Dr. Parkash Photay

Dr Parkash Photay - Midfield Parade

Inspection Report

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Overall summary

We carried out a focused inspection of Dr Parkash Photay – Midfield Parade on 7 December 2017 and 14 February 2018.

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

We carried out the inspection to follow up concerns we originally identified during a comprehensive inspection at this practice on 23 June 2017 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 to people's needs?
- Is it well-led?

When one or more of the five questions is not met we require the service to make improvements and send us an action plan. We then inspect again after a reasonable interval, focusing on the areas where improvement was required.

At the previous comprehensive inspection we found the registered provider was providing caring and responsive care in accordance with relevant regulations.

We judged the practice was not providing safe, effective or well-led care in accordance with Regulations 17, 18 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 Dr Parkash Photay – Midfield Parade on our website www.cqc.org.uk.

Our findings were:

Are services safe?

We found this practice was not providing not 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

The Commission is considering its range of enforcement powers to secure improvements and to protect people against the risk of unsafe care and treatment.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Enforcement action 

We found that this practice was not providing safe care in accordance with the relevant regulations. The provider had not made the required improvements to the safety of the service.

The practice had limited systems and processes to provide safe care and treatment. Improvements had not been made to ensure there was a protocol in place for reporting, formally documenting and sharing learning from incidents.

Staff did not know how to recognise the signs of abuse and they were not clear on how to report

concerns to external safeguarding contacts. Evidence of safeguarding training was not available for staff members.

The practice arrangements for dealing with medical and other emergencies were not monitored to ensure that appropriate equipment and medicines were available and that staff knew how to act in the event of a medical emergency.

There were limited arrangements for reducing the possibility of Legionella or other bacteria developing in the water systems.

There were no records to show that all staff working at the practice were qualified for their roles.

The provider was not able to demonstrate that they had completed essential recruitment checks for all staff.

Are services effective?

Enforcement action 

We found that this practice was not providing effective care in accordance with the relevant regulations. The provider had not made the required improvements to the effectiveness of the service.

Improvements had not been made to ensure dental care records were maintained in line with current guidelines.

The practice had not established clear arrangements for managing and monitoring the referral of patients to other dental or health care professionals.

There were limited systems in place to help the practice monitor staff training, learning and development needs. There was no evidence to demonstrate that all staff had completed key training in respect of their roles and responsibilities. Staff lacked knowledge and awareness in areas including safeguarding children and vulnerable adults, dealing with medical emergencies, infection control and Legionella management. Evidence of staff training in these areas was not available.

Summary of findings

Are services well-led?

We found that this practice was not providing well-led care in accordance with the relevant regulations. The provider had not made the required improvements to the management of the service.

The provider had limited and ineffective arrangements to ensure the smooth running of the service. Improvements had not been made as needed in several areas such as those for assessing and monitoring safety, ensuring appropriate policies and procedures were available and established, maintaining records, and ensuring staff received key training.

There management structure was not clearly defined and improvements had not been made to ensure all staff were supported to understand and fulfil their roles and responsibilities.

The provider did not demonstrate how it monitored clinical and non-clinical areas of their work to help them improve and learn.

Enforcement action

Are services safe?

Our findings

At our inspection on 23 June 2017 we judged that the service was not providing safe care and told the provider to take action as described in our warning notice and requirement notice. The provider sent us an action plan and told us how they intended to make the required improvements.

At the inspection on 7 December 2017 and 14 February 2018 we found the practice had not made the improvements to meet the warning notice and the requirement notice. We found that the service was not providing safe care::

