call or turn up at the practice if they wanted to know when the practice was open.

If patients required an emergency appointment they were directed to the local dental hospitals via a message on the answerphone.

Concerns & complaints

The provider had a complaints policy in place; however it had not been updated in many years. The dentist told us they had never received any complaints since the practice opened. We spoke with staff in the practice and they told us that written information was not available to give to patients about how to make a complaint, instead they gave them verbally.

Are services well-led?

Our findings

Governance arrangements

The provider did not have effective governance arrangements in place. We reviewed the practice's policies and saw that they had not been reviewed or updated in many years. For example, the infection control policy was not written in line with or with consideration to HTM 01-05 guidance; the safeguarding policy did not make reference to recent safeguarding guidance and did not have details of the local authority or any other agency to report concerns to.

There were no formal meetings in the practice and staff did not have one-to-one meetings with their line manager.

The practice had not completed any audits to assess the on-going quality of the service. We spoke with the dentist and they told us that they did not think it necessary to conduct audits.

Leadership, openness and transparency

Leadership in the practice was lacking. The dentist was the infection control lead but he was not aware of the HTM 01-05 guidance so it could not be implemented in the practice. The dentist did not demonstrate leadership qualities of openness or transparency. For example we were given conflicting information about when the practice was open, when and whether patients were being currently seen, and what treatments were being undertaken.

Structures were not in place for staff to learn from incidents or to know who to report to. The dentist did not demonstrate their leadership ability. For example the dentist was lead for safeguarding and had not completed training and did not demonstrate appropriate awareness of safeguarding issues.

Management lead through learning and improvement

We found that the practice did not have a formalised system of learning and improvement. There was no schedule of audits at the practice and the dentist confirmed they had not undertaken any audits for approximately 10 years. Staff meetings were not held and there were no formal mechanisms to share learning.

We found that there was no centralised monitoring of professional development in the practice. The dentist was unable to provide confirmation of training and development they had undertaken. There was no programme of induction for staff and no mechanisms in place for staff to learn from incidents.

Practice seeks and acts on feedback from its patients, the public and staff

The practice did not have any systems in place for seeking or acting on feedback from patients, staff or the public. We asked the dentist how feedback was collected from patients and they told us that whilst they did not have formal processes in place to collect feedback, patients were free to comment at any time.