

Mr Richard Lloyd Jones

Jersey Farm Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 19 January 2017 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this practice was providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this practice was providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations.

Background

Jersey Farm Dental Practice is a general dental practice situated in the Hertfordshire town of St Albans.

The practice has three dental treatment rooms and offers general dentistry to adults and children funded by the NHS or privately.

The practice has two dentists, two dental hygienists, three dental nurses and two receptionists. The premises are situated on the first floor of a development within a commercial courtyard, with use of a central car park.

The practice is open between 8 am and 5 pm on Monday to Thursday and 8 am to 4 pm on a Friday.

The practice owner is registered with the Care Quality Commission (CQC) as an individual. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience. We received feedback from 35 patients. These provided a positive view of the services the practice provides. Patients commented on the quality of care, the polite and friendly nature of staff and the cleanliness of the practice.

Our key findings were:

Summary of findings

- The practice was visibly clean and clutter free.
- Comments from patients indicated that the staff were kind and caring and were skilled at putting nervous patients at ease.
- At the time of the inspection the practice was accepting new patients. Children could be offered appointments funded by the NHS, adults were privately funded.
- The practice had policies in place to assist in the smooth running of the service.
- The practice used national guidance in the care and treatment of patients.
- The practice met the national guidance in decontamination of dental instruments.
- Risk assessments were in place to identify, monitor and mitigate risks arising from carrying out the regulated activities.
- Clinical audit was used as a tool to highlight areas where improvements could be made.
- Patients commented that options for treatment were explained to them in detail and this was in evidence in the dental care records we were shown.
- Staff demonstrated good knowledge and procedures in the process of consent, although not all staff had a clear understanding of the situations when a child can consent for themselves.

There were areas where the provider could make improvements and should:

- Review arrangements for monitoring the availability of equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review staff awareness of Gillick competency and ensure all staff are aware of their responsibilities.

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?

We found that this practice was providing safe care in accordance with the relevant regulations.

The practice had medicines and equipment to manage medical emergencies, although some sizes of oropharyngeal airway were missing. Certain equipment also seemed old or dusty. Missing or old emergency equipment was replaced following the inspection.

The practice was carrying out appropriate pre-employment checks on staff to ensure they employed fit and proper persons.

Equipment had been serviced and tested in line with manufacturers' instructions and national guidance.

No action



Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations.

The dentists used nationally recognised guidance in the care and treatment of patients.

A comprehensive screening of patients was carried out at check-up appointments, and included screening for gum disease.

The practice demonstrated good knowledge and systems in the process of consent, and this was evidenced by the dental care records. In discussions around children giving consent it was clear that although the principle was understood some staff were less clear on how to apply this in practice.

No action



Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations.

Comments from patients were overwhelmingly positive about the care and treatment they received.

Patients were involved in the decisions around their treatment and care.

Written treatment plans were given to patients for them to be able to consider their options.

No action



Are services responsive to people's needs?

We found that this practice was providing responsive care in accordance with the relevant regulations.

The practice endeavored to see all emergency patients on the day they contacted the practice.

The practice were aware of their limitations in accessibility due to being on the first floor, however took what steps they could to ensure the premises were as accessible as possible.

Interpreters could be arranged for patients that did not speak English as a first language.

No action



Summary of findings

Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations.

Polices were available to assist in the smooth running of the service. These had all been reviewed in the year before our visit.

The practice used clinical audit as a tool to highlight areas where improvements could be made.

Staff had annual appraisals where their training needs were addressed and a personal development plan drawn up to reflect it.

No action



Jersey Farm Dental Practice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an announced, comprehensive inspection on 19 January 2017. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Before the inspection we asked the provider for information to be sent this included the complaints the

practice had received in the last 12 months; their latest statement of purpose; the details of the staff members, their qualifications and proof of registration with their professional bodies.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had a system in place for reporting and learning from significant incidents. A template was available and this gave details of the investigation and prompted staff to indicate the outcome and what learning could be taken away to prevent reoccurrence. This demonstrated duty of candour. Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

The practice kept a log of all accidents and incidents so that trends could be easily identified, and a policy in reporting accidents was available for staff to reference.

