Dr. Adam Dirir

Milk Dental

Inspection Report

22 The High Street
Wavertree
Liverpool
L15 8HG
Tel: 0151 733 2153
Website: www.milkdental.co.uk

Date of inspection visit: 09/07/2019
Date of publication: 11/09/2019

Overall summary

We undertook a follow-up, focused inspection of Milk Dental on 9 July 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 the inspection by selecting the 'all reports' link for Milk Dental on our website www.cqc.org.uk.

We undertook a follow-up inspection of Milk Dental on 5 April 2019 under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions, to review in detail the actions taken by the provider to improve the quality of care, and to confirm whether the practice was meeting the legal requirements. We focused on the requirements of regulations 12 and 19.

During the inspection we found the provider had not acted sufficiently to ensure compliance with these regulations. We also identified additional risks. We took urgent action to ensure people could not be exposed to 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. You can read our report of the inspection by selecting the 'all reports' link for Milk Dental on our website www.cqc.org.uk.

As part of the follow-up inspection on 9 July 2019 we asked:

• Is it safe?

We found the provider was not providing safe care and had not fully complied with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our findings were:

Are services safe?

Summary of findings

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 and risks we identified at our inspections on 13 February 2019 and 5 April 2019.

Background

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

The dental team includes a principal dentist. 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. We looked at practice policies and procedures and other records about how the service is managed. We also reviewed the provider's action plan and evidence sent to us to support the action plan.

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 in relation to the strength and safety of the practice floor to ensure people were not exposed to a risk of harm.

We identified a regulation the provider was continuing not to meet. They must:

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

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?

Enforcement action

Are services safe?

Our findings

At our follow-up inspection on 9 July 2019 we found the provider had acted on the following issues identified as breaches of Regulations 12 and 19.

- The provider had obtained an automated external defibrillator, and this was available at the practice as recommended by the Resuscitation Council UK.
- The provider was aware of the Department of Health publication "Decontamination Health Technical Memorandum 01-05: Decontamination in primary care dental practices" guidance. We saw the provider had carried out an infection prevention and control audit, had carried out a temporary repair of the floor in the decontamination room and re-attached the ventilation fan, and had improved the storage of the colour-coded equipment for cleaning the practice.
- The provider had registered the use of X-ray equipment on the premises with the Health and Safety Executive under the correct category and had arrangements in place to obtain Radiation Protection Adviser services where necessary.
- We saw the provider had completed the General Dental Council's, (GDC), highly recommended radiography and radiation protection continuing professional development, (CPD), training and that all staff had completed the GDC's highly recommended CPD in disinfection and decontamination.
- 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.
- The provider had obtained the required information for each person employed at the practice and had carried out checks to ensure people employed at the practice were registered with the General Dental Council where relevant. We saw that the provider had carried out Disclosure and Barring Service checks for the two members of staff.

The provider had taken insufficient action to address the following: -

- We saw that the provider had carried out remedial work on the beams, joists and piers in the basement of the practice, which supported the floor, however the provider could not confirm whether the floor was safe or of adequate strength and stability. The registered person had not sought approval from the relevant local authority prior to commencing the work and could not demonstrate that the completed work rendered the floor safe and in compliance with current building regulations.
- The provider had acted on the risks identified in the fire risk assessment of 5 March 2019 and on the Fire & Rescue Service's recommendations. The provider had not obtained confirmation from the Fire & Rescue Service that the actions taken were sufficient to reduce the risks from fire and improve fire safety. The provider obtained this from the Fire & Rescue Service after the inspection and sent us evidence of this.
- The provider had carried out the high priority actions identified in the Legionella risk assessment of 19 February 2019 as to be completed within a month. One high priority action remained to be acted on. The action recommended a sampling regime be implemented to ensure that the current guidance about Legionella is met. The provider was monitoring water temperatures to assist in controlling the development of Legionella but was recording the temperatures of the hot water only; the relevant cold-water temperatures were not recorded.
- The provider had no means for carrying out protein testing to check the efficacy of the ultrasonic bath, in accordance with the Department of Health publication "Decontamination Health Technical Memorandum 01-05: Decontamination in primary care dental practices" guidance. The provider obtained this after the inspection and sent us evidence of this.

We were not assured that the provider had acted sufficiently to reduce the risk of harm to people, particularly in relation to the adequacy of the floor strength and safety. We were concerned that people may be exposed to a risk of harm. We extended the provider's urgent suspension for an additional month to ensure people could not be exposed to a risk of harm and to allow the provider a further opportunity 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
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users **How the regulation was not being met** 1. The floor in the registered person's treatment room sloped, was uneven and areas were soft to walk on. 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. The Fire and Rescue Service 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. The registered person did not seek approval from the relevant local authority prior to commencing the work and could not demonstrate that the completed work rendered the floor safe and in compliance with current building regulations. 2. The registered person had acted on the risks identified in the fire risk assessment of 5 March 2019, and on the Fire & Rescue Service's recommended actions. The registered person had not obtained confirmation from the Fire & Rescue Service that the actions taken were sufficient to reduce the risks from fire and improve fire safety. 3. The registered person had not acted sufficiently on one of the high priority actions identified in the Legionella risk assessment of 19 February 2019 as to be

This section is primarily information for the provider

Enforcement actions

completed within a month. The action recommended a sampling regime be implemented to ensure that the requirements of the HSG 274 Part 2 are met. The registered person was not recording the relevant cold-water temperatures to assist in controlling the development of Legionella.

Regulation 12 (1)