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Denmark Hill Dental Surgery

Inspection report

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Date of inspection visit: 13 December 2021
Date of publication: 06/01/2022

Overall summary

We carried out this announced inspection on 13 December 2021 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 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 specialist dental adviser.

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

• 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:

Are services safe?

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

Are services effective?

We found this practice was providing effective 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.

Summary of findings

Background

Denmark Hill Dental Surgery is in the London Borough of Lambeth and provides NHS dental care and treatment for adults and children.

The practice is located close to public transport links and car parking spaces are available near the practice.

The dental team includes the principal dentist, one trainee dental nurse and a hygienist. The practice has one treatment room.

The practice is owned by an individual who is the principal dentist there. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

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

The practice is open:

Monday to Friday from 9.00am – 5.00pm

Our key findings were:

- The provider asked staff and patients for feedback about the services they provided.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- Staff provided preventive care and supported patients to ensure better oral health. However, improvements were needed to ensure that information related to patient care was suitably recorded within the dental care records.
- The practice appeared to be visibly clean and well-maintained. Improvements, however, were needed to the storage arrangements for cleaning equipment.
- The provider did not have infection control procedures which reflected published guidance.
- Not all equipment had been serviced and maintained according to manufacturer's instruction and guidance
- Staff knew how to deal with emergencies. Emergency equipment and medicines however, were not available as described in the Resuscitation Council UK 2021 guidelines.
- Risks to staff and patients from undertaking of the regulated activities had not been suitably identified and mitigated.
- The provider did not have suitable staff recruitment procedures.
- There was ineffective leadership and a lack of management oversight for the day-to-day running of the service.
- There were ineffective systems to ensure facilities were safe and equipment was serviced and maintained according to manufacturers' guidance.

We brought our concerns to the attention of the provider and requested urgent action. They voluntarily decided to close the practice for a period of time to make urgent improvements.

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.

Summary of findings

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 Action 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)

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. Staff we spoke to knew about the signs and symptoms of abuse and neglect and how to report concerns.

The provider had a system to highlight vulnerable patients and patients who required other support such as with mobility or communication, within dental care records.

The provider had an infection prevention and control policy and procedures. The policy document followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care. However, we found several shortcomings in the infection prevention and control procedures at the dental practice.

Staff completed infection prevention and control training and received updates as required.

The provider had ineffective arrangements for transporting, cleaning, checking, sterilising and storing instruments. We found the pouching and storage arrangements of the dental instruments was not in accordance with the guidelines. For example, some pouched instruments were left unsealed once sterilised and we found pouches that had passed their use-by date and there was no system in place to ensure these were re-processed before use.

Instruments were not scrubbed immersed in a detergent solution and the quantity of cleaning agent used was not in accordance with the manufacturer's guidelines. The HTM01-05 recommended weekly testing protocol for the steriliser, which include residual air test and air leakage test were not being carried out. Instruments were also not being dried appropriately in accordance with the guidance.

The systems in place to ensure that patient-specific dental appliances were disinfected prior to being sent to a dental laboratory and before treatment was completed were ineffective in that the materials used had expired in 2016.

We saw the practice had some procedures to reduce the possibility of legionella or other bacteria developing in the water. We looked at the risk assessment carried out in February 2021 and noted that a recommendation had been made, relating to the removal of some flexible pipework; however, this had not been actioned. A system had been implemented to monitor the hot and cold-water temperatures and the provider was able to show us records to demonstrate this was an ongoing process. However, on the day of the inspection we noted that while there was a protocol in place for flushing the dental unit waterlines (DUWLs) these were not disinfected periodically as set out in the HTM01-05.

We found the practice was visibly clean; however, the cleaning equipment, such as the mops and buckets, were not available and not stored appropriately as per national guidance.

The principal dentist described the procedures in place in relation to COVID-19. Additional standard operating procedures had been implemented to protect patients and staff from Coronavirus. These included social distancing and screening

measures which had been implemented. We saw evidence that Personal Protective Equipment (PPE) was in use and the principal dentist had been appropriately fit tested for filtering facepiece (FFP) masks. The trainee dental nurse, however, had not been appropriately fit tested; the provider assured us this was scheduled to be carried out shortly after the inspection.

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

The principal dentist showed us an infection prevention and control audit dated August 2020; however, records were not available to demonstrate subsequent audits had been carried out since in accordance with HTM01-05

The provider had a whistleblowing policy. Staff felt confident they could raise concerns without fear of recrimination.

The dentist told us they used dental dam in line with guidance from the British Endodontic Society when providing root canal treatment. On the day of the inspection we noted the dental dams available were past their use-by dates of 01/2016 and 04/2016 respectively. Additionally, no frame and no sterile clips were available.

The provider had a recruitment procedure to help them employ suitable staff. This reflected the relevant legislation. We checked three staff recruitment records and found these to be incomplete. Enhanced Disclosure and Barring Services (DBS) checks had not been undertaken at the time of recruitment for all members of staff, and there was no evidence the risks around this had been considered. In addition, records were not available to show that satisfactory evidence of conduct in previous employment had been sought for one member of staff.

