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Dovecot Dental Practice

Inspection report

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Overall summary

We carried out this announced focused inspection on 16 February 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 appeared to be visibly clean and well-maintained.
- The practice had infection control procedures in place.
- Staff knew how to deal with medical emergencies. Appropriate medicines and life-saving equipment were available.
- Some of the systems and processes to help manage risk to patients and staff did not work effectively.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children. There were ways that these could be strengthened.
- The practice had staff recruitment procedures in place, but records in respect of this were not available on our inspection day.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- The provider had not carried out some key audits, for example, on the prescribing of antibiotics for patients and for radiography.

Summary of findings

- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.
- Leadership for the practice was limited by the provider working across two sites which were not geographically close to each other.
- Staff worked as a team to deliver patient care and treatment.
- The dental clinic had information governance arrangements.

Background

The provider has two dental practices and this report is about Dovecot Dental Practice.

Dovecot Dental Practice is in Liverpool and provides predominantly NHS 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 two dentists and four dental nurses. Administrative support is provided remotely. The practice has two treatment rooms.

During the inspection we spoke with both dentists, two dental nurses, and the practice administrator who provides administrative support remotely. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open Monday to Thursday from 9am to 12.45pm and from 2pm to 5.30pm. Friday from 9am to 12.45pm and from 2pm to 5pm.

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

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

Full details of the regulation the provider is 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?	No action	✓
Are services effective?	No action	✓
Are services well-led?	Requirements notice	✗

Are services safe?

Our findings

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

The impact of our concerns, in terms of the safety of clinical care, is minor for patients using the service. Areas that we raised with the provider were addressed quickly. 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)

The practice had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children. However, the policies in place did not reflect local arrangements and did not give contact details of local safeguarding leads.

The practice had infection control procedures which reflected published guidance. The practice had introduced additional procedures in relation to COVID-19 in accordance with published guidance.

The practice had procedures to reduce the risk of Legionella or other bacteria developing in water systems, in line with a risk assessment.

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

We saw the practice was visibly clean and there was an effective cleaning schedule to ensure the practice was kept clean.

The practice did not have a recruitment policy and procedure in place that reflected legislation. The provider told us recruitment checks had been carried out in accordance with relevant legislation. Our review of records held showed the provider did not have copies of checks made. Records that were sought by the provider on the day, showed one staff member was qualified and registered with the General Dental Council (GDC) and had undergone an enhanced background check. There was no evidence of professional indemnity cover, no indication of level of immunity to bloodborne diseases, for example, Hepatitis B and no proof of identity. For one of the dental nurses there was evidence of an enhanced background check and a copy of their employment contract. There was no evidence of identity, proof of address, references, evidence of immunity to Hepatitis B, evidence of qualification and registration with GDC or evidence they had sufficient indemnity cover either through provision of the Principal Dentist or under their own personal cover. For another nurse who had started in 2019, there was a copy of an employment contract but nothing else. For another nurse there was a copy of a new starter checklist which gave their national insurance number, passport number and provisional drivers licence number, but no copies of either of these items. There was no evidence of Hepatitis B immunity status, no references and no copy of enhanced DBS check.

Some equipment at the practice was maintained and serviced according to manufacturers' instructions, for example the autoclave. We saw the practice compressor had not been serviced since 2018. In respect of radiographic equipment, we observed that local rules required some updating to reflect Ionising Radiation (Medical Exposure) Regulations 2017. The last maintenance and testing of radiography equipment was in 2018 which means it is now overdue for servicing. Later in our inspection the provider responded to our finding and confirmed that he had booked this for 24 March 2022.

Risks to patients

The practice had implemented some systems to assess, monitor and manage risks to patient and staff safety, for example in relation to sharps safety, but some key areas had been overlooked, for example, sepsis awareness for all staff, and sepsis prompt posters being displayed.

Are services safe?

Emergency equipment and medicines were available and checked in accordance with national 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 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

The practice had systems for appropriate and safe handling of medicines. However, we observed that antimicrobial prescribing audits were not carried out.

Track record on safety, and lessons learned and improvements

The practice had implemented systems for reviewing and investigating when things went wrong. There was a system for receiving safety alerts, for example, from the Medicines and Healthcare Products Regulatory Agency (MHRA) However the principal dentist who received these alerts, was not at the practice on a daily basis and no deputy had been identified to receive, share and cascade these in their absence.

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 discussed how oversight of this could be improved.

Helping patients to live healthier lives

The practice provided preventive care and supported patients to ensure better oral health.

Staff were aware of and involved with national oral health campaigns and local schemes which supported patients to live healthier lives, for example, local stop smoking services. They directed patients to these schemes when appropriate.

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 (MCA).

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 detailed dental care records in line with recognised guidance

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.

The practice had not carried out radiography audits in line with current guidance and legislation.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

Newly appointed staff had a structured induction and clinical staff completed continuing professional development required for their registration with the General Dental Council.

