Mr. John Kanogo

Sterlingway Dental Surgery

Inspection report

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Overall summary

We undertook a follow up focused inspection of Sterlingway Dental Surgery on 27 January 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 second inspector and a specialist dental advisor.

We had previously undertaken a comprehensive inspection of Sterlingway Dental Surgery on 7 June 2023 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 still not providing safe and 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 safe?
- Is it well-led?

Our findings were:

Are services safe?

Summary of findings

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

The provider had made improvements in relation to the regulatory breaches we found at our inspection on 27 January 2023.

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 7 June 2022 and 23 September 2022. However, we identified new concerns.

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.

We spoke with one carer who had brought their child to follow up a previous enquiry about an urgent referral. We could not speak with any other patients as no other patients were scheduled to be seen on the day.

The practice is open:

Monday to Friday 8am to 7pm.

Saturday 8am to 2pm.

We identified regulations the provider was not meeting. They must:

- 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:

- Improve the practice's protocols for medicines management and ensure all medicines are stored in line with the manufacturer`s guidance.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**No action**
Are services well-led?	**Enforcement action** 

Are services safe?

Our findings

We found that this practice was providing safe care and was complying with the relevant regulations.

At the inspection on 27 January 2023 we found the practice had made the following improvements to comply with the regulations:

- We saw evidence that the recommendations made in the fire risk assessment undertaken in October 2022 had been acted upon. The practice had reduced and reorganised combustible materials around the premises. They carried out regular fire safety checks; this included periodic in-house tests of the fire detection system. Fire drills were carried out and staff undertook fire awareness training.
- Emergency equipment and medicines were available and checked in accordance with national guidance. We observed that Glucagon (an emergency medicine used to treat severe low blood sugar) was not stored in the fridge. Improvements were needed to ensure the expiry date was revised in line with the manufacturer`s 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 made improvements to ensure infection prevention and control procedures were in line with the current guidance. For example, there were processes in place to ensure that the ultrasonic bath was drained at the end of every clinical session. Dental instruments were sterilised and wrapped in line with the relevant guidance. Surfaces and the decontamination area appeared to be clean with no dust, cobwebs or foliage.
- Soap was available in the decontamination room to ensure that staff could practice appropriate hand-hygiene at key stages of the decontamination process.
- Staff told us that they would flush Dental Unit Water Lines (DUWLs) for 2 minutes at the beginning of the day and for 20-30 seconds between patients. This was in line with the current national guidance.
- NHS prescription pads were stored securely. Improvements were needed to ensure that the process of monitoring prescription was effective, and the log included the date and name of medication prescribed.

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 27 January 2023 we found the practice had made some improvements to comply with the regulations:

- Annual appraisal of staff had been undertaken in November 2022. This covered review of training needs and a feedback.
- The provider had made improvements to ensure patient care records were stored appropriately. These had now been reorganised in lockable metal cabinets.
- We saw evidence that the recommendations made in the Legionella risk assessment undertaken in October 2022 had been acted upon. Staff were aware of the correct range for hot and cold water temperatures and this correlated with the measurements appearing on the records. We checked hot and cold water temperatures during the inspection and these were in accordance with guidelines to minimise Legionella growth in the waterlines.
- The provider had made improvements to ensure that recommendations made in the Disability Access Audit dated May 2022 had been acted upon. They had installed a manifestation on the glass entrance door to prevent injury, removed the disabled sign from the toilet door (as it was incorrectly labelled as an accessible toilet when it was not) and installed a hearing loop at the reception.
- An infection control audit had been completed in January 2023. It included findings and an action plan.
- Improvements could be made to ensure the radiography audit included patient identifiers and full dates, including year to ensure findings could be cross referenced to radiographs taken.
- The provider had engaged a compliance company who they were planning to continue working with closely to maintain compliance with the legal requirements.

