Implant Expert DSO UK Ltd

Implant Expert Liverpool Street

Inspection report

22-23 Widegate Street
London
E1 7HP
Tel: 02038077500
www.implantexpert.co.uk

Date of inspection visit: 24 May 2021
Date of publication: 01/07/2021

Overall summary

We carried out this announced focused follow up inspection on 24 May 2021 under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to follow up on concerns we identified during our inspection of the service on 18 March 2021 and 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 adviser.

When we inspected on 18 March 2021, we identified significant concerns in relation to safety of patients and staff. We took urgent enforcement action to suspend the provider's registration.

You can read our report of that inspection by selecting the 'all reports' link for Implant Expert Liverpool Street on our website www.cqc.org.uk.

To consider the concerns we received we asked the following questions

• Is it safe?

• Is it well-led?

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

Our findings were:

Are services safe?

Summary of findings

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

Are services well-led?

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

Background

Implant Expert Liverpool Street is in the city of London and provides private dental care and treatment for adults and children.

The practice is owned by an organisation. At the time of inspection there was no registered manager in post as required as a condition of registration. A registered manager is legally responsible for the delivery of services for which the practice is registered.

As the provider's registration was suspended and the practice was closed, when we visited on 24 May 2021, staff other than the practice manager were not available. We looked at practice policies and procedures and other records about how the service is managed.

Our key findings were:

- The provider had ineffective infection control procedures to reduce the risk of infections including transmission of the COVID-19 virus.
- The provider had ineffective systems to help them manage risks to patients and staff.
- 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.

- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.
- 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.

We have taken enforcement action in relation to the regulatory breaches identified. The provider's registration with the care Quality Commission to undertake regulatory activities from this location is currently suspended. We will reinspect the service to ensure that all the required improvements are made before the imposed suspension is removed.

Full details of the regulations the provider is not meeting are at the end of this report.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

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

Are services safe?

Our findings

We found this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action.

We have taken enforcement action in relation to the regulatory breaches identified. We will report further when we re-inspect the service to check that the required improvements have been made.

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

The provider had not made sufficient improvements to ensure there were effective systems to keep patients and staff safe.

When we inspected the practice on 18 March 2021 there were no policies and procedures available to staff in relation to safeguarding adults and children. One dentist had recently undertaken the role as safeguarding lead for the practice. Staff including the dental nurse told us that they did not have training in safeguarding adults and children. Staff told us they were unsure about safeguarding procedures.

On 6 May 2021 we saw that a safeguarding policy was available. This was detailed in respect of how to recognise signs of abuse and neglect. The policy also included clear procedures for reporting safeguarding concerns and contact details for the local safeguarding teams. We did not have access to staff training records and were unable to speak with staff. Therefore, were unable to determine that staff had undertaken training and an understanding in safeguarding people against the risk of abuse and neglect.

When we inspected the practice on 18 March 2021, staff did not have access to an infection prevention and control policy. The practice manager told us that they had recently introduced procedures in relation to COVID-19 and these were being followed. The dental nurse was the infection control lead for the practice. They told us that they had not undertaken training in infection prevention and control.

On 25 May 2021 we saw that an infection prevention control policy and procedure was available. This set out procedures in relation to the management of COVID-19, decontamination of dental instruments, general and specific cleaning and hand hygiene.

A review of the arrangements for mitigating risks where aerosol generating procedures (AGPs) would be carried out was available. This review had been carried out on 13 May 2021 by the consultant the provider employed to assist in making the required improvements. The review identified that improvements were required to ensure suitable ventilation of treatment rooms to determine a safe and suitable fallow time (period to allow generated aerosols to settle before cleaning). The practice manager was unable to tell us of any measures planned to review the ventilation systems in the treatment rooms. Prior to our visit on 24 May 2021 we were told that all clinical staff had been fit tested for filtering facepiece masks (FFP). These masks are designed to protect wearers against inhalation of liquids and aerosols and testing is required to ensure that they work effectively. When we visited the practice, we found that staff had not undertaken these tests.

On 18 March 2021 we found that infection prevention and control audits were not carried out to monitor infection control practices and procedures in line with Guidance. When we visited the practice on 24 May we were shown one infection prevention and control audit dated 29 April 2021. However; this audit was not completed accurately. For example; the audit referred to the use of a washer disinfector. There was no washer disinfector at the practice. The audit also referred to a Legionella risk assessment as having been conducted in December 2020. The practice manager told us that this audit had not been carried out.

Are services safe?

