Mr. John Kanogo

Sterlingway Dental Surgery

Inspection report

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Overall summary

We carried out this announced focused inspection on 7 June 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.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff provided preventive care and supported patients to ensure better oral health.
- The practice did not have infection control procedures which reflected published guidance.
- Staff did not know how to deal with medical emergencies. The medical emergency drugs and equipment were not checked regularly as per current national guidance.
- There were ineffective processes in place to prevent abuse of vulnerable adults and children.
- The provider did not have suitable staff recruitment procedures to comply with current legislation.
- There were ineffective systems to ensure that staff were up to date with their training.
- Risks to staff and patients from undertaking of regulated activities had not been suitably identified and mitigated.

Summary of findings

- There were ineffective systems to support continuous improvement.
- There were some arrangements in place for the servicing of equipment. However, improvements were needed to ensure that all dental equipment were serviced and validated in line with the manufacturer`s guidance and the premises were safe.
- Staff generally worked as a team. However, improvements were needed to ensure that they were supported and involved in the delivery of care and treatment.
- There was ineffective leadership and a lack of oversight for the day-to-day management of the service.

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.

Metered parking spaces are available near the practice and it is also located close to public transport services.

The dental team includes one principal dentist, one dental nurse, one trainee dental nurse and two part-time receptionists. The practice has two treatment rooms.

During the inspection we spoke with the dentist, the dental nurse, and one 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 complying with. They must:

- Ensure care and treatment is provided in a safe way to patients.
- Ensure patients are protected from abuse and improper treatment.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them carry out their duties.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

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:

- Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the College of General Dentistry (CGDent)
- Ensure clinicians take into account relevant nationally recognised evidence-based guidance when undertaking patient assessments.

Summary of findings

- Improve the practice protocols regarding auditing patient dental care records to check that necessary information is recorded.
- Improve staff awareness of sepsis.

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.

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

The practice did not have effective safeguarding processes to prevent abuse of vulnerable adults and children. Internal safeguarding arrangements were not communicated effectively. Staff were uncertain about safeguarding arrangements within the practice and who the named safeguarding lead was. When asked about systems to monitor children who repeatedly failed to attend their appointment, staff told us that they would record this information in the dental care records as 'failed to attend', but they were not able to explain what they did with this information to identify potential neglect.

The provider could not demonstrate that staff received safeguarding training that was relevant, and at a suitable level for their role. Processes were ineffective to ensure that staff updated training at appropriate levels to enable them to recognise different types of abuse. We noted that three out of the five members of staff at the practice had not undertaken safeguarding training.

Information about current procedures, and guidance about raising concerns about abuse were not accessible to people who use the service and to staff. The contact details of the Local Authority`s safeguarding board were not available or shared with staff.

The practice had infection control procedures which broadly reflected published guidance. However, we found shortcomings in the infection prevention and control procedures.

The practice had infection control procedures which broadly reflected published guidance. However, we found shortcomings in the infection prevention and control procedures.

Instruments were not immersed for scrubbing and the quantity of cleaning agent used was not in accordance with the manufacturer`s guidelines. The daily automatic control test and the weekly residual air test for the autoclave were not carried out as recommended 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. We also found that clean and dirty transportation boxes were not clearly marked.

Worktops were not impervious or sealed and tiles in the decontamination room were cracked, potentially allowing inadequate cleaning of the surfaces.

The procedures to reduce the risk of Legionella or other bacteria developing in water systems were ineffective. The risk assessment carried out on 23 February 2018 had a number of recommendations. These included having systems for monitoring and recording the temperature of hot and cold-water taps. However, there were no records to indicate that these recommendations had been acted upon.

The systems for flushing and disinfecting Dental Unit Waterlines (DUWLs) were not in line with the recognised national guidance. There were processes in place to ensure that DUWLs were flushed at the beginning and end of the day, however they were not flushed for at least 20-30 seconds between patients. Furthermore, we noted that the quantity of solution used to disinfect DUWLs was not in line with the manufacturer`s guidance.

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

Are services safe?

We saw the practice was visibly clean. However, improvements could be made to ensure that cleaning equipment, such as mops and buckets were stored appropriately.

The recruitment procedure to help the practice employ suitable staff did not reflect national legislation. We checked staff recruitment records and found these to be incomplete. 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 that the risk around these had been considered. In addition, records were not available to show that satisfactory evidence of conduct in previous employment had been sought for three members of staff. There was no evidence that identification and right to work in the UK checks had been carried out.

Systems to check relevant qualification or training for all members of staff were ineffective. For example, the college certificate for the trainee dental nurse was an undated document without the full details of the training provider. The provider could not demonstrate that they sought assurances of the validity of the course in the absence of full details about the training and course provider.

