Dr. Simon Lewis

Dr Simon Lewis - Rodney Street

Inspection Report

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Date of inspection visit: 29/11/2017
Date of publication: 09/01/2018

Overall summary

We carried out a follow up focused inspection on 29 November 2017 at Dr Simon Lewis – Rodney Street.

On 22 August 2017 we undertook an announced comprehensive inspection of this service as part of our regulatory functions. During this inspection we found a breach of the legal requirements.

A copy of the report from our comprehensive inspection can be found by selecting the 'all reports' link for Dr Simon Lewis – Rodney Street on our website at www.cqc.org.uk.

After the comprehensive inspection, the practice did not send us the requested action plan to say what they would do to meet the legal requirements in relation to the breach.

This report only covers our findings in relation to those requirements.

We revisited Dr Simon Lewis – Rodney Street on 29 November 2017 to check whether they met the legal requirements in the Health and Social Care Act 2008 and associated regulations. We carried out this announced inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

We reviewed the practice against one of the five questions we ask about services: is the service well-led?

The inspection was led by a CQC inspector who was supported by a second CQC inspector.

Our findings were:

Are services well-led?

We found that this practice was not providing well-led care in accordance with the relevant regulations.

Background

Dr Simon Lewis - Rodney Street is close to the centre of Liverpool and provides dental care and treatment to adults and children on a privately funded basis.

There are steps at the front entrance to the practice. The practice has one treatment room. Car parking is available near the practice.

The dental team includes one dentist and a dental nurse. The team is supported by a practice manager, who is also a dental nurse.

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.

The practice is open:

Summary of findings

Tuesday 11.00am to 4.00pm

Wednesday 9.00am to 4.00pm

Thursday 9.00am to 3.30pm.

Our key findings were:

- Appropriate medical emergency medicines and equipment were now available.
- The practice now received patient safety alerts and acted on these. Staff had not reviewed relevant historic alerts.
- Arrangements had been put in place for staff to raise concerns where necessary. These did not include details of external organisations staff could contact.
- The practice had infection control procedures in place but these did not always reflect published guidance.
- Staff had improved some aspects of risk management. Not all risk management processes were operating effectively, for example, no Legionella risk assessment had been carried out.
- The practice had a leadership structure and governance arrangements in place. The practice had not considered how good governance would be maintained in the long term.
- There were limited means for asking staff for feedback about the services they provided. Staff did not always receive adequate support for their roles.

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

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Send CQC a written report setting out what plans are in place to make improvements.

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 and should:

- Review the practice's arrangements for reviewing relevant historic patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency and through the Central Alerting System, as well as from other relevant bodies such as, Public Health England.
- Review the practice's arrangements for ensuring good governance and leadership are sustained in the longer term.

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 well-led?

We found that 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 at the end of this report).

Since the last inspection on 22 August 2017 the practice had taken action to improve some aspects of the service, for example, in relation to medical emergency equipment and medicines, and some of the infection prevention and control processes. Other aspects had not been improved, for example, some of the risk management processes, in relation to Legionella and infection control.

The practice had introduced new procedures to help them ensure dental equipment and materials were within their expiry dates.

We found that the practice had not considered how good governance would be maintained in the long term.

Staff monitored clinical and non-clinical areas of their work to help them improve and learn. The monitoring was not always operating effectively.

The practice had limited means to ask for the views of staff.

The practice received patient safety alerts and acted on these. We found they had not reviewed relevant historic alerts to ensure no action was required.

During our inspection we highlighted the importance of acting on our concerns to ensure the provider reduced any potential risk posed to staff and patients.

Requirements notice ✖

Are services well-led?

Our findings

Governance arrangements

The principal dentist had overall responsibility for the management and clinical leadership of the practice. The practice manager was responsible for the day to day running of the service, and also provided occasional dental nursing support and administrative support. The practice manager was the lead for infection control. We found adequate support for this role was not in place.

We reviewed the practice's systems and processes for monitoring the quality and safety of the service in relation to patient safety alerts. We saw that the practice now received these, and they were reviewed and acted on by the practice manager where necessary. We observed that the practice had not reviewed relevant historic alerts to ensure no action was required.

