Photay And Associates

PS Photay and Associates - Picardy Road

Inspection report

13-15 Picardy Road
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Overall summary

We undertook a follow-up focused inspection of PS Photay and Associates – Picardy Road on 10 February 2022. This inspection was carried out to review in detail the actions taken by the registered provider to improve the quality of care and to confirm that 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 focused inspection of PS Photay and Associates – Picardy Road on 13 April and 6 May 2021 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We found the registered provider was not providing safe or well led care and was in breach of regulations 12 safe care and treatment and 17 good governance 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 PS Photay and Associates – Picardy Road on our website www.cqc.org.uk.

At the inspection of 10 February, we followed up these two questions:

• Is it safe?

• Is it well-led?

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 put right the shortfalls and had not responded to the regulatory breaches we found at our inspection on 13 April and 6 May 2021.

Summary of findings

Are services well-led?

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

The provider had made insufficient improvements to put right the shortfalls and had not responded to the regulatory breaches we found at our inspection on 13 April and 6 May 2021.

Background

The provider has ten practices and this report is about PS Photay and Associates – Picardy Road.

PS Photay and Associates – Picardy Road is in the London Borough of Bexley and provides NHS and private dental care and treatment for adults and children.

There is no level access to the practice for people who use wheelchairs and those with pushchairs.

The dental team includes three dentists two dental nurses, one trainee dental nurse. The clinical team are supported by a receptionist / practice manager. The practice has two treatment rooms.

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

The practice is open:

Monday to Friday from 9am to 6pm

Saturday 9am to 1pm

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

Full details of the regulations the provider was not meeting are at the end of this report.

There was an area where the provider could make improvement. They should:

- Improve the practice's protocols and procedures for the use of X-ray equipment in compliance with The Ionising Radiations Regulations 2017 and Ionising Radiation (Medical Exposure) Regulations 2017 and taking into account the guidance for Dental Practitioners on the Safe Use of X-ray Equipment. This relates specifically to the use of rectangular collimators.

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 well-led?	**Enforcement action** 

Are services safe?

Our findings

We found that this practice was not providing safe care and was complying with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement Notices section at the end of this report).

The practice had made improvements to the infection control procedures. The practice had introduced additional procedures in relation to COVID-19 in accordance with published guidance. However, there were areas where improvements were required:

- Some work surfaces in both treatment rooms were not smooth to ensure effective cleaning and there was tape used on the work surfaces to separate clean and dirty zoning. This tape made cleaning ineffective.
- There were no paper towels available at the handwash sinks. We were told paper towels were stored in a cupboard in the treatment rooms.
- Infection prevention and control audits were carried out. The last audit was carried out in October 2021. This audit indicated that all surfaces were smooth and easily cleaned.
- We noted a number of single (single patient) use items – rotary files which were stored unpouched in one treatment room.
- There were no records to show that the appropriate tests (Helix test Bowie Dick tests) were being carried out for the vacuum autoclave
- There were no records to demonstrate the effectiveness of the Hepatitis B vaccine for both trainee dental nurses.

We were unable to assess the improvements made in relation to the cleaning and decontamination of dental instruments as there were no patient appointments booked on the day of our inspection and no nurse was present. We noted that a large number of dental instruments (25 dental kits) had a sterilisation date for the day prior to our inspection. Some of these pouches looked old and did not appear to have been recently sterilised.

The practice had made improvements to the procedures to reduce the risk of Legionella or other bacteria developing in water systems, in line with a risk assessment. Hot and cold water temperatures were monitored and maintained in accordance with relevant guidance.

.However, improvements were needed to ensure the recommendations made in the Legionella risk assessment were actioned. The report from the most recent Legionella risk assessment carried out in June 2021 advised the removal of flexible hose pipe to minimise the risk of bacterial growth. The practice manager told us that this had been actioned. However, we observed flexible hose pipe in both treatment rooms.

The practice had made improvements to the recruitment policy and procedure to help them employ suitable staff and had checks in place for agency and locum staff. Clinical staff were qualified, registered with the General Dental Council.. Improvements were needed to ensure that the principal dentists' professional indemnity insurance covered all aspects of the dental care which they carried out. We noted that their indemnity insurance specifically did not cover the provision of dental implants which the principal dentist carried out.

Improvements had been made to the arrangements for assessing and mitigating the risk of fire at the practice in line with a fire risk assessment which was carried out on 22 April 2021.

Improvements had been made to the practice arrangements to ensure the safety of X-ray equipment. Records were available to show that X-ray equipment was tested in accordance with relevant guidance and legislation. Improvements were needed so that a rectangular collimator was used in accordance with relevant guidance.

Are services safe?

