Dr. Howard Stean

Howard Stean - Mortlake Road Kew

Inspection report

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Overall summary

We carried out this announced focused inspection on 01 July 2022 under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered practice was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a Care Quality Commission (CQC) inspector who was supported by a specialist dental adviser.

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

• Is it safe?

• Is it effective?

• Is it well-led?

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

Our findings were:

- The dental clinic was visibly clean and well-maintained.
- Patients were treated with dignity and respect and staff took care to protect their privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- Staff felt involved and supported and worked as a team.
- The dental clinic had information governance arrangements.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children. However, not all staff had undertaken appropriate training.

Summary of findings

- The practice had infection control procedures which largely reflected published guidance.
- Staff knew how to deal with medical emergencies although further training was needed. Not all medicines and life-saving equipment were available.
- The practice had staff recruitment procedures which reflected current legislation; however, staff records were incomplete.
- The practice had some systems to help them manage risk to patients and staff; however, these were not documented effectively.
- There were systems to support continuous improvement, but these could be reinforced.
- There were ineffective systems to ensure that staff were up to date with their training.
- Risks to staff and patients from undertaking regulated activities had not been suitably identified and mitigated.

Background

Howard Stean - Mortlake Road Kew is in Richmond-upon-Thames and provides private dental care and treatment for a small selection of long-standing adult patients

There is level access to the practice for people who use wheelchairs and those with pushchairs. Dedicated car parking spaces, including some for disabled people, are available in the neighbouring retail park near the practice.

The dental team includes one dentist and one dental nurse. The practice has one treatment room.

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

The practice is open Monday to Thursday

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 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 their duties

Full details of the regulations the provider was 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?	**Requirements notice**

Are services safe?

Our findings

We found this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement Actions 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.

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

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

The practice had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children. However, staff had not undertaken appropriate training in safeguarding vulnerable adults and children.

The practice had infection control procedures which largely reflected published guidance. The temperature of the water used for the manual scrubbing process was not checked as per the national guidance in the Health Technical Memorandum 01-05 Decontamination in Primary Dental Practices (HTM01-05). Staff had not completed mandatory training in infection prevention and control as recommended.

The practice had introduced additional procedures in relation to COVID-19 in accordance with published guidance.

The practice did not have adequate procedures to reduce the risk of Legionella or other bacteria developing in water systems. A risk assessment had been carried out in response to our inspection in respect of Legionella contamination, however, the provider could not demonstrate that steps had been taken to implement the recommendations.

Records were not available to demonstrate that water testing and dental unit water line management were carried out.

The practice did not have policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. In particular there was no evidence that hazardous radiographic processing chemicals were disposed of safely which is contrary to The Hazardous Waste Regulations 2005 and the current national guidance- Health Technical Memorandum 07-01 Safe management of healthcare waste (HTM 07-01).

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

The practice had a recruitment policy and procedure to help them employ suitable staff; however, some records were unavailable on the day of inspection as they could not be located. For example, Disclosure and Barring Service (DBS) records and employment history were not available.

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

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

The provider did not have effective fire safety management procedures. In particular, the fire risk assessment had not identified that there had been no servicing of fire extinguishers or alarms. There was no evidence that smoke detectors were tested. There was no form of emergency lighting or clear signage for use of extinguishers and evacuation procedures. Staff had no fire safety training or had taken part in fire drills. We asked to see a gas safety certificate, but this was unavailable.

Are services safe?

The practice did not have arrangements to ensure the safety of the X-ray equipment. The required radiation protection information including Local Rules (written instructions on the basic steps applied to reduce exposure to radiation) and a Radiation Protection File was unavailable, for example, a Radiation Protection Advisor had not been appointed and the X-ray equipment had not been serviced and maintained according to manufacturer's requirements. The provider told us that this had been arranged. Rectangular collimation to reduce radiation dose to patients was not in use.

Risks to patients

The practice had implemented some systems to assess, monitor and manage risks to patient and staff safety. This included sharps safety, sepsis awareness and lone working. The health and safety risk assessment had stated that the dental nurse was the first-aid lead; however, they were not aware of this and did not have the appropriate training.

Emergency equipment and medicines were not available and checked in accordance with national guidance. Piped medical oxygen was readily available, but only in the treatment room. There was no portable oxygen to manage casualties in the waiting room or corridor.

We found the practice did not have oromucosal midazolam, a medicine used to manage prolonged epileptic fits, and the correct formulation of aspirin used to treat heart attacks. There was no spacer device available to assist the delivery of a medication used to treat asthma.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support. However, Immediate Life Support training for staff providing treatment to patients under sedation had not been completed by all members of staff.

The practice had not carried out risk assessments in relation to the safe storage and handling of substances hazardous to health.

Information to deliver safe care and treatment

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

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

Safe and appropriate use of medicines

The practice had systems for appropriate and safe handling of medicines.

Track record on safety, and lessons learned and improvements

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

Are services effective?

(for example, treatment is effective)

Our findings

We found this practice was providing effective care in accordance with the relevant regulations.

Effective needs assessment, care and treatment

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

The practice offered conscious sedation for patients. The practice's systems included checks before and after treatment, emergency equipment requirements, medicines management, sedation equipment checks, and staff availability. However, ongoing training as recommended in the Standards for Conscious Sedation in the Provision of Dental Care published by the Intercollegiate Advisory Committee for Sedation in Dentistry (IASCD) had not been carried out.

