Mr. John Kanogo

Sterlingway Dental Surgery

Inspection report

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Overall summary

We undertook an unannounced follow up focused inspection of Sterlingway Dental Surgery on 31 March 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.

We had previously undertaken a comprehensive inspection of Sterlingway Dental Surgery 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.

We undertook a focused follow up inspection on 23 September 2022 and found that the registered provider had remained in breach of regulations 12 and 17 and was not providing safe and well-led care.

A second follow up inspection was undertaken on 27 January 2023, and we found that the registered provider had remained in breach of regulations 17 and was still not providing well-led care.

You can read our reports of those inspections by selecting the 'all reports' link for Sterlingway Dental Surgery dental practice 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 well-led?

Additional concerns were identified while undertaking the review of the Well-led key question and we also asked:

Summary of findings

- Is it safe?

Our findings were:

Are services safe?

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.

The provider had made some improvements to put right the shortfalls and had responded to the regulatory breach we found at our inspection on 27 January 2023. However, we identified new concerns and some of our previous concerns remain outstanding.

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 receptionist. The practice has 2 treatment rooms and a separate decontamination room.

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

The practice is open:

Monday to Friday 8am to 7pm.

Saturday 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.

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

There were areas where the provider could make improvements. They should:

Summary of findings

- Improve 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, ensure that intraoral X-ray units are fitted with a rectangular collimator.
- Take action to ensure the dentist is aware of the guidelines issued by the British Endodontic Society for the use of rubber dam for root canal treatment.

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

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 31 March 2023, we found:

- At our previous inspection visits we had identified concerns with the practice's protocols for infection prevention and control. During this visit we identified further areas of concern. We observed that some dental instruments appeared rusty and pitted and were still in use. 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. In addition, we found un-wrapped dental instruments in the drawers in Surgery 1, including a straight handpiece, a spatula and a sickle scaler. The guidance states that unwrapped instruments in the clinical area can be stored for 1 day and practices should have protocols and procedures to prevent contamination of these instruments. We further observed that the high-speed handpiece was sterlisied with the bur left in the handpiece.
- NHS prescription pads were not stored securely. A pre-stamped prescription pad was kept in an unlocked metal box with the key in. The NHS prescription log did not include the prescription number of each sheet within a pad and was not effective to identify missing prescriptions. Furthermore, improvements could be made to ensure that the name and date of medication prescribed was recorded consistently in the log.

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).

At the inspection on 31 March 2023 we found the practice had made some improvements to comply with the regulations:

- The provider had made improvements to ensure that patient care records were available for patients who had received treatment at the practice. On the day of inspection, we asked to see 9 patient care records of patients seen on 30 March 2023 and 6 March 2023. All patient records we requested to review were made available. However, clinical information was written in shorthand and difficult to decipher. We were not assured that these records could be readily understood by another clinician in the absence of the principal dentist.
- The provider had made improvements to ensure that referrals made for treatments the practice did not provide were submitted securely. They used an online portal to submit the completed referral forms. The practice had engaged the services of an external compliance company to implement effective systems for the tracking and monitoring of referrals. They now had a template for logging non-urgent referrals and a separate tracker for urgent referrals. We however noted that these were blank templates and had not yet been implemented. The provider told us that they had undertaken training on referrals monitoring on 23 March 2023 where all members of staff had participated, and they were planning to implement the use of logs.

At this inspection we identified the following areas of concern:

- We found that systems to ensure that the provider maintained up to date records in relation to persons employed were ineffective. A member of staff had a T4 student visa status which had expired in January 2019. There was no record within the recruitment files showing their current residence permit.
- We noted that a number of radiographs were of unsatisfactory diagnostic quality, with some being elongated and others blurred. This was not reflected appropriately in the quality assurance grade recorded in the patient records. In addition, we noted that the intraoral X-ray unit in surgery 1 did not have a rectangular collimator.
- We asked the provider about the 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 principal dentist told us that when a patient attended, an envelope was labelled with their name and address. Envelopes were stored in boxes and when appropriate, staff sent the pre-labelled envelope with an appointment slip, inviting the patient to contact the practice for a follow up appointment. The principal dentist told us that they would usually send out 50-70 letters each week, and currently they were inviting patients for their 6 monthly recalls. We sampled 3 records of patients the principal dentist told us they were due to recall. We found that two of them had not been seen since 2019, and a third one was seen in December 2022. In addition, there was no evidence that the practice had a record of the patients they had invited to contact them for review, and neither of those who had not responded. We were not assured that the systems in place to ensure patients were seen based on their clinical needs were effective.
- We were not assured that there were effective systems in place to ensure staff responded in a timely manner to incoming enquires from patients, including potential emergencies. The principal dentist told us that patients were booked in based on incoming calls. When the inspection team pointed out that they had not observed the practice receiving any incoming calls, the principal dentist showed us the practice mobile which had 21 missed calls on the day of inspection. This meant that calls had not been answered, although three members of staff were present in the practice and not involved in the delivery of care as no patients were seen during the day.
- Systems and processes to ensure patients were provided with a treatment plan to support their informed consent were ineffective. We noted that patients signed blank FP17DC forms, containing the personal dental treatment plan. The practice retained both the patient and the practice copies. This meant that patients did not have a written

Are services well-led?

treatment plan they could refer to about details of the proposed treatment and the realistic indication of cost. This was not in line with the General Dental Council's Standards for the Dental Team (Principle 2.3.6), which states that '*You must give patients a written treatment plan, or plans, before their treatment starts and you should retain a copy in their notes. You should also ask patients to sign the treatment plan.*'

- The principal dentist was not aware of the current evidence-based guidance in relation to the periodontal management of patients.

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 failed to assess the risk of, and prevent and control the spread of, infections in accordance with • The pre-stamped NHS prescription pad was not stored securely. • The prescription log was not effective to identify missing prescriptions. 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 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: • 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. • There were ineffective systems in place to ensure staff responded effectively to incoming enquires from patients, including potential emergencies. • The provider could not demonstrate that patients were provided a written treatment plan or plans before their treatment. 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 member of staff did not have record of their current residence permit on file.

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 ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular:

- A number of radiographs were of unsatisfactory diagnostic quality, and this was not reflected appropriately in the quality assurance grade recorded.

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.

Regulation 17 (1)