We saw that the provider had improved the systems relating to the identification and removal of expired dental materials from the practice. We were told all out of date materials had been removed and a system was now in place to review the expiry dates of dental materials to prevent this happening in the future.

We found the practice had made some improvements to their risk management systems, for example, we saw that all the recommended medical emergency equipment and medicines were available and checked at the recommended intervals.

We saw that risks to staff when they were manually cleaning used instruments had been reduced further, for example, by providing the recommended protective equipment including heavy duty gloves.

We found that some risks had not been fully assessed, monitored and mitigated, for example, in relation to Legionella. The practice manager assured us this would be discussed with the provider and arranged as soon as possible.

The provider could not demonstrate that a pressure vessel test had been carried out on the sterilisation equipment but was in the process of arranging to have this test carried out.

We reviewed the practice's systems and processes for assessing and monitoring risks in relation to infection prevention and control. We found that staff were taking further account of the recommended guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices, published by the Department of Health, in that the dental water lines were being appropriately flushed, the practice now had a magnifying inspection light, and cleaning equipment was now identified for specific areas of the practice. Other aspects of the guidance were not being taken into account, for example, the arrangements relating to the re-processing of unused instruments were unclear and guidance was not always followed in relation to the sterilisation of instruments whilst patients were in the treatment room.

Leadership, openness and transparency

We saw the provider now had arrangements in place for staff to raise concerns should the need arise. We observed that this could be further improved by the addition of external contacts, such as Public Concern at Work. The provider assured us this would be added.

We found that the provider had not identified ways in which good governance and leadership could be maintained in the longer term. We were told the practice had not discussed this as a team.

Learning and improvement

We observed that opportunities had been identified by staff for the practice to receive support, for example, in relation to obtaining advice on how to further improve infection control systems. We observed that these opportunities had not been taken further. After the inspection the practice manager submitted evidence that training and assessment for the practice had been arranged with an external infection control and prevention consultant.

We reviewed the practice's quality assurance arrangements in relation to the use of auditing to encourage learning and continuous improvement. We observed that improvements had been made to the auditing of X-rays. We saw that the audit of infection prevention and control had no learning points or action plan associated with it to help the practice learn and improve.

Practice seeks and acts on feedback from its patients, the public and staff

Are services well-led?

The practice had limited means to gather feedback from staff. We found that staff were allocated additional responsibilities but adequate support for these was not provided or discussed with them.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met** Assessments of some of the risks to the health and safety of service users of receiving care or treatment were not being carried out. In particular: • A Legionella risk assessment had not been carried out. The registered persons 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: • A Written Scheme of Examination, (pressure vessel test), had not been carried out on the autoclave, (Pressure Systems Safety Regulations 2000). The provider had not assessed all the risks, and had not put all reasonably practicable measures in place in relation to the prevention, detection and control of the spread of infections, including those that are health care associated. In particular: • The arrangements relating to the re-processing of the unused instruments were unclear • No records were maintained of every sterilisation cycle. • The door of the autoclave in the surgery was opened whilst patients were undergoing dental treatment to let sterilised unwrapped instruments cool down, exposing them to potential contamination. • The autoclave was in use and venting steam whilst patients were in the surgery undergoing treatment. • Surfaces in the surgery were cluttered and therefore not easily cleansable. **Regulation 12 (1)**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met** The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. In particular: • The provider had not actively sought feedback from the staff in relation to the knowledge, training needs and time requirements appropriate for a lead role in infection control. The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to evaluate and improve their practice in respect of the processing of the information obtained throughout the governance process. In particular: • The provider had not included identified learning points in the infection prevention and control audit nor produced an action plan to rectify the non-compliances. **Regulation 17 (1)** On 5 October 2017, CQC requested from the registered person any plans the registered person had for improving the standard of the services provided to service users with a view to ensuring their health and welfare. The registered person has failed to send any plans for improvement to CQC. **Regulation 17 (3)**