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

Helping patients to live healthier lives

The practice provided preventive care and supported patients to ensure better oral health.

Consent to care and treatment

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

Staff understood their responsibilities under the Mental Capacity Act 2005.

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

Monitoring care and treatment

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

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

We saw evidence the dentists justified, graded and reported on the radiographs they took. The practice had not carried out radiography audits six-monthly following current guidance.

Effective staffing

Although staff had the skills, knowledge and experience to carry out their roles, we found that the practice did not have systems in place to ensure clinical staff had completed Continuing Professional Development (CPD) as required for their registration with the General Dental Council

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

The dentists confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide.

Are services well-led?

Our findings

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

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

We found that both staff members worked well together. However, improvements were needed to ensure information about systems and processes was readily available and embedded in the day to day running of the practice.

The inspection highlighted some issues and omissions. In particular, the provider was unaware of key regulations and guidance. For example: Ionising Radiation Regulations 2017 (IRR17), Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER17), The Hazardous Waste Regulations 2005 and General Dental Council (GDC) CPD requirements.

The information and evidence presented during the inspection process was disorganised and poorly documented. For example, we asked for recruitment records, but these had been mislaid. We also asked to see the gas safety certificate, and this could not be located.

Culture

Staff stated they felt respected, supported and valued and this was highly apparent on the day of inspection. They were proud to work in the practice. However, the practice did not invite staff to discuss their training needs.

Governance and management

The provider had overall responsibility for the management and clinical leadership of the practice and was responsible for the day to day running of the service.

The practice had an ineffective clinical governance system in place. For example: the governance system included policies, protocols and procedures; however, we were not assured these were accessible to all members of staff. Information relating to the Control of Substances Hazardous to Health (COSHH) was disorganised. Some records relating to the validation of the autoclave were not kept.

There was no evidence the practice's policies, protocols and procedures were reviewed on a regular basis.

The practice did not have clear and effective processes for managing risks. Some essential requirements and equipment checks had not been undertaken regularly in the past and some were only booked in response to the CQC inspection being announced. For example, the performance testing of the X-ray units was arranged and the Legionella risk assessment was carried out just days before the inspection.

Appropriate and accurate information

The practice had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information.

Engagement with patients, the public, staff and external partners

The provider gathered feedback from patients in the form of a testimonial album and demonstrated commitment to acting on feedback.

Are services well-led?

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

The provider is the chairman of Aesthetic Dentistry and Professional Testing (ADAPT) which helps patients find dentists and maintain links with dental authorities and manufacturers. Meetings take place at the practice and dental products are tested and evaluated by ADAPT members for education purposes.

Continuous improvement and innovation

The practice had systems and processes for learning, continuous improvement and innovation although some improvements are recommended.

The practice had quality assurance processes to encourage learning and continuous improvement. These included audits of disability access, radiographs and infection prevention and control. Records of these audits were kept. Records were not available to demonstrate that audits of radiographs were undertaken and re-assessed at the required intervals. The radiographic audit seen on the day of inspection contained incorrect grading of radiographs. There was no evidence of a quality assurance programme for the film-based radiographs.

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 17 HSCA (RA) Regulations 2014 Good governance **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 17 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. How the Regulation was not being met: The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • Radiographic audits were not completed correctly or at the recommended intervals. The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to maintain securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity or activities. In particular: • Recruitment records had not been retained securely and documentation pertaining to gas safety was unavailable. The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:

This section is primarily information for the provider

Requirement notices

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

Regulation17 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 18 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. • The provider did not have a system for monitoring staff training • There were no arrangements in place for staff to discuss their training needs at an appraisal. • Not all staff had completed training as per recommended guidance. Regulation 18 (2)

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.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 12 Safe care and treatment** The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: There were ineffective arrangements to deal with medical emergencies. • There was no Oromucosal Midazolam to treat Status Epilepticus. • There was no portable oxygen. • Aspirin to treat heart attacks was not in a dispersible format. • There was no spacer device to assist the delivery of medication to treat asthma. There were ineffective arrangements to assess and mitigate the risk of fire at the practice: • There was no record of periodic in-house testing of the fire safety equipment, including the fire alarm system, smoke alarms or extinguishers, and we saw no evidence of the servicing of these. • Fire drills had not been carried out. • There was no emergency lighting and exits were not clearly signposted. • The gas safety certification was not available. • The fire extinguishers did not have clear instructions displayed which was not in accordance with the available fire policy.

This section is primarily information for the provider

Enforcement actions

There were ineffective arrangements to ensure the use of X-ray equipment was in accordance with Ionising radiation Regulations 2017 (IRR17) and Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER17):

- Three yearly performance tests had not been carried out.
- The provider had not consulted with a Radiation Protection Advisor (RPA) and had not completed necessary risk assessments and local rules.
- Rectangular collimation was not used.

The risks associated with water systems and dental unit water lines (DUWLs) were not regularly reviewed and mitigated.

- Monthly water temperature testing was not being carried out.
- Disinfection of dental DUWLs did not follow recognised protocols described within current national guidance: Health Technical Memorandum 01-05 Decontamination in primary dental care practices (HTM01-05).

The safe disposal of chemicals used to develop radiographs could not be evidenced. This is contrary to The Hazardous Waste Regulations 2005 and the current national guidance- Health Technical Memorandum 07-01 Safe management of healthcare waste (HTM 07-01).

Regulation 12 (1)