The practice received communication from the Medicines and Healthcare products Regulatory Agency (MHRA). These were kept in a file and the principal dentist took responsibility for actioning the alerts and cascading relevant information to the staff.

The practice were aware of their responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). RIDDOR is managed by the Health and Safety Executive (HSE). The practice had a folder which contained RIDDOR forms and information on how and when to make a report.

Reliable safety systems and processes (including safeguarding)

The practice had a policy in place regarding safeguarding vulnerable adults and child protection. This was dated December 2016, and the practice had completed an action plan to ensure that everything necessary was being done by the practice to safeguard its patients.

The process for reporting concerns was documented with a flow chart which was available to reference in the policy folder along with relevant contact numbers. All staff had received training appropriate to their roles, and staff we spoke with were able to describe how they would raise a concern should the situation arise.

The practice had an up to date Employers' liability insurance certificate which was due for renewal in February 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

We discussed the use of rubber dam with the dentist in the practice. A rubber dam is a thin, rectangular sheet, usually of latex rubber. It is used in dentistry to isolate a tooth from the rest of the mouth during root canal treatment and prevents the patient from inhaling or swallowing debris or small instruments. The British Endodontic Society recommends the use of rubber dam for root canal treatment. We found that a rubber dam was being used routinely by the principal dentist, and the practice used rotary endodontic equipment which meant that the instruments were used in a hand piece and less likely to become an inhalation risk.

A protocol was in place detailing the actions required in the event of a sharps injury. This directed staff to seek advice from the dentist, and directed staff to occupational health or accident and emergency for further advice and support.

The practice were using 'safer sharps' at the time of the inspection. These are medical sharps that have an in built safety features to reduce the risk of accidental injury. The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 require that practices switch to 'safer sharps' where it is reasonably practicable to do so.

Medical emergencies

The dental practice had medicines and equipment in place to manage medical emergencies. These were stored together and all staff we spoke with were aware how to access them. Emergency medicines were in date, stored appropriately, and in line with those recommended by the British National Formulary. Emergency medicines were checked and logged weekly.

Equipment for use in medical emergency was available mostly in line with the recommendations of the Resuscitation Council UK. The oro-pharyngeal airways were not available in all sizes and were not in sealed bags. These should be available in a range of sizes and support the airway in an unconscious patient. They were purchased immediately following the inspection.

Other equipment for use in a medical emergency was found to be yellowing and dusty, again these were immediately replaced.

Are services safe?

The practice had an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.

All staff had undertaken training in medical emergencies. An external company provided the training to the whole practice, most recently in March 2016.

Staff recruitment

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all recruitment files. This includes: proof of identity; checking the prospective staff members' skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed). DBS checks identify whether a person had a criminal record or was on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

We reviewed the staff recruitment files for four members of staff and found that DBS checks had been sought for all staff, and appropriate pre-employment checks had been carried out.

Monitoring health & safety and responding to risks

The practice had systems in place to monitor and manage risks to patients, staff and visitors to the practice. A health and safety policy was updated in May 2016 and was available for all staff to reference. This included topics such as RIDDOR, pressure vessels and manual handling.

The practice had risk assessments in place to assess, monitor and mitigate the risks within the premises; these included a health and safety risk assessment which had been completed in 2016 and stated that 'safer sharps' had been introduced to the practice.

A fire risk assessment had been carried out in December 2016 and any actions highlighted had been completed. An emergency evacuation plan was available and staff we spoke with were able to detail their actions in the event of an evacuation, including the external meeting point. Fire drills were carried out six monthly, most recently in December 2016.