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 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 practice demonstrated a transparent and open culture in relation to people's safety, but there was a lack of consistent leadership and oversight at the practice.

Systems and processes were not embedded among staff. The inspection highlighted some issues and omissions; systems and processes to ensure required maintenance and servicing was completed, and that clinical audits were undertaken, were insufficient.

- Antibiotic audits were not being undertaken.
- Radiography audits were not being undertaken.
- Action points raised by infection prevention and control audit were not acted on.
- Servicing for radiography equipment had not been carried out as required. The provider advised us later in the day that the servicing and testing of this had been booked for later that day.
- The compressor was past its due date for service and testing.

The information and evidence presented during the inspection process was disorganised and poorly documented. We saw that systems and processes to collect and maintain staff recruitment records were ineffective.

Culture

The practice could show how they delivered high-quality care and treatment. However, due to staff shortages, sustaining services at the required levels in the longer term was dependent on successful recruitment of further dental professionals.

Staff felt the impact of loss of leadership on the days the principal dentist was at a sister practice. Systems in place did not adequately support staff. Oversight of staff training needs could be strengthened.

Governance and management

The practice did not have effective governance and management arrangements. In particular, we found:

- Sepsis posters and prompts for staff were not available. These were introduced and displayed immediately following our inspection.
- Safeguarding policies in place did not reflect local arrangements. These were generic policies that had not been tailored for the practice. Flow charts with essential information were not available for staff to refer to, with the correct contact details for local authority safeguarding leads. There were no alerts on the clinical records of any child or vulnerable adult, who were subject to a safeguarding plan.
- Record keeping in respect of staff recruitment was not to the standard required by legislation.
- Important safety alerts, for example, Medicines and Health Care Products Regulatory Agency alerts came to the principal dentist only; there was no system in place for staff to receive these directly, should the principal dentist be away from work.
- Although infection prevention and control audits were carried out, action points from the audit were not acted on by the provider.

Are services well-led?

- There was no evidence the practice's policies, protocols and procedures were reviewed on a regular basis. Policies we reviewed for example whistle blowing policies, had not been adapted for the practice, did not contain key information for example contact details of people or bodies they can speak to, when raising concerns.

Appropriate and accurate information

The practice did not use quality and operational information, for example audits, to ensure and improve performance. Action points from audit were not acted on. Prescribing audits had not been completed. Although radiography images were graded, there was no regular cycle of audit of radiography in place.

The practice had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information. In terms of the safekeeping and confidentiality of patient records, there were no concerns.

Engagement with patients, the public, staff and external partners

Staff gathered feedback from patients, through the re-instatement of the NHS Friends and Families test. During the COVID-19 pandemic the practice had not been able to gather patient and staff feedback due to the restrictions in place.

The practice gathered feedback from staff through meetings and informal discussions. However, we observed staff lacked confidence that issues raised would be addressed.

Continuous improvement and innovation

The practice did not have systems and processes in place for learning, continuous improvement and innovation. Although some clinical audit was in place, other audits had not been completed. Where audit had been completed, action points from these had not been addressed. There was limited oversight of staff learning and development.

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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none">• Systems to ensure policies are reviewed and updated were insufficient. Policies we read failed to provide staff with the necessary contact details for safeguarding leads in the area, and contacts for staff in the event of whistleblowing concerns.• Systems for record keeping in respect of recruitment of staff were ineffective; for a recently recruited staff member you had to secure legible documents on the day of the inspection. There was no evidence of professional indemnity cover, no indication of level of immunity to bloodborne diseases, for example, Hepatitis B and no proof of identity. For a dental nurse there was no evidence of identity, proof of address, references, evidence of immunity to Hepatitis B, evidence of qualification and registration with GDC or evidence they had sufficient indemnity cover either through provision of the Principal Dentist or under their own personal cover.• For another dental nurse there was a copy of an employment contract but nothing else. For another nurse there was a copy of a new starter checklist which gave their national insurance number, passport number

Requirement notices

and provisional drivers licence number, but no copies of either of these items. There was no evidence of Hepatitis B immunity status, no references and no copy of enhanced DBS check.

- Infection control audit was carried out but action points arising from the audit were not acted upon. For example, in respect of the maintenance of dental unit water lines and the flushing regime applied to them.
- Systems and processes to ensure required servicing of equipment was carried out, were ineffective. For example, we saw that radiography equipment had not been serviced since 2018. The compressor was also overdue for servicing and testing.
- Systems to manage the receipt of essential safety alerts, for example from the Medicines and Healthcare Products Regulatory Agency (MHRA) were insufficient. These were received by the Principal Dentist; there was no deputy appointed to receive these in the absence of the Principal Dentist.
- Processes to ensure required audits were completed were ineffective. There had been no radiography or antibiotic audit carried out at the practice, since 2020.

Regulation 17(1)