Mr. Anantkumar Patel

Ilford Dental Practice

Inspection report

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Overall summary

We carried out this announced inspection on 10 June 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 usually ask five key questions, however due to the ongoing 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 are three of the five questions that 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 not 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

Ilford Dental Practice is in the London Borough of Redbridge and provides private dental treatment to adults and children. The practice is accessible by Transport for London rail and bus services and is within easy access to local amenities including banks, supermarkets and a post office. The practice is not suitable for people who are in wheelchairs as there is no lift on the premise to access treatment rooms on the first floor. Paid parking spaces are available near the practice.

The practice is located on the first floor of the building which is accessed using two flights of stairs. The first floor has four treatment rooms (two viable-one functional), a treatment room which is now the decontamination room, an office area used for storage, a toilet, reception area and a waiting area.

The practice is owned by an individual who is the principal and only dentist there and is supported by two GDC registered dental nurses- one of whom serves as the reception staff and was furloughed at the time of our inspection. The principal dentist who is the responsible individual has a 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 Monday to Friday from 10:00am to 3pm. When the practice is closed, out of hours services are provided by the NHS 111 services. They did not have a website at the time of the inspection.

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

Our key findings were:

- The practice needed redecoration, refurnishing and general refurbishment.
- There was inadequate arrangements in place to monitor staff training.
- The treatment room which was used to deliver care and treatment appeared visibly clean.
- Improvements were needed in relation to infection prevention and control and fire safety.
- Not all risks to service users were appropriately assessed and managed.
- The practice had some policies and procedures to govern activities, however some were not current.
- Clinical waste was not disposed suitably.
- Equipment such as the autoclave, ultrasonic bath, dental chair, suction and compressor had not been serviced as per manufacturer's guidance.
- There were ineffective arrangements to assess and mitigate risks of fire at the practice.
- The practice did not have suitable arrangements to ensure safety of the X-ray equipment.
- Emergency equipment and medicines were not available as described in recognised guidance.
- The practice did not have systems to keep dental professionals up to date with current evidence-based practice.
- Dental care records we checked were not completed as per recommended guidance and were stored insecurely.
- The team was qualified to undertake their roles; however, they had limited systems to ensure they kept up to date with emerging guidance.
- The dental team was long-standing which meant there was continuity of care and treatment for patients.

We identified regulations the provider was not complying with. They must:

- Ensure care and treatment is provided in a safe way to patients.

Summary of findings

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

There were areas where the provider could make improvements. They should:

- Improve the decoration and overall aesthetic of the premise.
- Take action to improve the system for sending electronic referrals.

The CQC have received formal notification from the provider- Mr Ananatkumar Patel that they have ceased the delivery of all regulated activities from the registered location as of 15 June 2021. The location will remain closed for a period of four weeks whilst the provider takes steps to rectify the concerns raised during the inspection of 10 June 2021. The Commission will review the improvements at a follow up inspection.

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?	**Enforcement action** 
Are services well-led?	**Enforcement action** 

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 and 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 provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw evidence that staff had received safeguarding training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC.

The provider had an infection prevention and control policy and procedures, however these needed improving to ensure they are in line The Health Technical Memorandum 01-05 guidance: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care. Staff did not complete infection prevention and control training nor received updates as required.

The provider had some arrangements for cleaning, checking and sterilising instruments, however those around transportation and storage needed reviewing to ensure compliance with the guidance. We found unused-unwrapped instruments were not sterilised at the end of the day or beginning of the next working day.

The building was in a state of disrepair, the carpeted area in the waiting area was badly stained, walls were dirty in some places and all areas needed updating. The provider told us there was a refurbishment plan to renovate the whole practice come September 2021.

The provider had not ensured equipment were serviced in line with manufacturer's recommendation. Records we checked, showed that daily tests and housekeeping tasks were carried out on the equipment used by staff for cleaning and sterilising instruments. For example, we saw that they recorded the temperature and pressure of the autoclave before it was used for sterilising instruments; similar logs were maintained for the ultrasonic bath.

The staff had 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.