When we inspected the practice on 18 March 2021 there were ineffective systems to ensure that equipment used at the practice to deliver care and treatment was maintained, tested and serviced to ensure its safe and proper working. There were no records available to show that the practice had registered with the Health and Safety Executive (HSE), no records to show that a critical examination and acceptance test had been carried out for the dental X-ray equipment. There were no records to show that the required annual electrical and mechanical tests or three yearly radiological tests had been carried out. On 24 May 2021we saw records in respect to these tests for dental X-ray equipment had been carried out.

When we inspected the practice on 18 March 2021 there were no records available to demonstrate when the compressor had been serviced. These records were not available when we visited on 24 May and the practice manager could not tell us when or if the compressor had been serviced.

When we inspected the practice on 18 March the provider did not have suitable recruitment procedures to help them employ suitable staff. We looked at four staff recruitment records. No references had been sought for clinical staff. No checks had been conducted for the newly appointed practice manager. Disclosure and Barring Service checks had only been recently carried out for staff, within the previous two weeks.

We were told when we inspected the practice on 24 May that staff folders were unavailable as the cupboard which these records were held was locked and the key was broken in the lock. Therefore, we were unable to assess if the required improvements had been implemented.

Risks to patients

The provider had not made sufficient improvements to ensure effective systems to assess, monitor and manage risks to patient safety.

On 18 March 2021 we found there were ineffective procedures for dealing with a medical or other emergency. Staff told us that they could not make calls to emergency numbers such as 999 or 101 from the practice telephone in the event of an emergency. The practice manager told us that this issue was identified when they had been subjected to a physical assault by a service user and staff had been unable to call the police via the practice telephone system. Staff told us that they would rely upon using their personal mobile telephones to make these calls. The practice manager and other members of staff present raised concerns that mobile telephone reception was not always reliable while in the practice.

On 24 May 2021 we observed that staff could make calls to emergency numbers such as 999 or 101 from one telephone in the reception area in the event of an emergency. The practice manager told us that staff could use a whistle to summon staff assistance should they need this when in the treatment rooms located to the rear of the premises. We asked the practice manager to demonstrate how this worked. The inspection team could not hear the whistle when in the reception area. Therefore, this method of raising an alarm and seeking urgent assistance was ineffective. We also observed that a medicine used to treat low blood sugar (Hypoglycaemia) was stored in the fridge. However, there were no arrangements to monitor the fridge temperatures to ensure this medicine was stored in accordance with the manufacturer's instructions.

On 18 March there were no health and safety policies and procedures available to staff. Health and safety risk assessments were not carried out to help manage potential risk. On 24 May we found that health and safety policies and procedures had been carried out. The practice manager told us that staff could access these via the practice computer system. However, a number of these procedures were not accessible due to issues with the cloud-based computer system. The practice manager told us that there have been on-going issues in accessing the computer system. Therefore, we could not be assured that staff would be able to access policy's when needed.

On 18 March there were ineffective systems to assess and manage the risks of Legionella or other bacteria in the water systems. A Legionella risk assessment was undertaken at the practice in July 2020. The report identified that flushing and

disinfecting dental unit waterlines to minimise growth of Legionella bacteria should be carried out. On the day of the inspection there were no records to demonstrate that these measures were being carried out. We saw some dental unit water bottles contained, what appeared to be, a disinfection product, while others did not. Staff were unable to tell us what method for disinfecting was used or how frequently disinfecting products should be replaced.

The Legionella risk assessment also identified that monitoring of hot and cold water temperatures within the practice to minimise the risk of Legionella bacteria growth was not being carried out. During the inspection staff told us that these temperature checks were being carried out. However, when we tested, we found that the temperatures for hot water did not reach the required temperature to minimise the risk of Legionella bacteria growth. We observed that hot water was heated by individual electrical water heaters which were installed in each surgery. There were no records to demonstrate that these heating units were tested or serviced to ensure that they worked properly. Staff present during the inspection were unaware of any checks which should be carried out for the water heaters or how often these should receive maintenance or service checks.

Prior to our visit on 24 May the provider told us that a new Legionella risk assessment had been carried out. We were also told that all of the issues identified had been addressed. When we visited the practice on 24 May we saw that some improvements had been made. There were procedures for flushing and disinfecting the dental unit waterlines. However, when checked the hot water temperatures did not reach the required temperature (>55°C) to minimise the risk of bacterial growth. We noted that temperatures reached between 40°C and 45°C after three minutes. We noted that this issue had been identified by the engineer who had installed the water heating equipment, who had also recommended alternative water heating solutions.

On 18 March there were ineffective arrangements to mitigate the risk of fire at the practice. A fire safety risk assessment was carried out in July 2020. The assessment report identified areas where improvements were required. The report recommended that fire doors are fitted with three hinges and have suitable and serviceable intumescent strips and cold smoke seals. There were no records to demonstrate that these issues identified had been addressed. There were no arrangements for checking or testing emergency lighting system and staff present during the inspection were not aware that this system was installed.