- Improvements had not been made were to ensure that there were effective policies and procedures to report, investigate, respond and learn from incidents and significant events. One incident in relation to a needle stick injury had been recorded since 2016. The principal dentist told us that this had been discussed with relevant staff. However there were no records available and no evidence that incident had been reviewed to minimise future risks. Staff were unable to demonstrate that they were aware of what incidents should be reported should they occur.
- Improvements had not been made to ensure that national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) were received, reviewed, acted on and shared with relevant staff. The principal dentist told us that they received these alerts. There was no evidence that recent alerts had been reviewed and the principal dentist could not demonstrate that they were aware of these.
- Improvements had not been made to ensure that there were reliable systems and processes in place to safeguard children and vulnerable adults against abuse and neglect. When we visited the practice on 14 February 2018 the safeguarding policy had been updated to include the contact details for the local safeguarding team. However staff remained unclear about how to recognise signs and symptoms of possible abuse or neglect and were unaware of how to report concerns. Staff had not undertaken safeguarding training.
- Improvements had not been made to the arrangements for dealing with medical emergencies. When we visited the practice on 7 December 2017 some items of recommended equipment and medicines were not available, namely adult adhesive pads for Automated External Defibrillator (AED) and Adrenaline for the treatment of anaphylaxis. Aspirin was not available in the recommended dose. Staff were unable to demonstrate that they could set up for use the oxygen cylinder and the AED in the event of a medical emergency. When we visited the practice on 14 February 2018 the recommended medicines and equipment were available, with the exception of Aspirin. There were three different formulations and dosages of Aspirin and staff were unsure which should be used in the event of a cardiac medical emergency. The battery pack had been removed from the AED which meant that it was not ready for use if needed in an emergency. The principal dentist told us that staff had undertaken training in basic life support in January 2018 but was unable to provide any records in relation to this.
- Improvements had not been made to the arrangements for recruitment of staff. For example, there was no evidence of identification, immunisation records, qualification, background checks, references, employment histories or registration with the appropriate bodies for dentists that worked in the practice. On 7 December 2017 we were shown Disclosure and Barring Service (DBS) checks and evidence of indemnity insurance for both dentists who worked at the practice. No other records were available, submitted or available when we visited again on 14 February 2018.
- Improvements had not been made to the arrangements for monitoring health and safety and responding to risks. There was no health and safety policy available and limited risk assessments available.
- A fire risk assessment dated from 2015 was available when we visited the practice on 7 December 2017. This did not properly identify fire risks in relation to the premises and equipment at the practice, including oxygen and electric heaters. There was limited information within the assessment as to how risks were to be minimised and managed. An updated risk

Are services safe?

assessment dated 8 December 2017 was available when we visited the practice on 14 February 2018. This assessment did not adequately identify fire safety risks or the measures in place to reduce and manage these.

- The practice had not reviewed its responsibilities as regards the Control of Substances Hazardous to Health (COSHH) Regulations 2002. Documentation in relation to COSHH including risk assessments were not available and staff lacked understanding how to minimise risks associated with the use and handling of these substances.
- The practice had not made all of the required improvements to its arrangements for infection prevention and control. On 7 December 2017 we were shown an infection control audit dating from 2012. This document was not practice specific and did not identify any areas for improvements. The principal dentist told us that the assessment was reviewed annually. When we visited the practice on 14 February 2018 we were shown an audit dated 11 December 2017. This audit was not fully accurately completed and did not identify areas for improvement including build-up of scale on taps which we observed during the visits to the practice in December 2017 and February 2018.
- Staff were not aware of or following the guidance in The Health Technical Memorandum 01-05 Decontamination in primary care dental practices (HTM01-05) published by the Department of Health in relation to manual cleaning of dental instruments. Hot water temperature records provided indicated that instruments were cleaned in water at temperatures of 50 degrees Celsius, which is above the recommended temperature. Staff were unaware of the rationale for cleaning dental instruments at or below 45 degrees Celsius.
- The practice had limited systems in place to reduce the possibility of Legionella or other bacteria developing in the water systems. When we visited the practice we were shown a Legionella risk assessment dating from 2012. This document included a number of areas identified where improvements were needed; including maintaining the water heating unit and maintaining hot water temperatures to minimise bacteria growth. The principal dentist could not confirm that the recommendations from the risk assessment had been acted on. Staff had limited awareness of procedures to mimimise the risk of Legionella growth. When we visited the practice on 14 February 2018 we were told that a review of the Legionella risk assessment had been undertaken in January 2018. This report from this review was unavailable. We requested that a copy be submitted for review, which had not been received at the time of completing this report.
- On 14 February 2018 we found that the hot water heating system was set to the lowest temperature setting and the water from the hot water outlets was cold. Records for hot water temperatures we were shown recorded hot water delivery from outlets at 50 degrees Celsius.
- Staff told us that they dental unit water lines were not flushed or cleaned and there was no cleaning agent available.
- We observed a build-up of scale on taps in the decontamination room and the dental surgery during both visits to the practice. Staff told us that they had attempted to remove this and that the cleaning agent was beyond its use by date and had been disposed of.
- Improvements were needed to ensure that medicines were stored in accordance with the manufacturer's instructions. When we visited the practice on 7 December 2017 we observed that Glucagon was stored within a refrigerator. However there were no records to show that the temperature has been checked since October 2017. When we visited the practice on 14 February 2018 we were shown records of daily temperature checks for the refrigerator. We asked staff to check the temperature and they produced a clinical thermometer, which we were told was not working. We explained to the principal dentist and staff that this type of thermometer was unsuitable for recording the air temperature within a refrigerator. The principal dentist disagreed and obtained a new similar type thermometer which they attempted unsuccessfully to use to monitor the temperature within the refrigerator.
- The practice had reviewed its protocols and procedures for use of X-ray equipment taking into account Guidance Notes for Dental Practitioners on the Safe Use of X-ray Equipment. We saw service and maintenance documentation in relation to the X-ray equipment.
- Improvements had not been made to the practice arrangements for monitoring and improving the quality and safety in relation to dental radiography. When we