We observed that clinical staff were qualified and registered with the General Dental Council and had professional indemnity cover.

The provider did not ensure all facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. We noted the fixed wiring electrical installation testing and the gas safety check for the premises had not been undertaken. In addition, there was no evidence the suction motor, the compressor and the dental chair had been serviced. The provider could not demonstrate that all portable appliances had been safety checked as records available indicated that only five portable appliances had been assessed.

The risks around fire safety had not been fully assessed.

The provider did not have records to indicate that smoke detectors were tested and serviced regularly, and there was no evidence of fire training for staff or fire drills undertaken. The risks around this had not been considered and suitably mitigated.

The practice had arrangements to ensure the three-yearly safety checks of the X-ray equipment were carried out and we saw the required radiation protection information was available. There was no evidence the X-ray equipment was serviced and maintained in accordance with the manufacturer's instructions.

We saw limited evidence the dentist justified, graded and reported on the radiographs they took within the dental care records we were shown. The provider told us they carried out radiography audits however records were not available to review. Clinical staff completed continuing professional development in respect of dental radiography.

Risks to patients

The provider had current employer's liability insurance and health and safety policies and procedures; however, improvements were needed to the practice's risk management processes.

The provider had ineffective systems to assess, monitor and manage risks to patient safety.

We looked at the practice's arrangements for safe dental care and treatment. A comprehensive sharps risk assessment that considered risks relating to all forms of sharps had been undertaken.

Are services safe?

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including vaccination to protect them against the hepatitis B virus, and that the effectiveness of the vaccination was checked.

Sepsis prompts for staff and information posters were not available within the practice. The principal dentist told us they currently triage patients; however we discussed the advantages of undertaking sepsis specific training to ensure all staff were able to recognise the signs and symptoms and triage patients correctly if needed.

Staff knew how to respond to a medical emergency; however improvements were needed to ensure records were available to demonstrate all staff had completed training in emergency resuscitation and basic life support as per current guidance.

Emergency equipment and medicines were not available as described in the Resuscitation Council UK 2021 guidelines. The provider did not have effective monitoring systems in place; on the day of the inspection we found the portable oxygen cylinder to be completely empty. The provider took action immediately after the inspection to rectify this. The adhesive pads for use with the Automated External Defibrillator (AED) expired in March 2020. Not all the recommended sizes of airways were available. There was no self-inflating bag for use on an adult or a child and none of the recommended sizes of clear face masks were available. The medicine used to treat low blood sugar was stored at room temperature and the date was not adjusted in accordance with the manufacturer's storage guidance, this meant it was beyond its use-by date and the provider could not be assured of the efficacy of the medicine. The medicine used to treat asthma and the corresponding spacer device were not available.

The system for monitoring the medicines was ineffective. The medicine used to treat epileptic seizures had expired and we were told had been re-ordered, however this was not available on the day. The system also failed to ensure oxygen and other important medicines for use in an emergency were available and within their use-by date. The risks around this had not been suitably considered and mitigated.

We brought our concerns to the attention of the provider and requested urgent action. They voluntarily decided to close the practice for a period of time to make urgent improvements.

A dental nurse worked with the clinicians when they treated patients in line with General Dental Council Standards for the Dental Team.

On the day of the inspection, the provider had some information available in relation to the use and storage of hazardous substances as per Control of Substances Hazardous to Health Regulations 2002 (COSHH). Improvements were needed to ensure the information was organised and easily accessible. Risk assessments were also required to ensure individual materials were up-to-date and mitigating actions were available.

Information to deliver safe care and treatment

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at dental care records with the dentist to confirm our findings and observed that improvements were needed to the level of detail recorded.

The provider had systems for referring patients with suspected oral cancer under the national two-week wait arrangements. These arrangements were initiated by National Institute for Health and Care Excellence to help make sure patients were seen quickly by a specialist.

Safe and appropriate use of medicines

The clinicians were aware of current guidance with regards to prescribing medicines.

On the day of the inspection we found a large amount of out of date materials in the surgery. The provider did not have suitable or effective systems for ensuring dental materials, were disposed of adequately once they were beyond their

Are services safe?

recommended use-by date. For example; Paste used to treat a dry socket (exp. 10/2006 and 11/2019), Calcium Hydroxide Liner (exp. 04/2020), Etching Gel (exp. 02/2020), Varnish (exp.11/2016), Ethyl Chloride (exp. 08/2012) and rubber dam (exp.01/2016 and 04/2016) were available in the surgery drawers and cupboards that were significantly beyond their use-by date and the risks around this had not been suitably considered and mitigated.

Improvements were needed to the storage and monitoring systems for NHS prescription pads to ensure they are stored and monitored as described in current guidance.

An antimicrobial prescribing audit had been undertaken in February 2021.

Track record on safety, and lessons learned and improvements

The provider had implemented systems for reviewing and investigating when things went wrong. In the previous 12 months there had been no safety incidents. Staff told us incidents would be investigated, documented and discussed to prevent such occurrences happening again.