We saw that the provider had taken some steps to minimise the risk of COVID-19 transmission in line with the most recent standard operating procedures (SOP), however these were not effectively embedded. The provider had an extractor fan in the treatment room and we saw that patients were booked generous appointment times which allowed for fallow (period of time designed to allow droplets to settle and be removed from the air following treatments involving the use of aerosol generating procedures (AGPs). However, they had not ensured staff had been fit tested for filtering facepiece masks (FFP) and they did not have access to full coverage gowns as part of personal protective equipment (PPE) when carrying out AGPs which posed a risk of transmission to Covid-19.

The provider did not have a formal legionella risk assessment; however we found they had some arrangements to reduce the possibility of Legionnaire's disease or other bacteria developing in the water systems. For example, they undertook daily flushing of the dental waterlines and they told us they monitored the hot and cold-water temperature.

The provider had limited policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. Clinical waste bags, filled sharp containers and waste amalgam were stored in an

office type room which was also used to store other non-clinical items including archived paper records. We did not see evidence that dental study models containing gypsum were disposed of appropriately. The process used for developing dental X-rays was analogue; at the time of the inspection, the practice could not evidence X-ray fixer and developer fluids were collected and disposed of in line with guidance.

The provider could not demonstrate they carried out infection prevention and control audits twice a year. The latest audit completed in full was on 11 February 2015.

The practice had a whistleblowing policy, however this needed updating to ensure it remains fit for purpose.

The dentists used dental dam in line with guidance from the British Endodontic Society when providing root canal treatment.

The provider had a recruitment policy and procedure to help them employ suitable staff, however it was difficult to judge whether the provider adhered because they had not employed a new member of staff for over 15 years. Staff recruitment records were disorganised, and we found records for staff who no longer worked at the practice; the provider told us information relating to employed staff were held on a laptop which was kept at his personal residence.

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

The provider had not ensured equipment maintained their good working and according to manufacturers' instructions; for example, the autoclave, ultrasonic bath, dental chair, suction and compressor had not been serviced "for some time". The provider told us they undertook portable appliance testing (PAT) on electrical appliances; however, we saw no record to demonstrate this was carried out in the last three years.

We saw no evidence that the five-year fixed electrical testing had been undertaken and emergency lighting had been inspected and tested at regular intervals to check whether they were in a satisfactory condition for continued use.

There were ineffective arrangements to assess and mitigate risks of fire at the practice. A fire safety risk assessment was done on 18 February 2014 which meant this was obsolete. There were no records to demonstrate that the fire alarms were regularly tested. We saw there were fire extinguishers, however, we were unsure if they were in good working order; the provider told us they were purchased locally around five years ago. There was an evacuation procedure and staff we spoke with knew what to do in the event of a fire. We saw no evidence regular fire drills were undertaken.

The practice did not have suitable arrangements to ensure the safety of the X-ray equipment. The provider was failing to comply with pertinent legislations and guidance. They had local rules; however, they were not current and did not include the relevant information required by law. The provider was unsure who their radiation protection adviser (RPA) was to provide advice on complying with the Ionising Radiations Regulations 2017 (IRR17). There was failure to ensure mandatory radiological and critical examination tests and recommended annual electro-mechanical inspection were carried out on the intra-oral X-ray equipment. In addition, the provider could not provide evidence they were registered with the Health and Safety Executive (HSE) as per the Ionising Radiations Regulations 2017 (IRR17).

We saw some evidence the principal dentist justified, graded and reported on the radiographs they took. The provider carried out radiography audits every year; however, these were not used as a quality improvement initiative to develop the practice.

Risks to patients

The provider had some systems to assess, monitor and manage risks to patient safety, however, they operated ineffectively or were lacking in some cases.

The practice's health and safety policies, procedures and risk assessments were not reviewed regularly to help manage potential risk. The provider had no current employer's liability insurance; they told us this was covered by the landlord.

Are services safe?

A sharps risk assessment was available in a folder we checked; however, this was not displayed in the treatment room or decontamination room.

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.

Staff had not completed sepsis awareness training. Sepsis prompts for staff and patient information posters were not available.

The arrangements for responding to medical emergencies needed strengthening to ensure patient safety. We found staff kept limited records of their checks of these to make sure they were available, within their expiry date, and in working order.