During the follow up inspection we identified the following areas of concern:

- A member of staff who had a student visa status had now enrolled onto a decontamination course. However, no evidence was provided of the staff member being enrolled on a course leading to a recognised qualification.
- The provider could not demonstrate that they were maintaining accurate, complete and contemporaneous records in respect of each patient. On the day of inspection, we asked to see clinical records for the patients who had visited the practice two days ago on 25 January 2023. The principal dentist told us that out of the 16 patients originally booked in, 13 had attended their appointment. 9 out of the 13 records were not available for review and the practice was unable to produce these before the end of the inspection. Of the 4 records that were available for patients seen by the practice on 25 January 2023, one patient did not have record of the treatment they had received that day.
- We requested a sample of further records of patients seen in November 2022 and looked at a total of 11 record cards. The records we reviewed were paper records. Clinical information was written in shorthand and was difficult to decipher. This was contrary to the General Dental Council (GDC) Standard 4.1 that states “that you must ensure that all documentation that records your work, including patient record is clear, legible, accurate, and can be readily understood by other.” We were not assured that these records could be readily understood by another clinician in the absence of the principal dentist. Furthermore, the patient records we reviewed were missing details such as risk assessments, recall intervals according to risk, and justification and grading on radiographs.
- The record of antibiotics prescribed to a child on 2 November 2022 did not include dosage and the duration it was prescribed for.
- Systems to monitor referrals, including urgent referrals, were not effective. The principal dentist told us that in case of an urgent referral, they would complete the referral form on paper and take photographs using their personal mobile phone. They further said that they would then forward these, using their personal email account, to another member

of staff`s or an external person's personal email address. That staff member would then submit the photograph of the form to the referral center by logging in to the practice's NHS email account. We were concerned that this method of referral meant that confidential patient information was shared unsecurely using non-encrypted email accounts and potentially with people who were otherwise not part of the organisation. Furthermore, there were no systems in place to ensure that referrals, including urgent referrals were effectively followed up and monitored to identify potential delay and possibly mitigate risks to patient safety.

- We observed that a patient record card we reviewed included the medical history details belonging to another patient. The patient, whom the record card belonged to, had signed the medical history document on a number of occasions, indicating that they had reviewed the contents of the document. The practice had failed to identify that the patient had signed the medical history document relating to another patient. The practice also failed to identify that they had shared confidential personal details, including a full medical history with another patient.
- We found two boxes of Amoxicillin 500mg with prescription labels in the practice. The principal dentist admitted that they had prescribed antibiotics to themself. In respect of the other box the principal dentist told us that they had prescribed these for a patient who had returned these antibiotics to the practice. We asked if this had been recorded and asked to see the patient's dental care records. No records were found for this patient in the practice. Additionally, there were no records of the reasons for prescribing or record of the patient returning or not completing the course of antibiotics.

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 There were no systems or processes that enabled the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular: • There were no patient records available for 9 out of 13 patients who we were told attended an appointment at the practice on 25 January 2023. • Of the 4 records that were available for patients seen by the principal dentist on 25 January 2023, one patient did not have record of the treatment they received that day. • All clinical records were paper records, written in shorthand, difficult to decipher and could not be readily understood by others. This is contrary to the General Dental Council (GDC) Standard 4.1. We found that some records were missing details such as risk assessments, recall intervals according to risk, and justification and grading on radiographs. • Record of antibiotics prescribed to a 3-year-old patient did not include the dosage and the duration it was prescribed for.

This section is primarily information for the provider

Enforcement actions

The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:

- The record card of a patient included a medical record of another patient. The patient whose record it belonged to had signed to say they had reviewed the details. This meant that the provider had failed to identify that they had shared confidential details of a patient, including the full medical history, with another patient.
- The provider told us that in addition to one member of staff, they used another 'person' to help them with computer related tasks, including urgent referrals containing personal patient information and NHS claims. The provider could not demonstrate that this person has had the necessary recruitment checks carried out. Furthermore, confidential patient information was shared via personal email accounts.
- We were not assured that there were effective arrangements for monitoring referrals, including urgent referrals the provider made.

There was additional evidence of poor governance. In particular:

- We found two boxes of Amoxicillin 500mg prescribed for 7 days in the practice. The principal dentist admitted that they prescribed one of these to themself. In respect of the other box of antibiotics they told us that they had prescribed these, and antibiotics had been given back by the patient. No records were found for this patient and there were no records of the reasons for prescribing or record of the patient not completing the course of antibiotics and returning them to the practice.

Regulation 17 (1)