Mr. John Kanogo

Sterlingway Dental Surgery

Inspection report

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Overall summary

We undertook an unannounced focused inspection of Sterlingway Dental Surgery on 5 September 2023. This inspection was carried out to review the actions taken by the registered provider to improve the quality of care and to confirm that the practice was now meeting legal requirements.

The inspection was led by a CQC inspector who was supported by a specialist dental advisor.

Previous regulatory history

An announced focused inspection of Sterlingway Dental Surgery was undertaken on 7 June 2022 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We found the registered provider was not providing safe and well-led care and was in breach of regulations 12,13,17,18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An unannounced focused inspection was carried out on 23 September 2022 to review the actions taken by the provider in response to our findings of 7 June 2022. At this follow up inspection we found that while some improvements had been made, a number of areas of concern remained outstanding. We found that the provider was still not providing safe and well-led care and remained in breach of regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Another unannounced focused inspection was carried out on 27 January 2023 to review the actions taken by the provider in response to our findings of 23 September 2022. At this review we found that although the provider had implemented actions to address our previous concerns, we identified new concerns. We found that the provider was still not providing well-led care and remained in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Summary of findings

We undertook a third follow-up inspection on 31 March 2023 to review the actions taken by the provider in response to our findings of 27 January 2023. At this inspection we found that the practice implemented some improvements to address our previous findings, but we found some outstanding concerns and identified new issues. We found that the provider was still not providing safe well-led care and was in breach of regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can read our report of that inspection by selecting the 'all reports' link for Sterlingway Dental Surgery on our website www.cqc.org.uk.

When 1 or more of the 5 questions are not met we require the service to make improvements and send us an action plan. We then inspect again after a reasonable interval, focusing on the areas where improvement was required.

As part of this inspection we asked:

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

Our findings were:

Are services safe?

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

The provider had made some improvements to put right the shortfalls and had responded to the regulatory breach we found at our inspection on 31 March 2023. However, some of our previous concerns remained outstanding.

Are services well-led?

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

The provider had made insufficient improvements to put right the shortfalls and had not responded to the regulatory breach we found at our inspection on 31 March 2023.

Background

Sterlingway Dental Surgery is in Edmonton, in the London Borough of Enfield, and provides NHS and private dental care and treatment for adults and children.

There is level access to the practice for people who use wheelchairs and those with pushchairs. Car parking spaces are available near the practice.

The dental team includes the principal dentist, 1 dental nurse and 1 trainee dental nurse, who also undertakes receptionist duties. The practice has 2 treatment rooms and a separate decontamination room.

Summary of findings

During the inspection we spoke with the dentist, the trainee dental nurse and a receptionist (who was otherwise not scheduled to work that day). We looked at practice policies, procedures and other records to assess how the service is managed.

The practice is open:

Monday to Friday from 8am to 7pm.

Saturday from 8am to 2pm.

We identified regulations the provider was not meeting. 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

The five questions we ask about services and what we found

We asked the following question(s).

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

Are services safe?

Our findings

Our findings

We found that this practice was not providing safe care and was not complying with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report).

At the inspection on 5 September 2023 we found the practice had made the following improvements to comply with the regulations:

- We found that NHS prescription pads were now stored securely. In addition, the practice had implemented a system to ensure that the prescription log was effective to identify missing prescriptions.

The practice had also made further improvements:

- Improvements had been made to the practice's protocols and procedures for the use of X-ray equipment in compliance with The Ionising Radiations Regulations 2017 and Ionising Radiation (Medical Exposure) Regulations 2017 and taking into account the guidance for Dental Practitioners on the Safe Use of X-ray Equipment. In particular, the practice had ensured that the intraoral X-ray unit in Surgery 1 was fitted with a rectangular collimator. The intraoral unit in Surgery 2 did not have a rectangular collimator; we were told that this surgery was not in use.

At the inspection on 5 September 2023 we identified the following concerns:

