Azamay Ltd

Azamay

Inspection report

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Overall summary

We carried out this announced comprehensive inspection on 17 March 2023 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 advisor.

To get to the heart of patients' experiences of care and treatment, we always ask the following 5 questions:

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

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

Our findings were:

- The dental clinic appeared clean and well-maintained.
- The practice had infection control procedures which reflected published guidance.
- Staff knew how to deal with medical emergencies. Appropriate medicines and life-saving equipment were available.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children. Patients were treated with dignity and respect. Staff took care to protect patients' privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.

Summary of findings

- The appointment system worked efficiently to respond to patients' needs.
- The frequency of appointments was agreed between the dentist and the patient, giving due regard to National Institute of Health and Care Excellence (NICE) guidelines.
- Staff felt involved, supported and worked as a team.
- Staff and patients were asked for feedback about the services provided.
- Complaints were dealt with positively and efficiently.
- The practice had some information governance arrangements. Improvements were needed to ensure that CCTV (Closed Circuit Television) signage was displayed to inform people about its presence.
- The practice had some systems to manage risks for patients, staff, equipment and the premises. Improvements were needed to the systems for assessing, monitoring and mitigating risks associated with fire, equipment and the use of sharps.
- The practice had staff recruitment procedures which broadly reflected current legislation. Improvements were needed to ensure that the provider obtained satisfactory evidence of conduct in previous employment.
- Clinical staff provided patients' care and treatment in line with current guidelines. Improvements were needed to ensure that there were effective systems in place to track and monitor referrals, including urgent referrals where oral cancer was suspected.

Background

The provider is part of a corporate group (The Smile Studios) and has 5 practices, and this report is about Azamay.

Azamay is in Cockfosters, in the London Borough of Enfield and provides private dental care and treatment for adults and children.

There is step free access to the practice for people who use wheelchairs and those with pushchairs. Car parking spaces are available near the practice. The practice has made reasonable adjustments to support patients with access requirements.

The dental team includes 1 principal dentist, 3 associate dentists, 1 qualified dental nurses, 1 trainee dental nurse, 1 receptionist and 1 regional manager. The practice has 2 treatment rooms.

During the inspection we spoke with the qualified dental nurse and the regional manager. We looked at practice policies, procedures and other records to assess how the service is managed.

The practice is open:

Monday to Friday from 9am to 6pm.

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.

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

- Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the College of General Dentistry.

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?	**Requirements notice** ✖
Are services effective?	**No action** ✓
Are services caring?	**No action** ✓
Are services responsive to people's needs?	**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 Requirement Notices 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 processes in place for safeguarding vulnerable adults and children. On the day of inspection, we noted that information about current safeguarding processes and guidance about raising concerns about abuse were not made available to staff. Following the inspection, the provider submitted photographic evidence that they had now displayed safeguarding information in the decontamination room.

The practice had infection control procedures which broadly reflected published guidance. On the day of inspection, we observed significant accumulation of dust on the decontamination room ventilation fan. Following the inspection, we received photographic evidence that this task had now been cleaned and the provider told us that cleaning the fan had been added to the cleaner`s schedule. In addition, we noted that the clinical waste bins in Surgery 1 and in the decontamination room were not foot operated. This is not in line with the Health Technical Memorandum 07-01: Safe and sustainable management of healthcare waste 2022 guidance published by NHS England which states that waste bins should be lidded and operated with foot-pedal in clinical areas and toilets.

The practice had procedures to reduce the risk of Legionella, or other bacteria, developing in water systems, in line with a risk assessment.

The practice had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance.

The practice appeared clean and there was an effective schedule in place to ensure it was kept clean.

The practice had a recruitment policy and procedure to help them employ suitable staff, including for agency or locum staff. These broadly reflected the relevant legislation. We looked at 8 recruitment records and found these to be incomplete. Records were not available to show that satisfactory evidence of conduct in previous employment had been sought for all members of staff. In addition, proof of identity including a recent photograph and Hepatitis B antibody blood test levels were not stored within the recruitment files for one member of staff. The regional manager requested copies of these on the day of inspection. One member of staff did not have Hepatitis B antibody blood test report on file to evidence that they had responded to the three doses of vaccination they had received in 2021. Improvements were needed to ensure that there were effective systems in place for the obtaining, storage and monitoring of recruitment documents.