Emergency equipment and medicines were not available as described in recognised guidance: For example: The provider did not have Buccal Midazolam (Oromucosal Midazolam) as part of their standard emergency drugs instead they had rectal diazepam instead. (Buccal midazolam has been tested and approved for seizure management and is now the NICE recommended drug of choice for emergency treatment for prolonged convulsive seizures). Furthermore, self-inflating bag with reservoir for children,oxygen face mask with reservoir and tubing–child, spacer device/disposable cup, portable suction, oropharyngeal airways (sizes 0, 1, 2, 3, 4), self-inflating bag with reservoir- adult, clear face masks for self-inflating bag (sizes, 0, 1, 2, 3, 4) and single use syringes for use with ampoules were not available on the day of inspection.

There was a full tank of oxygen cylinder, however, it had a use-by date of 20 October 2020; we raised this with the provider who showed us the receipt that the oxygen cylinder was replaced in January 2021.

Staff had completed online training basic life support training (BLS) within the last year; however the last time they had face to face training was around five years ago.

The provider had some risk assessments to minimise the risk that can be caused from substances that are hazardous to health, however the folder did not include safety data sheets which contains the information necessary to do the risk assessments. This was not in line with the Control of Substances Hazardous to Health Regulations (COSHH) 2002.

Information to deliver safe care and treatment

We found that the provider had not implemented system or processes to ensure information was readily available to deliver safe care and treatment to patients.

We reviewed 12 clinical records and found the provider did not record comprehensive clinical notes to establish individual patient needs and assessments. For example, we found limited records of medical history, treatment options discussed, intra oral and extra oral soft tissue examination, Basic Periodontal Examination (BPE), local anaesthetic dosage/serial number, consent, diagnosis, and social history.

We noted that dental care records were stored using unlockable shelving type units and which were not fire resistant.

The provider did not have formal 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 dentist was not aware of current guidance with regards to prescribing antimicrobials as it relates to periodontitis.

The provider had no system for receiving and acting on safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

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

We have told the provider to take action (see full details of this action in the Requirement and 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.

Effective needs assessment, care and treatment

The practice did not have systems to keep dental professionals up to date with current evidence-based practice. For example, the provider was unaware of the changes to current guidance with regards to the prescribing of antimicrobials for periodontitis.

Helping patients to live healthier lives

The practice told us, and we saw some instances of how they supported patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentist prescribed high concentration fluoride products if a patient's risk of tooth decay indicated this would help them.

The dentist told us that where applicable they discussed smoking, chewing of paan (a preparation combining betel leaf with areca nut), alcohol consumption and diet with patients during appointments; however, this was not evident in the dental care records we checked.

Consent to care and treatment

Staff were not obtaining 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, however, these were not recorded in any of the 12 dental care records we reviewed.

Staff had completed training in mental capacity and there was some understanding around assessing capacity, Lasting Power of Attorney (LPA) and Gillick competence.

Monitoring care and treatment

The provider undertook a clinical record audit in the last year. However, learning and improvements were unclear and did not reflect our findings based on the records we checked.

Effective staffing

Staff had the qualifications needed to undertake their roles; however, better oversight was needed to ensure skills, knowledge and clinical practice were up-to-date and in accordance with legislations and guidance.

Staff records were not available to view in full on the day. We saw some evidence of training, for instance, on safeguarding of children and vulnerable adults.

Records were not available to demonstrate that clinical staff completed the continuing professional development required for their registration with the General Dental Council.

Co-ordinating care and treatment

Are services effective?

(for example, treatment is effective)

The dentists confirmed they referred patients to a range of specialists in primary and secondary services for treatment the practice did not provide. They did not have a process to monitor, receive responses or follow up on outgoing referrals. All electronic referrals had to be completed away from the practice as there was no computer or internet facility onsite to facilitate this function.

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 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.

Leadership capacity and capability

The principal dentist demonstrated openness, honesty, transparency and responsiveness to the inspection findings. They told us their overall aim was to deliver high-quality, holistic and sustainable care. The provider welcomed the findings and as a result had voluntarily closed the practice on 15 June 2021 which will lasts for four weeks. During this time they will take action to address the concerns raised with the assistance of a compliance organisation.

Culture

The practice team had worked together for over 30 years; they appeared personable and close-knit.

Staff stated they felt respected, supported and valued. They were proud to work in the practice. The examples they described portrayed a principal dentist who was understanding, caring and supportive. They told us they were committed to their roles and welcomed the CQC inspection findings. Staff could raise concerns and were encouraged to do so, and they had confidence that these would be addressed.