There were no records available at the practice to demonstrate that a five-year electrical installation report had been completed.

On 24 May we asked if the issues identified in the fire safety risk assessment had been addressed. We were provided with documents to show that regular testing for the emergency lighting, fire alarm system and fire extinguishers were carried out. A satisfactory five-year electrical installation report was available. However; the practice manager told us that door hinges, intumescent strips and the cold smoke seals had not been fitted. They told us that they were awaiting a new fire safety risk assessment for the practice. We also observed a number of bags with shredded paper waste were stored in the premises' basement, which posed an additional fire risk.

There were no records available to demonstrate when the compressor had been serviced. The practice manager could not tell us when or if the compressor this had been carried out. The provider cannot be assured that this equipment is serviced in line with the manufacturers' instructions to ensure that it is operating safely.

On 18 March there were ineffective systems in relation to substances hazardous to health in accordance with Control of Substances Hazardous to Health (COSHH) Regulations 2002. Staff told us they did not have access to information in relation to the handling, storage, and disposal of hazardous materials. There were no policies or other information available to staff to help them manage an accidental exposure to hazardous materials used in the practice.

On 24 May we saw that there were policies and procedures for the safe handling and disposal of hazardous materials to help mitigate risks. However, while the practice manager had started to compile safety data and risk assessments for hazardous materials used at the practice, these were incomplete.

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.

We have taken enforcement action in relation to the regulatory breaches identified. We will report further when we re-inspect the service to check that the required improvements have been made.

Leadership capacity and capability

On 18 March 2021 we identified there was a lack of clear leadership and the systems for the day to day monitoring and management of the practice were not effective. The practice is owned by an organisation. The practice owner does not reside in the UK. The previous registered manager left the practice in January 2021. There was a lack of oversight for the day to day management of the service. Some members of staff told us that there were difficulties in accessing support from the practice owner.

When we re-visited the practice on 24 May 2021, we saw that a number of improvements had been made and the provider had employed a consultant to assist them in making the required improvements. However, there remained a number of areas where improvements had not been made to ensure that the service was managed in a safe way. The practice manager reported difficulties in communicating with the provider. The practice manager did not feel empowered to make decisions and implement systems for the day-to-day management of the practice. They also expressed concerns that practice owner did not yet fully understand the legal requirements in relation to the management of the practice

On 18 March 2021 staff did not have access to policies or other information in relation to procedures such as infection control, dental radiography, Legionella management, the safe use and maintenance of equipment, health and safety and monitoring referrals. On 24 May we saw that a new compendium of policies and procedures had been implemented and there was a system in place to monitor these. We were told that all staff could access these policies and procedures via the practice computerised systems. However, on the day of our visit the practice manager was unable to access a number of these. They also reported that there have been intermittent issues accessing the computerised systems, files and folders.

Culture

Staff stated they did not feel supported. Some staff told us that they were concerned to work in the practice because they did not feel that the owner understood their responsibilities and did not respond to their requests for assistance.

On 18 March 2021 there were no systems to monitor staff learning and development needs or to ensure that all staff had undertaken training required to enable them to carry out their roles and duties. We reviewed training records for eight members of staff. Five members of staff did not have safeguarding training. Two of the four dentists had not completed training in dental radiography and six of the eight staff had not completed infection prevention and control training. Were unable to assess improvements made when we visited the practice on 24 May as we did not have access to staff records and there were no staff available at the practice to speak with.

Governance and management

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

On 18 March 2021 we identified a lack of governance systems. For example; the practice infection control procedures were not in accordance with current guidance. There were no systems to ensure that staff were following these procedures. There were ineffective systems to assess and manage risks in relation to areas including fire safety, infection prevention and control and Legionella management.

Are services well-led?

There were no audits of dental radiographs to assess the quality of dental radiograph images taking into account the Ionising Radiation (Medical Exposure) Regulations 2017 and taking into account the guidance for Dental Practitioners on the Safe Use of X-ray Equipment.

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

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

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

When we visited the practice on 24 May we saw that the provider had made some improvements to the service: Practice specific policies and procedures, which reflected current legislation and guidelines had been developed. However; there were issues identified with access to the cloud-based system which meant that these could not always be accessed.

There were systems to audit the quality of dental radiographs and the required tests had been carried out for the dental X-ray equipment. There were policies for making and receiving patient referrals. There were arrangements for receiving, reviewing and acting on patient safety information.

