Mr Gehad Philobbos

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Inspection Report

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Overall summary

We undertook a focused follow up inspection of Mr Gehad Philobbos on 12 June 2019. 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 previously undertook a comprehensive inspection of Mr Gehad Philobbos on 29 August 2018 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, effective or well led care and was in breach of regulations 9, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We carried out a focused inspection on 19 December 2018 to check whether the provider had made the required improvements. The provider had made some improvements, these were insufficient to put right the shortfalls we found at our inspection on 29 August 2018. You can read our report of the previous inspections by selecting the 'all reports' link for Mr Gehad Philobbos on our website www.cqc.org.uk.

As part of this inspection we asked:

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

When one or more of the five questions are 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.

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 put right the shortfalls and had not responded effectively to the regulatory breaches we found at our inspection on 29 August 2018 and 19 December 2018.

Are services effective?

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

The provider had made some improvements in relation to the regulatory breach. These were insufficient to put right the shortfalls we found at our inspections on 29 August 2018 and 19 December 2018.

Are services well-led?

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

Summary of findings

The provider had made some improvements in relation to the regulatory breach. These were insufficient to put right the shortfalls we found at our inspections on 29 August 2018 and 19 December 2018.

Background

Mr Gehad Philobbos is in Oldham and provides NHS treatment to adults and children.

There are two steps leading to the entrance of the premises. On street parking is available near the practice.

The dental team includes one dentist, a trainee dental nurse and a practice manager who also carry out reception duties. The practice has one treatment room.

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 with the dentist, the practice manager and the trainee dental nurse. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Tuesdays and Thursdays 9.30am to 12.45pm and 2pm to 5.30pm

Our key findings were:

- Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support. The medical emergency kit had been reviewed and appropriate items were available.
- Systems to identify and respond to risk were not effective. For example, in relation to decontamination processes and radiography.
- The provider did not demonstrate effective leadership of the practice. They were unaware of the ongoing issues highlighted during the inspection.
- The improvements made were insufficient to demonstrate that care and treatment was assessed and delivered in line with current legislation.
- Discussions with the provider showed they lacked understanding of how to analyse the results of audits and use these to make improvements in line with General Dental Council standards.

We identified regulations the provider was not meeting. They must:

- Ensure the care and treatment of patients is appropriate, meets their needs and reflects their preferences.
- 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 is not meeting are at the end of this report.

The provider has cancelled their registration as a provider of regulated activities. A new provider has now taken over the practice and is responsible for the leadership, governance and provision of patient care.

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 

We found that this practice 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).

Staff demonstrated that the product used to clean dental unit water lines was now used in line with the manufacturer's instructions.

The registered person had ensured the safety of the radiographic equipment in use. The steriliser had been serviced in response to recommendations in the pressure vessel testing and validation report. The provider had not improved the quality of radiographs sufficiently to prevent X-rays needing to be repeated.

Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support. The medical emergency kit had been reviewed. Items were available as described in Resuscitation Council UK guidance.

The security of NHS prescriptions had been reviewed. The logging system would identify if a prescription was missing.

The results of efficacy tests which highlighted the ineffectiveness of decontamination processes had not been reported or acted on. This was not identified by the practice's audit processes.

Are services effective?

Enforcement action 

We found that this practice 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).

The improvements made were insufficient to demonstrate that care and treatment was assessed and delivered in line with the regulation. The provider had attended continuing professional development (CPD) but confirmed they were still unfamiliar with nationally agreed evidence-based standards.

The care provided was not supported by clear clinical pathways and protocols. For example, selection criteria and frequency of radiographs, carrying out periodontal assessments and care, and providing oral health advice and disease prevention measures.

The use of templates had improved the documentation of dental examinations. The dental care records were not in line with the standards expected. They lacked diagnosis, treatment planning and discussions of treatment planning, options, risks and benefits.

Summary of findings

Are services well-led?

We found that this practice 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).

The provider had accessed support, attended CPD events and audited dental care records. Discussions with the provider showed they lacked understanding of how to analyse the results of these and compare standards with those expected by the General Dental Council.

The provider did not demonstrate effective leadership of the practice. They were unaware of the issues highlighted during the inspection in relation to clinical care and infection prevention and control.

Systems to ensure needs were assessed and care and treatment delivered in line with current legislation and nationally agreed evidence-based standards were ineffective and not supported by clear clinical pathways and protocols.

Systems to identify and respond to risk required improvement. For example, in relation to the use of radiography and processes to decontaminate instruments.

Enforcement action 

Are services safe?

Our findings

At our previous inspections on 29 August 2018 and 19 December 2018 we judged the practice was not providing safe care and was not complying with the relevant regulations. We told the provider to take action as described in our requirement notice. At the inspection on 12 June 2019 we found the practice had made the following improvements to comply with the regulation:

- Staff had ensured that a full biofilm removal protocol was carried out on the dental unit water line followed by a maintenance solution. We saw the product manufacturer's instructions were being followed.
- The medical emergency kit had been reviewed. A new adult-sized oxygen mask had been obtained. A new emergency medicine Glucagon had been obtained and the expiry date had been changed in line with the manufacturer's instructions. A child sized self-inflating oxygen bag and mask was available.
- A full service had been carried out on the steriliser in response to recommendations in the previous pressure vessel testing and validation report.

