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# Milk Dental

## Inspection Report

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## Overall summary

We undertook a follow-up focused inspection of Milk Dental on 5 April 2019. This inspection was carried out to review in detail the actions taken by the provider to improve the quality of care, and to confirm whether the practice was now meeting legal requirements.

The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

We undertook a comprehensive inspection of Milk Dental on 13 February 2019 under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. At a comprehensive inspection we always ask the following five questions to get to the heart of patients' experiences of care and treatment:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?
- Is it well-led?

We found the provider was not providing safe and well-led care, and was in breach of regulations 12, 17 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can read our report of that inspection by selecting the 'all reports' link for Milk Dental on our website www.cqc.org.uk.

When one or more of the five questions are not met we require the provider to make improvements. We then inspect again after a reasonable interval, focusing on the areas in which improvement was necessary. This inspection focused on regulations 12 and 19. We will inspect to check compliance with regulation 17 at a later date in accordance with our enforcement action timeframes.

As part of this inspection we asked:

- Is it safe?

**Our findings were:**

**Are services safe?**

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

The provider had made insufficient improvements to address the regulatory breaches we identified at our inspection on 13 February 2019.

**Background**

Milk Dental is in a residential suburb of Liverpool and provides NHS and private dental care for adults and children.

The practice is accessed via a flight of steps. Car parking is available nearby.

# Summary of findings

The dental team includes the principal dentist, and two dental nurses. The team is supported by a practice manager. The practice has two treatment rooms.

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.

During the inspection we spoke to the dentist, and the dental nurses. We looked at practice policies and procedures and other records about how the service is managed. We also reviewed information the provider had sent to us to support compliance.

The practice is open:

Monday, Wednesday and Friday 8.45am to 5.15pm

Tuesday and Thursday 8.45am to 7.00pm.

**Our key findings were:**

- The provider had acted on some issues but had not acted sufficiently to ensure people were not exposed to a risk of harm.

We identified regulations the provider was continuing not to meet. The provider must:

- Ensure care and treatment is provided in a safe way to patients
- Ensure specified information is available regarding each person employed
- Ensure, where appropriate, persons employed are registered with the relevant professional body.

# Summary of findings

## The five questions we ask about services and what we found

We asked the following question(s).

**Are services safe?**

We found that this practice was not providing safe care in accordance with the relevant regulations. We found the provider had not acted sufficiently to ensure people were not exposed to a risk of harm. 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).

During our follow-up inspection we identified additional risks.

We took urgent action to ensure people could not be exposed to a risk of harm and suspended the provider's CQC registration for a period of three months to allow the provider to act on the risks.

We will be following up on our concerns to ensure they have been put right by the provider.

**Enforcement action**

# Are services safe?

## Our findings

At our comprehensive inspection on 13 February 2019 we judged the practice was not providing safe care in accordance with the relevant regulations. We told the provider to take action as described in our enforcement action. At our follow-up inspection on 5 April 2019 we found that although the provider had acted on some of the issues identified at our comprehensive inspection in February 2019 which were part of the breaches of Regulation 12 and 19, the provider had not acted sufficiently to ensure compliance with these regulations.