The practice had some systems in place to ensure that equipment was safe to use and maintained and serviced according to manufacturers' instructions. The fixed wiring electrical installation testing had been carried out 3 June 2022 and we saw evidence that the X-ray equipment, compressor and dental chairs had been serviced on 2 June 2022.

We noted that the dental chair in Surgery 2 had a second chair mounted dental lamp added. The two metal parts were held together by a mole grip plier, an instrument intended to - locking things into position. All bolts, where the two metal plates should have been secured together were missing and the structure was unstable. There was no evidence that the risk of harm and injury to patients and staff arising from this temporary solution had been identified and mitigated.

The provider submitted photographic evidence on 9 June 2022 that the dental chair in Surgery 2 had been replaced.

We saw that fire extinguishers were available, serviced regularly and the fire exits were kept clear. The risk assessment carried out on 25 November 2015 had made a number of recommendations. These included having systems for the weekly testing and recording of smoke detectors, the monthly testing and recording of the emergency lighting systems and undertaking regular fire drills. However, there were no records to indicate that these recommendations had been acted upon.

In addition, we noted that the emergency lighting system has not been serviced and there was no evidence that staff appointed as fire marshals had fire awareness or fire marshal training.

The practice had arrangements to ensure the safety of the X-ray equipment and we saw the required radiation protection information was available.

Risks to patients

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

A comprehensive sharps risk assessment that considered all risks relating to all forms of sharps had not been undertaken.

The needlestick injury poster was not displayed and it did not include the Occupational Health, or the nearest Accident & Emergency department contact details.

Sepsis prompts for staff and information posters were not available within the practice.

Emergency medicines were not available in accordance with national guidance. On the day of inspection Buccal Midazolam (an emergency medicine to treat epileptic seizures) was not available. Glucagon (an emergency medicine used to treat severe low blood sugar) was not stored in the fridge and the expiry date was not reduced by 18 months. Aspirin 300mg was not available in a dispersible form as per national guidance.

Are services safe?

The provider took immediate action and placed an order for the missing and out of date medical emergency drugs with a nearby pharmacy who delivered them on the same day before the completion of the inspection.

Not all medical emergency equipment was available as recommended in the national guidance.

On the day of inspection, the spacer device, sizes 0,1 and 4 of the oropharyngeal airways, self-inflating bag for children and clear face masks for the self-inflating bag were missing. After the inspection the provider submitted evidence that these had now been ordered.

The provider did not have effective monitoring systems in place to check the medical emergency and equipment. Staff told us that they checked the medical emergency equipment, including medicines, the oxygen cylinder and the Automated External Defibrillator (AED) once every three months. The national guidance recommends that resuscitation equipment is checked weekly as a minimum.

No written records were available to confirm that these checks had been undertaken.

Staff did not know how to respond to a medical emergency. When asked, staff were unable to attach the battery to the AED and they could not demonstrate that they had an understanding of how it was to be used in the event of a medical emergency. In addition, staff mistook a prefilled Adrenaline syringe that was intended to be used for intravenous application to be an auto-injector. There was no record for any emergency resuscitation and basic life support training for one clinical member of staff.

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

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

On the day of inspection, we found that a pre-stamped prescription pad was stored in the treatment room in an unlocked drawer. Improvements were needed to ensure the storage and monitoring system for NHS prescription pads to ensure they are stored and monitored as described in current guidance.

We also noted that the provider did not undertake regular audits for antimicrobial prescribing.

Track record on safety, and lessons learned and improvements

The practice had implemented systems for reviewing and investigating incidents and accidents. In the previous 12 months there had been no safety incidents. The provider told us they had systems in place to review any 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. However, improvements could be made to ensure clinicians familiarise themselves with relevant nationally recognised evidence-based guidance, including those published by the National Institute of Excellence (NICE).

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 written dental care records in line with recognised guidance. However, improvements could be made by introducing a quality assurance processes to encourage learning and continuous improvement. The provider should carry out record card audits and use the results of these to drive further improvements.

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. However, the practice did not carry out six-monthly radiography audits in line with the current guidance and legislation.

Effective staffing

Staff had some level of 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 safeguarding, infection control, medical emergencies and basic life support.

We noted that there were no arrangements for staff new to the practice to have a structured induction programme and the provider could not demonstrate that there was a system and plan in place for the supervision and support of trainee staff.

Clinical staff completed continuing professional development required for their registration with the General Dental Council; however, based on our findings on the day this was not effective and the learning outcomes did not lead to a clear understanding of infection control processes and the management of medical emergencies. The provider failed to identify that the training clinical staff had undertaken was ineffective.

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). 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.

We found that staff members worked well together. However, improvements were needed to ensure information about systems and processes were communicated effectively across the organisation.

The information and evidence presented during the inspection process was not always well documented. Improvements were needed to ensure that records in relation to the management of regulated activities were readily available and easily accessible to all members of staff and those who would need to review them.

Culture

Staff we spoke with stated they enjoyed working at the practice.