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

The practice had some systems in place to ensure that equipment was safe to use, maintained and serviced according to manufacturers' instructions. However, we noted that the compressor had not been serviced since its last service on 30 March 2019. Following the inspection, the provider told us that they had now booked a compressor servicing for 27 March 2023.

We noted that the air conditioning system was last serviced on 15 March 2019. Following the inspection, the provider told us that the air conditioning service had been booked for 24 March 2023.

Are services safe?

On the day of inspection, we asked to see the practice fire risk assessment. We were shown a general risk assessment dated 22 September 2022. This included a section on fire hazards. However, it was a brief document and was not reflective of our findings on the day. It referred to testing of smoke alarms, which the practice did not have. It further stated that fire drills were held twice yearly, however there was no evidence the fire drills were undertaken in the practice.

The practice had two water extinguishers and we saw evidence that these were serviced on 8 December 2022. However, the regional manager could not provide information as to how the provider assured themselves that these were the appropriate number and type of fire extinguishers for the size of the premises.

The practice had a fire logbook with records of in-house periodic tests of the fire safety equipment. We noted that this was not reflective of practice specific arrangements as it referred to weekly check of call points which the practice did not have.

Following the inspection, the practice submitted a fire risk assessment dated August 2021. This had been undertaken by an external company and made a number of recommendations. Actions to be completed immediately included consulting with the local enforcing authority when planning effective evacuation strategy, carrying out and external evaluation to determine the most effective upgrade of the current fire alarm system, fitting fire-resisting doors with appropriate self-closing devices and ensuring Personal Fire Evacuation Plan was drawn up for every disabled person. The fire risk assessment also made a number of medium risk recommendations with actions to be completed within 3 months of the assessment. We were not provided evidence that the action plan in the fire risk assessment had been reviewed and the recommendations completed within the required timeframes.

The practice had arrangements to ensure the safety of the X-ray equipment, and the required radiation protection information was available. On the day of inspection, local rules for the Orthopantomogram (OPG) room were not made available for us to review. Following the inspection, the practice submitted the relevant local rules.

Risks to patients

The practice had an inoculation risk assessment dated 17 March 2022 and this included sharps waste and cleaning. Improvements were needed to ensure the practice had a sharps risk assessment with all types of sharps used withing the service and the practice specific control measures. On the day of inspection, a member of clinical staff was unaware where to locate practice specific information about the management of a sharps injury. Following the inspection, the provider told us that sharps injury protocols would be covered in the next staff meeting to ensure staff were aware of the procedure and that they had now updated their sharps risk assessment to include all sharps used.

Emergency equipment and medicines were available and checked in accordance with national guidance.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year.

The practice had risk assessments to minimise the risk that could be caused from substances that are hazardous to health.

Information to deliver safe care and treatment

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

The practice did not have systems for monitoring referrals made for patients with suspected oral cancer under the national two-week wait arrangements.

Safe and appropriate use of medicines

Are services safe?

The practice had systems for appropriate and safe handling of medicines. Improvements could be made to ensure that audits for prescribing of antibiotic medicines were carried out, taking into account the guidance provided by the College of General Dentistry.

Track record on safety, and lessons learned and improvements

The practice had systems to review and investigate 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.

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. They 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 patient care records in line with recognised guidance.

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

We saw evidence the dentists justified, graded and reported on the radiographs they took. The practice carried out radiography audits six-monthly following current guidance.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

Clinical staff completed continuing professional development required for their registration with the General Dental Council. Improvements could be made to have a structured induction programme in place to introduce practice specific arrangements to new members of staff.

Co-ordinating care and treatment

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

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

Are services caring?

Our findings

We found this practice was providing caring services in accordance with the relevant regulations.

Kindness, respect and compassion

Staff were aware of their responsibility to respect people's diversity and human rights.

Privacy and dignity

Staff were aware of the importance of privacy and confidentiality.

The practice had installed closed-circuit television to improve security for patients and staff. Relevant policies and protocols were in place.

Staff password protected patients' electronic care records and backed these up to secure storage. They stored paper records securely.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care and gave patients clear information to help them make informed choices about their treatment.

The practice's website/information leaflet provided patients with information about the range of treatments available at the practice.

The dentists they used to help patients understand their treatment options. These included for example photographs, study models and X-ray images.