- The provider had obtained adult and child-sized self-inflating bags with reservoirs and associated masks, as recommended by the Resuscitation Council UK. We found that the practice did not have an automated external defibrillator, (AED). The provider had carried out a limited assessment of the risks associated with providing dental care and treatment where no AED was available. We saw the risk assessment was based on inaccurate information, for example, the provider told us there was an AED in a public library nearby, and that this could be obtained and be ready for use on a collapsed patient within the Resuscitation Council UK's recommended timeframe. When we checked we found that the library did not have an AED.
- We saw that the provider had obtained all the medical emergency medicines as recommended by the British National Formulary, including sufficient quantities of medical emergency adrenaline for all age groups.
- We saw the provider had produced a log of emergency medicines available at the practice. The provider told us the expiry dates of the medicines were checked weekly. Staff confirmed they carried out these checks. The provider did not carry out checks on the medical emergency equipment to ensure it was in working order and within the expiry date.
- The provider had not carried out the General Dental Council's, (GDC), highly recommended radiography and radiation protection continuing professional development, (CPD), training. The provider told us they had carried out this training two years ago but could not find the certificate to confirm this.
- We saw that two of the staff had updated their training in safeguarding vulnerable adults, and children and young people. The two staff with lead roles for safeguarding had not completed safeguarding training to the GDC's CPD recommendations. The provider did not have evidence to confirm that all staff had completed the General Dental Council's highly recommended CPD in disinfection and decontamination.
- The provider told us they had arranged for a fire risk assessment to be carried out at the practice. We saw the report from the assessment which had been carried out on 5 March 2019. The report identified the fire risk at the practice as high, and outlined several high priority actions, for example, the fitting of smoke detectors, improving compartmentation in the building to reduce the speed of the spread of fire, and replacing some of the doors with fire doors. The provider had not addressed all the actions. We saw the provider had displayed a sign to guide staff to where the extinguishers were located, and had cleared the basement of the premises and the rear unused treatment room of combustible material.
- We saw the provider had arranged for a structural engineer to attend the practice to carry out a structural inspection of the condition and adequacy of the joists, beams and piers in the basement and to give recommendations for remedial work. The provider told us the engineer had indicated to him that the floor was safe. The provider forwarded the report to us on 9 April 2019. It was unclear from the report whether the floor was safe or of sufficient strength and stability. We saw it recommended remedial work to be undertaken. The provider did not know the safe working load of the dental chair in the treatment room.
- We saw the provider had registered the use of X-ray equipment on the premises with the Health and Safety Executive. We observed this was for an incorrect category. The provider did not have evidence of arrangements for the provision of Radiation Protection Adviser services. The provider had named themself as the Medical Physics Expert on the radiation protection local rules but did not have evidence of competency to act in this role.
- The provider had arranged for the recommended tests to be carried out on the X-ray machine. We saw this had been completed on 26 February 2019.
- We saw the provider had improved the recording of information in dental care records about X-rays taken.

# Are services safe?

- The provider had made arrangements for the segregation and storage of all types of waste. We saw contracts in place for the removal of waste from the practice.
- The provider was aware of the Department of Health publication "Decontamination Health Technical Memorandum 01-05: Decontamination in primary care dental practices". We observed the following: -
  - the provider had carried out an infection prevention and control audit. We saw it did not accurately reflect the circumstances in the practice,
  - the provider had arranged for a Legionella risk assessment to be carried out at the practice on 19 February 2019. We saw the report from the assessment which identified the risk at the practice as medium. We saw the report contained several high priority actions to be completed, including adjusting water temperatures to minimise the development of Legionella bacteria, and microbiological sampling. The provider had not completed the actions with the exception of the flushing of unused water outlets,
  - the floor in the decontamination room had been temporarily repaired but was soft to walk on,
  - the ventilation fan in the decontamination room was hanging down loose from the ceiling by its wiring and had not been re-fixed,
  - one of the sinks in the decontamination room had been designated for hand-washing only,
  - heavy duty gloves had been made available in the decontamination room for staff to use when manually cleaning instruments,
  - the provider had displayed information in the decontamination room about action to take in the event of an injury from a used sharp instrument. Staff confirmed they were aware of what action to take in the event of an injury,
  - the provider did not carry out protein testing to check the efficacy of the ultrasonic bath. Staff had not received training in how to do this,
  - we observed environmental cleaning mops were stored incorrectly.
- The provider had not carried out Disclosure and Barring Service, (DBS), checks for two recently employed members of staff, or a risk assessment in relation to this. The provider had obtained photographic identification, and evidence of qualification for one of the staff, but not references.
- The provider had no system to ensure staff members were registered with their professional body, the General Dental Council. Staff showed us their registration certificates.

During our follow-up inspection we also identified additional risks: -

- Following the structural engineer's inspection and report the provider could not demonstrate that the ground floor was safe or of sufficient strength and stability.
- We contacted the Fire and Rescue Authority after the inspection for advice. They expressed concerns as to the current level of risk to people from fire, and recommended actions to be completed as soon as possible to reduce the risk. The Fire and Rescue Authority also identified serious structural concerns in the basement and recommended the provider arrange a structural engineer's survey without delay and carry out remedial actions.