We found that there were no arrangements in place for staff to discuss their training needs at an appraisal. The provider could not demonstrate that there were effective systems in place to support staff in their professional development.

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. There were a lack of clear roles and systems for accountability to support good governance and management.

The practice did not have effective systems and processes in place in relation to the management of the service. We noted that the provider had a reactive rather than a proactive approach to governance. Several essential requirements, including servicing of equipment had not been undertaken regularly in the past and some were only booked in response to the CQC inspection announcement. For example, the servicing of dental equipment and the fixed wiring electrical installation testing had been carried out the week before the inspection.

Improvements were needed to the risk management processes to ensure they were effective. Where risks had been highlighted and recommendations made in risk assessments, there were no systems in place to ensure the relevant improvements and reviews had been carried out. This included, for example the fire safety and the legionella risk assessments.

On the day of inspection, a legionella risk assessment carried out on 23 February 2018 was made available for review. Not all recommendations made in the risk assessment had been acted upon. We noted that no other legionella risk assessment was available for review and the provider could not demonstrate that risk assessments had been regularly carried out and reviewed to allow ongoing identification and mitigation of risks associated with bacteria building up in DUWLs.

On the day of inspection, a fire risk assessment carried out on 25 November 2015 was made available for review. Not all recommendations made in the risk assessment had been acted upon. We noted that no other fire risk assessment was available for review and the provider could not demonstrate that risk assessments had been regularly carried out and reviewed to allow ongoing identification and mitigation of risks associated with fire.

Are services well-led?

Appropriate and accurate information

We found that accurate and appropriate information was not always shared with staff. For example, internal safeguarding arrangements and information about raising safeguarding concerns externally were not shared with staff.

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

Continuous improvement and innovation

The practice did not have effective systems and processes for learning, continuous improvement and innovation. Records were not available to demonstrate audits of radiographs were undertaken and re-assessed at the required intervals. Infection prevention and control audits were not carried out bi-annually in line with the relevant national guidance. The disability access audit we were shown was not reflective of our findings of the day; it did not address the steep approach and ramp at the entrance or that the downstairs toilet was without a grab rail and a pull cord.

The provider did not have a system for monitoring staff training and no training records were available for three members of staff on the day of the inspection. We could not be assured that the infection control and medical emergency training clinical staff completed were effective.

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 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: • Recommendations made in the fire risk assessment had not been carried out and risks associated with fire had not been appropriately addressed and mitigated. • The provider could not demonstrate that risk assessments in relation to legionella and fire had been regularly carried out and reviewed. • There was no sharps risk assessment that considered the risks associated with all forms of sharps and the provider had not mitigated those risks to staff 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: • Radiography audit was not available. • Infection prevention and control audit was not carried out bi-annually.

This section is primarily information for the provider

Requirement notices

- The disability access audit was not reflective of the arrangements within the service.

Regulation 17 (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 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: • There were no arrangements for staff new to the practice to have a structured induction programme. • There were no systems in place to support and supervise trainee staff. • There were no arrangements in place for staff to discuss their training needs at an appraisal. • The provider did not have a system for monitoring staff training. • The training clinic staff undertook as part of their continuous professional development did not provide effective learning outcomes. Regulation 18 (2)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 19 Fit and proper persons employed**

This section is primarily information for the provider

Requirement notices

The registered person`s recruitment procedures did not ensure that only persons of good character were employed. In particular:

- Disclosure and Barring Services (DBS) checks had not been undertaken at the time of recruitment for all members of staff.
- There was no evidence that identity checks had been carried out.
- Records were not available to show that satisfactory evidence of conduct in previous employment had been sought for all members of staff at the time of recruitment.

Regulation 19 (1) & (2)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 13 Safeguarding service users from abuse and improper treatment** The registered person did not have systems and processes in place that operated effectively to prevent abuse of service users. In particular: • Information about current procedures, and guidance about raising concerns about abuse were not accessible to people who use the service and to staff. • The provider could not demonstrate that staff received safeguarding training that was relevant, and at a suitable level for their role. Regulation 13 (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 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: • Not all recommendations made in the Legionella risk assessment had been actioned. • Processes and systems for managing Dental Unit Water Lines (DUWLs), including flushing and disinfection was not in line with the relevant national guidance and the manufacturer`s recommendations. • The medical emergency drugs and equipment were not checked regularly as per current national guidance. • Staff failed to demonstrate an understanding of how to manage medical emergencies. • The provider failed to ensure that the premises for undertaking the regulated activities were safe. The dental chair in Surgery 2 was unstable and had the potential to cause risk of harm and injury to patients. • The provider failed to assess the risk of, and prevent and control the spread of, infections in accordance with the Department of Health publication 'Health and Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05). • The provider did not have processes to log and monitor the medication prescribed to patients. The prescription pad was stored unsecured in an unlocked drawer. Regulation 12 (1)