The provider had a system for receiving and acting on safety alerts. The provider told us they reviewed any safety alerts and shared them with the team and act on them if required.

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. We saw clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

Helping patients to live healthier lives

The dentist told us, where applicable, they discussed smoking, alcohol consumption and diet with patients during appointments, however this was not consistently recorded in the dental care records.

The dentist described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients with preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition. However, we saw this was not documented consistently within the five dental care records we looked at on the day.

Consent to care and treatment

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

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentist told us they gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions. Improvements were needed to ensure this information is consistently recorded within the dental care records.

The practice's consent policy included information about the Mental Capacity Act (MCA) 2005. The team appeared to have limited understanding of their responsibilities under the act when treating adults who might not be able to make informed decisions. Records were not available to show staff had carried out MCA training and we discussed this with the provider.

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 typed dental care records containing information about the patients' current dental needs, past treatment and medical histories. The clinicians assessed patients' treatment needs in line with recognised guidance.

Improvements were needed to the quality assurance processes to encourage learning and continuous improvement. The provider should review the practice protocols regarding auditing dental care records to check that all necessary information was recorded and use the results of these audits and the resulting action plans to drive further improvements.

Effective staffing

We found staff had the skills, knowledge and experience to carry out their roles; however based on our findings on the day, we could not be assured staff had an understanding of important areas such as infection control, MCA, sepsis and fire safety. Staff new to the practice had an induction programme.

Co-ordinating care and treatment

Are services effective?

(for example, treatment is effective)

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

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

Staff worked together and with other health and social care professionals to deliver effective care and treatment. A referral monitoring system was in place to follow up on referrals and ensure patients are seen in a timely manner.

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 Notice 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, high quality care. The principal dentist could not assure us that they understood risks pertaining to the management of the service and the delivery of care.

Culture

Staff we spoke with were new to the practice but stated they enjoyed working at the practice and felt well supported.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

Staff could raise concerns and were encouraged to do so, and they had confidence that these would be addressed.

Governance and management

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

As it is a very small team staff knew the management arrangements and their roles and responsibilities within the practice.

The practice did not have effective systems for governance in relation to the management of the service.

The processes for managing risks were ineffective. The practice did not have adequate systems in place for recognising, assessing and mitigating risks in areas such as the medicines used to treat emergencies, the decontamination of dental instruments, the disposal of out of date stock, fire safety and legionella.

Where risks had been highlighted and recommendations made in risk assessments, there were no systems in place to ensure the relevant improvements, reviews and training had been carried out; for example in the legionella risk assessment.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

The provider had some 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 used patient surveys and encouraged verbal comments to obtain staff and patients' views about the service.

Continuous improvement and innovation

Are services well-led?

The provider did not have effective quality assurance processes to encourage learning and continuous improvement. Records were not available to demonstrate audits of radiographs and infection prevention and control were undertaken and re-assessed at the required intervals. The dental care record audits we were shown were not reflective of our findings on the day nor were they sufficiently detailed so as to drive continual improvement. A disability access audit had not been undertaken to consider patients with additional needs.

The provider did not have a system for monitoring staff training and no training records for one member of staff were available on the day of the inspection. We could not be assured all staff completed 'highly recommended' training, including Basic Life Support (BLS) training, as per General Dental Council professional standards.

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 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 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: • Not all fire safety risks had been considered. No fire drills had been carried out and no staff training had been undertaken in relation to fire safety. Records were not in place to demonstrate that the smoke detectors or the emergency lighting were monitored and serviced. • Recommendations made in the Legionella risk assessment had not been actioned. There was no evidence protocols were in place for disinfecting the DUWLs. • The cleaning equipment was not available nor stored appropriately. No cleaning schedules or records were available. • Information was not available for all materials in relation to the storage and handling of hazardous substances and the information available was disorganised. • NHS prescription pads were not stored and monitored in accordance with guidelines. • Not all staff members had been suitably fit-tested for PPE used when carrying out aerosol generating procedures.

This section is primarily information for the provider

Requirement notices

There were no systems or processes that ensured the registered person had maintained 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:

- There was no system in place to ensure important recruitment checks had been carried out, for all members of staff, at the time of recruitment.
- Records were not available to demonstrate that staff training was up-to-date and undertaken at the required intervals.

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 improve the quality and safety of the services being provided. In particular:

- A radiography audit and a disability access audit had not been undertaken.
- The Infection Prevention and Control audits were not undertaken bi-annually as required.

The registered person had systems or processes in place that 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:

- There was a lack of consistency in the information recorded in the dental care records.

Regulation 17 (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. 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 medicines and equipment used to treat medical emergencies were not available as per relevant national guidance. • Not all equipment had been serviced and maintained according to manufacturer's instruction and guidance. • Important safety assessments on the premises had not been carried out. A gas safety certificate and an electrical 5-year fixed wire safety certificate were not available. Not all portable appliances were safety checked. • The decontamination of used dental instruments was not carried out in accordance with HTM 01-05. • There were not effective systems for ensuring dental materials, were disposed of adequately once they were beyond their recommended use-by date. Regulation 12 (1)