Are services safe?

visited the practice on 7 December 2017 there were no audits available in relation to monitoring the quality of dental radiographs. The principal dentist submitted an audit to us on 12 December 2017. We reviewed this when we visited the practice on 14 February 2018 and the principal dentist confirmed at this time that the audit was from another one of their dental practices.

The lack of improvements showed the provider had not taken action to address the shortfalls we found when we inspected on 23 June 2017.

Are services effective?

(for example, treatment is effective)

Our findings

At our inspection on 23 June 2017 we judged that the service was not providing effective care and told the provider to take action as described in our warning notice and requirement notice.

At the inspection on 7 December 2017 and 14 February 2018 we noted the practice had not made the improvements to meet the warning notice and the requirement notice. We found that the service was not providing effective care::

- Improvements had not been made to the systems and processes that enabled the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each patient.
- We reviewed a sample of dental care records on 7 December 2017 and 14 February 2018. There were inconsistencies in the content and detail within patient's dental care records.
- Information including details of assessment, treatment and treatment options available, intended benefits, possible risks and complications were not recorded consistently.
- Some dental care records did not include a record of the patients' consent to treatment and in some instances consent had been obtained months prior to treatment and consent had not been reviewed before the treatment was carried out.
- Improvements had not been made to the arrangements for making and receiving referrals when patients received treatment from a different dentist from the one who completed the initial assessment. The principal dentist regularly carried out dental treatments for patients for whom they had not carried out the initial assessment. There was no evidence that the principal dentist reviewed the assessment and there were no records in respect of these referrals to ensure that they were monitored appropriately.
- The practice not improved the systems in place to review the training, learning and development needs of individual staff members at appropriate intervals. There was no process established for the on-going assessment and supervision of staff.
- Staff had not undertaken training in areas including infection control, basic life support and safeguarding children and vulnerable adults. When we visited the practice on 7 December 2017 we were shown a training plan for staff between June and December 2017. There were no records available in respect of this training and staff told us that they had not undertaken training. We were also shown a record for basic life support training in 2016 for the dental nurse.
- There was no evidence to show that all clinical staff that worked at the practice had completed the Continuous Professional Development required for their registration with the General Dental Council. On 7 December 2017 we were shown a record of the completed Continuous Professional Development for the principal up to 2016. There were no records available for the other dentist working at the practice.
- When we visited the practice on 14 February 2018 we were shown a certificate for incomplete training in safeguarding for one member of staff. No additional training records were available.

The lack of improvements showed the provider had not taken action to address the shortfalls we found when we inspected on 23 June 2017.

Are services well-led?

Our findings

At our inspection on 23 June 2017 we judged that the service was not providing well led care and told the provider to take action as described in our warning notice and requirement notices.

At the inspection on 7 December 2017 and 14 February 2018 we noted the practice had not made the improvements to meet the warning notice and requirement notices. We found that the service was not providing well-led care::

There were ineffective systems and processes in place that to enable the registered person to assess, monitor and improve the quality and safety of the services being provided:

- Staff demonstrated a lack of understanding of various protocols related to their roles and responsibilities for the running of the service. For example, staff were not aware of how to recognise or report concerns about vulnerable patients. Staff were not aware of or following guidance or procedures in relation to dealing with medical emergencies, minimising risks in relation to Legionella or maintaining infection prevention and control measures.
- There were limited policies and procedures available to assist staff in the day to day running of the practice. Policies and procedures where available were not regularly updated and several were not practice-specific.
- Risk assessments were not carried out robustly or used to monitor and improve safety. Assessments in relation to infection control, Legionella management and fire safety were not complete and areas for improvement where identified were not addressed.
- Improvements had not been made to the arrangements for encouraging learning and improvement.
- There were no audits carried to monitor the quality of dental radiographs.
- Improvements had not been made to the arrangements to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each patient.
- There were limited arrangements in place to ensure that staff were supported, trained knowledgeable in respect of their roles and responsibilities. There were no arrangements for reviewing staff performance; training and development needs and staff had not undertaken training relevant to their duties within the practice.

The lack of improvements showed the provider had not taken action to address the shortfalls we found when we inspected on 23 June 2017.