As a result of these additional risks identified, and the provider's non-compliance with Regulations 12 and 19, we were concerned that people may be exposed to a risk of harm. We therefore took urgent action to ensure people could not be exposed to a risk of harm and suspended the provider's CQC registration for a period of three months to allow the provider to act on the risks and to protect people from the risk of harm.

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 |
| --- | --- |
| | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>Care and treatment must be provided in a safe way for service users<br><br>**How the regulation was not being met**<br><br>1. No automated external defibrillator, (AED), was available at the practice as recommended by the Resuscitation Council UK. The registered person had carried out a limited assessment of the risks associated with carrying on the regulated activities with no AED immediately available.<br><br>2. The floor in the registered person's treatment room sloped, was uneven and areas were soft to walk on. The registered person did not know the safe working load of the dental chair in the treatment room. The registered person had arranged for a structural engineer to carry out a structural inspection of the beams, joists and piers. The structural engineer's report identified remedial work to be undertaken. The registered person could not confirm whether the floor was safe or of sufficient strength and stability. Following the inspection, the Fire and Rescue Authority also identified serious structural concerns in the basement and recommended the registered person arrange a structural engineer's survey without delay and carry out remedial actions.<br><br>3. The registered person had arranged for a fire risk assessment to be carried out at the premises. This was completed on 5 March 2019. The overall risk at the practice from fire was identified in the assessment as high. Twelve actions were identified in the assessment to be completed. The registered person had not addressed these. The Fire and Rescue Authority expressed concerns as to the current level of risk to people from fire, and recommended actions to be completed as soon as possible to reduce the risk. |

This section is primarily information for the provider

# Enforcement actions

4. The registered person was aware of the Department of Health publication “Decontamination Health Technical Memorandum 01-05: Decontamination in primary care dental practices” guidance but did not take account of this guidance as follows:

a) the registered person had carried out an infection control audit but it did not reflect the practice’s circumstances,

b) the registered person had arranged for a Legionella risk assessment to be carried out at the practice on 19 February 2019. The overall risk was identified in the assessment as medium. Six high priority actions were identified in the assessment to be completed within a month. The registered person had not addressed these,

c) the floor in the decontamination room had a bulge in it in front of the steriliser. This had created an uneven surface for staff to stand on when removing instruments from the steriliser, and additionally did not support good infection prevention and control. The registered person had carried out a repair of the floor but this was temporary,

d) the ventilation fan in the decontamination room was hanging down loose from the ceiling by its wiring,

h) no protein testing was carried out to check the efficacy of the ultrasonic bath,

i) the registered person had colour-coded mops and buckets for cleaning the practice. These were not stored appropriately.

5. The registered person had registered the use of X-ray equipment on the premises with the Health and Safety Executive under an incorrect category.

6. The registered person could not confirm the provision of Radiation Protection Adviser services. The registered person had named themself as the Medical Physics Expert on the radiation protection local rules but did not have evidence of competency to act in this role.

This section is primarily information for the provider

# Enforcement actions

7. The registered person had not completed the General Dental Council's, (GDC), highly recommended radiography and radiation protection continuing professional development, (CPD), training.

8. The registered person could not demonstrate that all the staff had completed the General Dental Council's highly recommended CPD in disinfection and decontamination.

9. The registered person could not demonstrate that the practice's two safeguarding leads, had completed the GDC's recommended CPD in safeguarding vulnerable adults, and children and young people, to the GDC's CPD recommendations.

**Regulation 12 (1)**

| Regulated activity | Regulation |
|---|---|

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed.

The registered person employed persons who must be registered with a professional body; such registration is required by an enactment in relation to the work that the person is to perform. The registered person had failed to ensure such persons were registered.

**How the regulation was not being met**

1. The registered person did not have the information specified in Schedule 3 to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 available as follows: -

a) the registered person had not carried out a Disclosure and Barring Service check for two members of staff, and had not obtained references for one member of staff.

This section is primarily information for the provider

# Enforcement actions

2. The registered person had no system to ensure staff were registered with their professional body, the General Dental Council.

**Regulation 19 (3) and (4)**