Staff told us and we saw some evidence that appraisals were carried out by the principal dentist; however, these were not done annually.

Governance and management

The principal dentist had overall responsibility for the management and clinical leadership of the practice. Based on the inspection findings on the day, we found the governance arrangements to be unclear and, in some areas, lacking which impacted the overall structure, systems and processes of the practice.

The provider had not sought to effectively manage and or minimise risks associated with infection control, emergency drugs and equipment and fire safety.

The provider did not have regulatory oversight of important business functions: for example,

- They had not ensured systems were in place to service equipment including the autoclave, compressor, dental chair, suction and the dental X-ray. We found no evidence these were maintained, tested and serviced in line with the manufacturer's instructions and relevant legislation and guidance.
- There was no arrangement in place to monitor staff training.
- The provider had some policies, protocols and procedures; however, they were not tailored to the practice and were not reviewed on a regular basis.
- The provider had some evidence quality improvement processes, namely, audits of dental care records and radiographs, however findings were not reflective of practice and learning was not demonstrable.
- The provider did not have systems in place for receiving, managing and cascading safety alerts such as those reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies, such as Public Health England (PHE).
- There was evidence to suggest the provider was not keeping up to date with current evidence-based guidance as it relates to record keeping, consent, antibiotic prescribing and registration with HSE.
- The provider had no system to follow up referrals; in particular, those referred for suspected oral cancer.
- Better management was needed in relation to staff files, training records and general risk assessments.

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 17 HSCA (RA) Regulations 2014 Good governance **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** 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 ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular: • The provider had ineffective systems which did not ensure dental care records were maintained to accurately reflect assessments carried out and treatments provided to patients. • Information, such as a detailed assessment including hard and soft tissue examination, oral cancer, screening, treatment options and Basic Periodontal Examination (BPE) were not recorded in most of the dental care records we looked at during the inspection. • The provider was failing to obtain consent for care and treatment in line with legislation and guidance. • Dental care records were not stored safely. 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: • There were ineffective systems in relation to staff training, staff files, policies, procedures, COSHH, audits and safety alerts.

This section is primarily information for the provider

Enforcement actions

- Quality improvements initiatives including audits were ineffective in that they did not demonstrate learning or improvement.
- There was ineffective system for checking emergency medicines and lifesaving equipment such as the oxygen cylinder to ensure they were in date and good working order.
- The provider did not have employer's liability insurance which is legally required of all businesses with one or more employees.

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 activity or activities. In particular:

- Records for clinical staff were not available to demonstrate that they were up to date with all the required training including continuing professional development (CPD) in accordance with the General Dental Councils Standards for the Dental team for clinical staff.
- There were no formal arrangements to ensure clinical staff had access to up to date guidance and legislations.

Regulation 17 (1)

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** **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 provider did not have the recommended emergency medicines and equipment. These included for example, Buccal Midazolam, self-inflating bag with reservoir for children, oxygen face mask with reservoir and tubing–child, spacer device/disposable cup,

Enforcement actions

portable suction, oropharyngeal airways (sizes 0, 1, 2, 3, 4), self-inflating bag with reservoir- adult, clear face masks for self-inflating bag (sizes, 0, 1, 2, 3, 4) and single use syringes for use with ampoules.

- The provider's infection prevention and control arrangements did not sufficiently mitigate the risks of cross infection including the risk of transmission of the COVID-19 virus.

In particular:

- Staff had not been fit tested for use of filtering facepiece masks (FFP) and they did not have access to long-sleeved gowns.
- The provider had not ensured dental instruments were transported and stored in accordance with the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05)
- There were ineffective arrangements for the storage and disposal of waste amalgam, x-ray fluids and study models containing gypsum.
- Infection prevention and control audits carried were not carried out in accordance with guidance.
- The arrangements to monitor and mitigate the risks of fire at the practice needed improving, in relation to, fire drills, fire risk assessment, fire alarms, and fire extinguishers.
- The provider did not have effective systems to monitor and maintain that equipment used at the practice, such as the autoclave, compressor, X-ray equipment, dental chair, suction and the fixed electrical installation remained fit for purpose and in good working order..
- The provider had failed to register with the Health and Safety Executive (HSE) as per the Ionising Radiations Regulations 2017 (IRR17).

Regulation 12 (1)