Are services responsive to people's needs?

Our findings

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

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs and preferences.

Staff were clear about the importance of providing emotional support to patients when delivering care.

On the day of inspection, we were not provided with the practice's Disability Access Audit. Following the inspection, the provider submitted a Disability Access Audit undertaken by an external company in August 2021. This had made a number of recommendations requiring immediate action, including installation of emergency lighting at rear, highlighting step edge and provision of a ramp, installation of a hearing loop, fitting thermostatically controlled mixer taps with a lever, nominating fire wardens and installing an audible alarm system. The disability access audit also made a number of medium risk recommendations with actions to be completed within 3 months of the assessment. We were not provided evidence that the action plan in the disability access audit had been reviewed and the recommendations completed within the required timeframes.

Timely access to services

The practice displayed its opening hours and provided information on their website.

Patients could access care and treatment from the practice within an acceptable timescale for their needs. The practice had an appointment system to respond to patients' needs. The frequency of appointments was agreed between the dentist and the patient, giving due regard to NICE guidelines. Patients had enough time during their appointment and did not feel rushed.

The practice's website and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open.

Patients who needed an urgent appointment were offered one in a timely manner. When the practice was unable to offer an urgent appointment, they worked with partner organisations to support urgent access for patients. Patients with the most urgent needs had their care and treatment prioritised.

Listening and learning from concerns and complaints

The practice responded to concerns and complaints appropriately. Staff discussed outcomes to share learning and improve the service.

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). 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, high quality care.

Improvements were required to ensure key information about systems and processes was communicated effectively across the organisation. On the day of inspection staff did not know how to access key information on procedures in relation to safeguarding and sharps injury. The regional manager did not have immediate access to the fire risk assessment and disability risk assessment undertaken in August 2021 and did not appear to be aware of the significant findings of these.

Improvements were required to ensure that records in relation to the management of regulated activities were readily available and accessible to all members of staff and those who would need to review them.

Culture

Staff could show how they ensured high-quality sustainable services and demonstrated improvements over time.

Staff stated they felt respected, supported and valued. They were proud to work in the practice.

Staff discussed their training needs during annual appraisals and 1 to 1 meetings. They also discussed learning needs, general wellbeing and aims for future professional development.

The practice had arrangements to ensure staff training was up-to-date and reviewed at the required intervals.

Governance and management

Staff had clear responsibilities, roles and systems of accountability to support good governance and management.

The practice had a governance system which included policies, protocols and procedures. However, we were not assured that all relevant documents, including those relating to safeguarding and sharps injury were made available to staff.

We saw there were clear and effective processes for managing risks, issues and performance.

Appropriate and accurate information

We were not assured that staff had access to and acted on appropriate and accurate information related to the undertaking of regulated activities.

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

Engagement with patients, the public, staff and external partners

Staff gathered feedback from patients, the public and external partners and demonstrated a commitment to acting on feedback.

Feedback from staff was obtained through meetings and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on where appropriate.

Continuous improvement and innovation

Are services well-led?

The practice had systems and processes for learning, quality assurance and continuous improvement. These included audits of patient care records, disability access, radiographs, and infection prevention and control. Staff kept records of the results of these audits and the resulting action plans and improvements.

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 Treatment of disease, disorder or injury Surgical procedures	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: • Recommendations made in the fire risk assessment date August 2021 had not been acted upon. • The provider could not demonstrate that fire risk assessments had been regularly reviewed. • Fire drills were not carried out. • The fire evacuation plan was not displayed. • There was no evidence that the fire emergency lighting received annual servicing. • Clinical waste bins were not foot operated. • There were no systems in place to track and monitor referrals, including urgent referrals. • The compressor had not been serviced since March 2019. Regulation 12 (1)

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

This section is primarily information for the provider

Requirement notices

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:

- Recommendations made in the disability access audit dated August 2021 had not been acted upon.

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 activities. In particular:

- The required recruitment documentation was not stored and maintained adequately.
- Not all members of staff had satisfactory evidence of conduct in previous employment.

There was additional evidence of poor governance. In particular:

- CCTV (Closed Circuit Television) signage was not displayed to inform people about its presence.
- Governance systems were ineffective as they did not include sufficient oversight, scrutiny and overall responsibility by the registered manager.

Regulation 17 (1)