- At our previous inspection visits we had identified concerns with the practice's protocols for infection prevention and control. We observed that some rusty and pitted instruments continued to be used. This was not in line with the guidance provided by the Department of Health and Social Care - 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05) which states that instruments that have rust spots should be removed. We reported on this concern in our previous report and were not assured that improvements had been implemented to address this shortcoming.
- During this visit we identified further areas of concern. We were not assured that the solution in the ultrasonic bath was drained at the end of each clinical session. We noted that the water in the ultrasonic cleaner appeared dirty and cloudy. In their response to our inspection feedback, the provider told us that this was due to the ultrasonic bath being used 'throughout the morning'. This was inconsistent with what we were told on the day of the inspection, namely that the dental team had only seen one patient before the inspection team arrived. However no dental instruments were used as part of that denture bite adjustment appointment. Furthermore, there was no evidence to show that any instruments had been processed that morning.
- The provider did not have systems in place to monitor the use of heavy-duty gloves and long-handled brushes. We noted that the long-handled brush in the sink was heavily worn. In their response to our inspection feedback, the provider submitted photographic evidence that they had a stock of spare long handled brushes and heavy-duty gloves, which we noted during the inspection. Our evidence related not to lack of stock, but the lack of effective systems to monitor use and replacing gloves as per current national guidance.
- We further noted that the trainee dental nurse demonstrating the decontamination process did not measure the enzymatic solution used to disinfect instruments to ensure the correct dilution of the solution was achieved as recommended by the manufacturer. We observed that they also cross contaminated surfaces by opening the autoclave and cabinets with dirty gloves.

Are services safe?

- We noted that the ultrasonic test strip the trainee dental nurse told us they used to ensure that the unit was operating effectively, expired in November 2021. In their response to our inspection feedback, the provider submitted a photograph of a box of ultrasonic bath test strips that were in date. This was not shown to us on the day of the inspection.

Are services well-led?

Our findings

We found that this practice was not providing well-led care and was not complying 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).

On 4 August 2023 we attempted to undertake an unannounced follow up inspection, but we found the practice closed. We arrived at 10am and left at 12pm. The opening hours displayed outside the practice stated that the practice was open Monday to Friday from 9am to 8pm. There was no other information displayed to inform patients why the practice was closed on a day it should otherwise be open. We attempted to call the displayed emergency mobile number but this number was out of service. One of the practice telephone numbers on display was also out of service. We further noted that the NHS out of service contact number displayed was no longer operational. We were not assured that the provider had systems in place to ensure that patients were given the correct information to contact the practice in case of an emergency.

At the inspection on 5 September 2023, we identified the following areas of concern:

- Systems and processes in place to ensure that the supervising General Dental Council (GDC) registrant carried out the necessary supervision, were ineffective and were not in line with the relevant guidance published by the GDC. The provider told us that the trainee nurse started their dental nurse training on a recognised program in August 2022; however, on the day of the inspection they could not provide any evidence of their enrolment. (The principal dentist submitted an enrolment letter, dated 6 September 2023, in response to our inspection feedback). They further told us that the qualified dental nurse working at the practice (who was not present on the day of the inspection) provided direct supervision and acted as a workplace witness for the trainee nurse. We were not shown any evidence that the qualified dental nurse had completed the relevant training to act as a witness. In addition, there was no log book of the training the trainee nurse received at the practice and there was no evidence that their training had been signed off by the designated supervisor. (Following the inspection the provider submitted an induction report, which was a list of the online modules the trainee nurse completed and not a formal training log).
- Arrangements for supervision of trainee staff were not effective, in that those overseeing the trainee dental nurse did not identify shortcomings in the infection control process. This meant that the practice did not have suitable arrangements in place to ensure staff were supported to undertake training, learning and development to enable them to fulfil the requirements of their role. Furthermore, the systems and processes in place did not enable the provider to identify where quality and safety were compromised.
- There were ineffective systems in place to ensure that recall intervals between oral health reviews determined for each patient were in line with the risk assessment of disease levels and risk of, or from dental disease. We asked how dental recalls were managed in the practice. The principal dentist told us that, although they have plans to move towards a digital system, their system remained that when a patient attended, an envelope would be labelled with their name and address. Envelopes were stored in boxes and when appropriate, staff would send the pre-labelled envelope with an appointment slip, inviting the patient to contact the practice for a follow up appointment. There was no evidence that the practice had a record of the patients they invited to contact the practice for review and of those who did not respond, or systems in place to ensure that appointment invites were sent out in line with the identified recall needs. These shortcomings were also identified at our previous inspection of 31 March 2023 and no improvements had been implemented to improve the effectiveness of the recall system.
- The practice did not ensure that they had sufficient numbers of staff deployed to provide safe care. On our arrival at the practice, the trainee dental nurse told us that they were carrying out reception and dental nurse duties. We noted from the appointment book that the practice had a full list of patients booked between 11.30am and 6.30pm. Another member of staff arrived around 1.30pm to cover the reception. They were not scheduled to work on the day of the

inspection, and they told us that they were unwell. We had to request the principal dentist on a number of occasions to tend to them. Furthermore, we were concerned that a member of staff was expected to show up at work when they were not well enough to do so. This meant that the practice did not have sufficient procedures to minimise the risks arising from staff absence and to cover both the emergency and routine work of the service. In addition, the systems in place to assess and monitor the risks relating to the health, safety and well-being of staff were ineffective.