The provider had also made further improvements:

- We saw that the premises were visibly clean and tidy. Additional renovation and decoration had been carried out in the bathroom and the hallway.
- The security of prescriptions had been reviewed, the logging system would now identify if a prescription was missing.

We identified areas of concern:

- An infection prevention and control audit had been completed in January 2019. There was no evidence the results of this had been reviewed. This process had failed to identify the concerns we highlighted during the inspection. The trainee dental nurse who carried out decontamination was not present during the inspection. We looked at the evidence of the decontamination processes and validation tests that were implemented as a result of the previous inspections. We saw protein residue tests had been carried out weekly to assess the efficacy of the ultrasonic bath. The results of these showed instruments were still contaminated after they had been decontaminated using this process. One foil ablation test had been carried out in January 2019, the results of these suggest the ultrasonic bath did not operate effectively.
- The provider had ensured the electrical safety of the radiographic equipment. We identified that the provider had not effectively reviewed the quality of radiographs. This resulted in repeat radiographs being required. Radiographs were not always graded effectively, this compromised the audit process.

These improvements showed the provider had taken some actions to comply with the regulation when we inspected on 29 August 2018 and 19 December 2018.

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspections on 29 August 2018 and 19 December 2018 we judged the practice was not providing effective care and was complying with the relevant regulations. We told the provider to take action as described in our requirement notice. At the inspection on 12 June 2019 we found the practice had made the following improvements to comply with the regulation:

The dentist had implemented templates to improve the quality of dental care records. We saw improvements in the way that medical and social histories, and examinations were carried out and recorded. They had engaged with NHS England and dental peers to review and audit clinical standards. Despite this we identified ongoing concerns.

- The dentist was not familiar with the evidence-based guidance on the assessment and delivery of periodontal care and advice. The dentist did not demonstrate they understood the process to be able to accurately carry out basic periodontal examinations (BPE). BPE is a screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need, assess and document levels of periodontal disease. They had obtained periodontal examination probes but did not understand the gradations and corresponding measurements to be documented from these. Discussions with the dentist highlighted that they did not assess all the teeth necessary and their lack of understanding indicated that more serious periodontal disease was not always identified and acted on appropriately. The dentist confirmed they did not carry out six-point pocket charting or bleeding indices as indicated in national guidance.
- The dentist did not document discussions of options, risks and benefits of procedures in line with General Dental Council Standards for the Dental Team. We asked to see clinical records to demonstrate improvements in this area. The records we reviewed showed no evidence of diagnosis, treatment planning or discussion of this, or options, risks and benefits with the patient. As a result, there was limited evidence of valid consent. There was no evidence of care planning beyond the treatment provided at each visit and it was difficult for the dentist to follow the treatment or to recall what was planned when we discussed these. The dentist assured us that these discussions do take place with patients but there was no evidence to support this.
- Although the number of radiographs taken appeared to have increased, the dentist was still not familiar with, or following nationally recognised Faculty of General Dental Practitioners standards for the frequency of radiographs. We noted that the quality of the radiographs we viewed continued to be poor and there was confusion over the documentation of these. For example, we saw dental care records where the quality of radiographs was graded as the highest quality, but the report stated the radiograph was of no diagnostic value and would need to be repeated. The dentist had not acted on feedback given at the previous inspection to conduct analysis of why radiographs appeared very dark and were of limited or no diagnostic value. For example, poor technique, beam aiming devices used incorrectly, over exposure as incorrect setting used on the X-ray machine and poor developing processes using developing tanks without regard for fluid temperature variations. The dentist had not considered and showed little understanding of the possible reasons for the poor quality of radiographs taken. The system for storing radiographs was ineffective, the dentist was unable to locate radiographs without the trainee dental nurse present and was unaware if those of limited diagnostic value had been stored or disposed of.

These improvements showed the provider had not taken sufficient action to comply with the regulation when we inspected on 29 August 2018 and 19 December 2018.

Are services well-led?

Our findings

At our previous inspections on 29 August 2018 and 19 December 2018 we judged the provider was not providing well led care and was not complying with the relevant regulations. We told the provider to take action as described in our requirement notice. At the inspection on 12 June 2019 we found the practice had made the following improvements to comply with the regulation:

- First floor rooms were kept locked and the provider had evidence to demonstrate that confidential patient records had been disposed of appropriately.
- The provider had reviewed and acted on recommendations to ensure the electrical safety of radiographic equipment and that dental unit water line management system was implemented in line with the manufacturer's instructions.

We identified ongoing concerns:

- The provider demonstrated a lack of awareness of the need to review the systems to ensure that standards and procedures were in place or whether staff were following correct decontamination processes.
- Audits were not effective. Discussions with the provider showed they lacked understanding of the issues highlighted during the inspection and what to do to make further improvements. The results of the radiography and record keeping audits had not resulted in sufficient improvements. There was no evidence that the findings of the infection prevention and control audit had been analysed. This had failed to highlight the concerns we highlighted with the decontamination processes.
- Systems to assess needs and deliver care and treatment were in line with current legislation and nationally agreed evidence-based standards were ineffective and not supported by clear clinical pathways and protocols. In particular, the provider was still not aware of, or following nationally recognised Faculty of General Dental Practitioners standards for the frequency of radiographs, Clinical Examination and Record-Keeping, or guidance from the British Society of Periodontology or Delivering Better Oral Health version 3.

These improvements showed the provider had not taken sufficient action to comply with the regulation when we inspected on 29 August 2018 and 19 December 2018.