However; there remained issues which had not been addressed. There were no records to show that the compressor had been serviced, there were no records or other evidence to demonstrate that the areas for improvement identified in the fire safety risk assessment carried out on July 2020 had been addressed. There were ineffective systems to ensure that hot water temperatures were maintained to minimise the risk of Legionella and other bacterial growth in the water systems.

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: The provider did not have proper arrangements to deal with medical or other emergencies at the practice. There were ineffective systems for staff to seek urgent assistance in the event of a medical or other emergency. The medicine used to treat low blood glucose was not stored in accordance with the manufacturer's instructions. Therefore; the provider could not be assured of the efficacy of this medicine. The provider did not have suitable infection prevention and control arrangements to monitor and minimise the risks of cross infection including the risk of transmission of the COVID-19 virus. The provider did not have systems to determine and employ safe and suitable fallow time when treatments involving the use of aerosol generating procedures would be carried out. Staff had not been fit tested for use of filtering facepiece masks (FFP). Infection prevention and control audits carried were not completed accurately to reflect infection control procedures in the practice. A Legionella risk assessment was carried out at the practice on 7 July 2020.

This section is primarily information for the provider

Enforcement actions

The Legionella risk assessment identified that monitoring of hot and cold water temperatures within the practice to minimise the risk of Legionella bacteria growth were not being carried out.

Prior to the inspection we were told that hot water temperatures were sufficient to minimise these risks.

During the inspection visit we checked the hot water temperatures in surgery one, surgery three and surgery four.

We found that the temperatures for hot water did not reach the temperature required to minimise Legionella growth.

The provider could not be assured that infection prevention and control procedures including the procedures to reduce the risk of bacterial growth in the water systems were being carried out safely to minimise risks to service users.

The provider did not have suitable arrangements to monitor and mitigate the risks of fire at the practice.

A fire safety risk assessment was carried out in July 2020. The assessment report identified areas where improvements were required. Prior to our inspection we were told that all of the improvements as identified in this risk assessment had been addressed. On the day of the visit there were no records to demonstrate that these identified issues had been addressed the practice manager was unable to tell us if the issues had been addressed.

The provider could not be assured that appropriate fire safety measure were carried out at the practice to minimise risks to service users and staff.

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

There were no records available to demonstrate when the compressor had been serviced to ensure that it was operating effectively and safely.

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 18 HSCA (RA) Regulations 2014 Staffing

The service provider had failed to ensure that persons employed in the provision of a 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 no arrangements to assess staff learning and development needs or to ensure that staff undertook required training including continuing professional development (CPD) in accordance with the General Dental Councils *Standards for the Dental team* for clinical staff:

We checked staff files and found that there were no safeguarding training records for one dentist, one dental nurse and two receptionists. The dental nurse told us that they were unsure about safeguarding procedures or their responsibilities in relation to these.

There were no training records in relation to dental radiography in accordance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R 2000 for one dentist and the dental nurse.

There were no training records in relation to infection prevention and control in accordance with the guidelines issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, and having regard to The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance' for two dentists and one dental nurse.

There were no records available for any staff working at the practice in relation to:

Fire safety

Legionella management.

18 (2)

This section is primarily information for the provider

Enforcement actions

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 The registered person's recruitment procedures did not ensure that potential employees had the necessary qualifications, competence, skills and experience before starting work. In particular: There were no references available for the practice manager, four dentists and one dental nurse. Disclosure and Barring Service (DBS) were not carried out when staff were recruited to work at the practice as part of ensuring each person's fitness to help keep people who use the service. Checks in respect of current registration with the General Dental Council (GDC) were not carried out when dentists and dental nurses were employed to work at the practice. There were no induction records for any staff working at the practice. We spoke with the practice manager, one dentist and one dental nurse and they told us that they did not have a period of induction when they commenced work at the practice. 19 (1) (2)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

This section is primarily information for the provider

Enforcement actions

There is a lack of managerial oversight for the practice since the registered manager left the practice in January 2021. The Nominated Individual and sole director of the organisation resides outside of the United Kingdom.

The practice manager expressed concerns about the lack of autonomy and not being enabled to deal with the day to day management of the practice.

Some concerns remained that the provider does not understand the requirements to manage the dental practice.

There were ineffective governance systems to assess and manage risks in relation to the service.

There remained concerns about staff access to the practice policies and procedures. While a system of policies and procedures have been developed, issues with internet connectivity meant that these could not always be accessed from the practice computer system.

The provider did not have systems for effective monitoring and quality improvement of the services provided:

Improvements had not been fully made in a number of areas including assessing and managing risks in relation to infection prevention and control, fire safety, Legionella management and dealing with medical and other emergencies.

17 (1)