- Not having sufficient numbers of staff deployed meant that incoming calls from patients, including potential emergencies, were not answered. We reported about the same concern previously and we noted that no significant improvements had been implemented to ensure that staff responded effectively to incoming enquires. We further noted that although the practice had 15 patients booked in for treatment on the day of the inspection, one patient left without being seen and only two were seen while we were on site between 12pm and 6pm.
- We requested to see the list of patients seen on a random date - 29 August 2023. The provider confirmed that out of the 13 patients originally booked in, 9 attended their appointment.
- We requested to see these patient care records.
  - 2 out of the 9 patients did not have a record entered on their record card on 29 August 2023.
  - A third record was undated, and we were not assured that this related to the treatment on 29 August 2023.
  - A fourth record was either not available or incorrectly dated as the provider told us that the record dated 29 June 1996 was in fact entered on 29 August 2023.
  - We further noted that one of the records available for review detailed the provision of crowns on dental implants the patient received overseas. However, the correlating NHS FP17DC Treatment Plan did not specify that the crowns in fact were replacement implant crowns.
  - The records available for review were all paper records written in shorthand and difficult to decipher. The General Dental Council (GDC) Standard 4.1 states – "you must ensure that all documentation that records your work, including patient record is clear, legible, accurate, and can be readily understood by other." The guidance published by the College of General Dentistry (CGDent) in the 'Clinical Examination and Record-Keeping: Good Practice Guidelines' documents state that 'all written records should be written contemporaneously, and be accurate, complete, logical, clear, concise, legible and easily understood by a third party'. The same document says that 'records will fall below acceptable standards when it is not clear to another clinician what was found, planned, discussed and what treatment was carried out'.
  - We reported previously on the lack of legibility of the records and the absence of accurate and complete detail. We noted that the improvements we identified in this respect on 31 March 2023 had not been sustained. We are not assured that the provider understood the importance of maintaining legible, complete records which clearly reflect the treatment provided.
- We noted that a member of clinical staff, who, we were told had started working as a trainee nurse in August 2022, had completed a basic DBS check rather than the enhanced DBS check required.
- The principal dentist was not aware of the current evidence-based guidance in relation to the periodontal management of patients. We reported on the same concern following our inspection on 31 March 2023 and were not assured that the principal dentist took appropriate steps to address this shortcoming.
- Between 7 June 2022 and 5 September 2023, we undertook 1 announced inspection and 4 follow up inspections. Over this period of time, we identified repeated concerns around infection prevention and control, record keeping, legionella management, recruitment, fire safety, management of medical emergencies and the safe management of medicines. While improvements have been implemented in response to our findings and some of our previously identified concerns have been fully addressed, we are concerned that there are still concerns around staffing, infection prevention and control and record keeping. We are not assured that that the provider understood the risks pertaining to the management of the service and the delivery of care. Over the past 14 months we have identified an ongoing lack of effective leadership which impacted the practice`s ability to deliver safe, high-quality care.

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 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 had failed to assess the risk of, and prevent and control the spread of, infections in accordance with the Department of Health and Social Care - 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05). Regulation 12 (1)

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 17 HSCA (RA) Regulations 2014 Good governance 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: • There were ineffective systems in place to ensure that recall intervals between oral health reviews determined for each patient was in line with the provider`s risk assessment of disease levels and risk of or from dental disease. • The provider did not have suitable arrangements in place to ensure staff was supported to undertake training, learning and development to enable them to fulfil the requirements of their role. • Arrangements for supervision of staff was not effective, in that those overseeing the trainee dental nurse did not identify shortcomings in the infection control process. The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • The provider did not ensure that they had sufficient numbers of staff deployed to provide safe care. • There were ineffective systems in place to ensure staff responded effectively to incoming enquires from patients, including potential emergencies. • Systems in place to assess and monitor the risks relating to the health, safety and well-being of staff were ineffective.

This section is primarily information for the provider

Enforcement actions

The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to maintain 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:

- A clinical member of staff did not have enhanced DBS check on file.

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

- All clinical records were paper records, written in short hand, difficult to decipher and could not be readily understood by another clinician. This is contrary to the General Dental Council (GDC) Standard 4.1 and the relevant guidance published by The College of general Dentistry.
- There were no patient records available for 2 out of 9 patients who we were told attended an appointment at the practice on 29 August 2023.

There was additional evidence of poor governance. In particular:

- The principal dentist was not aware of the current evidence-based guidance in relation to the periodontal management of patients.
- Over the past 14 months we have identified repeated breaches and an ongoing lack of effective leadership which has impacted the practice`s ability to deliver safe and high-quality care.

Regulation 17 (1)