Appropriate improvements had not been made to the arrangements for auditing the quality of dental radiographs. We were shown one audit which had been carried out on 3 December 2021. The results of this audit were recorded as 100% compliance. However, this did not correlate with comments made on the quality of dental radiographs, such as 'apex not visible', 'not very good contrast' and 'apical lrt not visible'. There was no action plan in place to identify and make improvements.

Improvements had been made to the arrangements for dealing with medical emergencies. Emergency equipment and medicines were available and checked in accordance with national guidance.

Improvements had been made to arrangements for appropriate and safe handling of medicines. There were no out of date medicines observed during our inspection.

The practice did not have adequate systems to minimise the risk that could be caused from substances that are hazardous to health. In particular the practice had not carried out risk assessments in relation to the safe storage and handling of substances hazardous to health.

Are services well-led?

Our findings

We found that this practice was not providing well-led care and was not complying 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).

Improvements had been made to the arrangements for monitoring staff learning and development needs. Records were available to show that clinical staff completed 'highly recommended' training as per General Dental Council professional standards and other important training.

There were arrangements to monitor training and development needs for the trainee dental nurses. Records were available to show that the nurses undertook training in infection prevention and control, safeguarding adults and children, basic life support and fire safety.

Appropriate improvements had not been made to ensure the service is managed so as to ensure good governance:

- Audits in respect of infection prevention and control, dental radiography and dental care records were not carried out in a way which identified areas where improvements were required and there were no action plans as part of a process for ensuring these improvements.

Appropriate improvements had not been made to the arrangements to ensure the completeness of patient dental care records and ensure that information in relation to the assessment and treatment of patients was recorded appropriately to reflect that proper assessments and treatments were carried out. We looked at a sample of eight patient dental care records:

- Where treatment was carried out for privately paying patients there were no written treatment plans available.
- Medical histories were not updated for two patients.
- Records of examinations such as soft and hard tissue examinations, basic periodontal examinations were not recorded.
- Patient presenting condition / complaint was not routinely recorded.
- Details of the dental treatments was not recorded in detail and some templates were not completed where dental implants were provided.
- Consent records for dental implant treatment were not available.
- Where dental X-rays were carried out the reason for taking and the findings were not recorded.

We were shown one audit of dental records which was carried out on 7 December 2021. This did not identify areas for improving the quality of dental care records and there was no action plan as part of the audit.

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.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 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: 1. Audits in respect of infection prevention and control and dental radiography were not carried out in a way which identified areas where improvements were required and there were no action plans as part of a process for ensuring these improvements. • The infection prevention and control audit carried out in December 2021 was not completed accurately and did not identify areas where improvements were required. • The audit of dental radiographs carried out on 3 December 2021 indicated 100% compliance for quality of dental radiographs. However, However, this did not correlate with comments made on the quality of dental radiographs, such as 'apex not visible', 'not very good contrast' and 'apical lrt not visible'. There was no action plan in place for analysis and to identify and make improvements. 2. The provider has failed to maintain accurate and complete records in respect of treatment carried out. We looked at eight patient dental care records. • The medical history had not been reviewed or updated for two patients • The patient presenting complaint / condition was not recorded in three records. • There was no diagnosis recorded in three records. • Clinical notes describing treatments were not recorded / incomplete in six records. • Where dental X-rays were carried out the reason for taking and the findings were not recorded.

This section is primarily information for the provider

Enforcement actions

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 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: The provider is failing to establish and operate effectively systems and processes to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities)Regulations 2014 by ensuring that care and treatment is delivered in a safe way to patients. 1. The provider is failing to ensure that infection prevention and control procedures are carried out and monitored in accordance with Health Technical Memorandum01-05: decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance' • Some work surfaces in both treatment rooms were not smooth to ensure effective cleaning. • Infection prevention and control audits were not carried out accurately to reflect infection prevention procedures. • There were no paper towels available at the hand wash sinks to facilitate effective hand hygiene procedures. • There were ineffective procedures in relation to single patient use dental items. • There were no records to show that the appropriate tests (Helix test Bowie Dick tests) were being carried out for the vacuum autoclave • There were no records to demonstrate the effectiveness of the Hepatitis B vaccine for both trainee dental nurses. • There were ineffective systems to ensure that dental items were sterilised in accordance with relevant guidance and legislation.

This section is primarily information for the provider

Enforcement actions

2. The provider is failing to ensure that all staff have appropriate indemnity insurance cover for the treatments which are undertaken.

3. The provider is failing to ensure that risks associated with the use, storage and disposal of substances hazardous to health identified by the Control of Substances Hazardous to Health Regulations 2002. There were no risk assessments or safety data information in relation to hazardous materials in use at the practice.

12 (1)