The practice had received in house training in health and safety including risk assessments and fire actions as part of the staff meeting in November 2016.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a file of information pertaining to the hazardous substances used in the practice and actions described to minimise their risk to patients, staff and visitors.

Infection control

The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for cleaning, sterilising and storing dental instruments and reviewed their policies and procedures.

The practice had an infection control policy in place which had been reviewed and updated in March 2016. This included topics such as hand hygiene, spillages, clinical waste and personal protective equipment.

The practice was visibly clean and tidy.

The practice had a dedicated decontamination facility; This had two sinks for manually cleaning and then rinsing dental instruments as well as a hand washing sink.

An illuminated magnifier was available to inspect the dental instruments prior to sterilising them in the autoclave.

Instruments were sterilised in an autoclave, and sterile instruments were then pouched and dated with a use by date.

Tests carried out on the process were in line with the recommendations of HTM 01-05.

Environmental cleaning was carried out by the practice staff. Cleaning schedules and discussions with staff indicated that certain areas were being cleaned less frequently than the recommendations outlined in HTM 01-05. This was addressed immediately following the inspection and new cleaning schedules implemented to ensure this change. The equipment used conformed to the national system of colour coding cleaning equipment.

Are services safe?

The practice had contracts in place for the disposal of contaminated waste and waste consignment notes were seen to confirm this. Clinical waste was stored in a segregated area of the decontamination room prior to its removal.

All clinical staff had documented immunity against Hepatitis B. Staff who are likely to come into contact with blood products, or are at increased risk of needle stick injuries should receive these vaccinations to minimise the risk of contracting blood borne infections. The practice had a log to indicate when boosters were required for specific staff members to ensure that this was carried out in a timely manner.

The practice had a risk assessment regarding Legionella. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The assessment had been carried out by an external company in February 2015. We were shown records pertaining to the checking of water temperatures monthly. In addition the practice were taking dip slides which assess the microbial activity in the water. These were completed most recently in January 2017 and before that in October 2016, the results had registered a 'pass'.

Equipment and medicines

The practice had a full range of equipment to carry out the services they offered and in adequate number to meet the needs of the practice.

Portable appliance testing had been carried out in September 2016, and the practice had a register of all electrical appliances on the premises.

The compressor and autoclaves had both been serviced and tested in the year before the inspection and in line with manufacturers' instructions.

A glucagon injection kit is used to treat episodes of severe hypoglycaemia which is defined as having low blood

glucose levels that requires assistance from another person to treat. It should be stored at a temperature of 2–8°C (in a refrigerator). If stored in the refrigerator the shelf life from the manufacturer is 36 months. It can be stored outside the refrigerator at a temperature not exceeding 25°C for 18 months provided that the expiry date is not exceeded.

Although the practice kept this medicine in the refrigerator they were not monitoring the temperature range and therefore could not be assured of its effectiveness. Following the inspection the practice purchased a new kit and amended the expiry date to account for it being kept out of the refrigerator.

The practice dispensed some medicines; these were stored and logged appropriately.

Prescription pads were secured but the serial numbers were not logged in line with the guidance from NHS Protect.

Radiography (X-rays)

The practice demonstrated compliance with the Ionising Radiation Regulations (IRR) 1999, and the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000.

The practice had two intra-oral X-ray machines that were able to take an X-ray of one or a few teeth at time.

Rectangular collimation limits the beam size to that of the size of the X-ray film. In doing so it reduces the actual and effective dose of radiation to patients. We saw that rectangular collimators were in use by clinicians.

The required three yearly testing of the equipment was carried out in November 2015. Local rules were available which listed the responsible persons as well as describing the controlled zone and contingency plans in the event of a malfunction.

Both dentists that took X-rays had received appropriate training as described by the General Dental Council.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

During the course of our inspection patient care was discussed with the dentists and we saw patient care records to illustrate our discussions.

A comprehensive medical history form was completed by patients at every examination appointment, and updated verbally at each attendance. This ensured that the dentist was kept informed of any changes to the patient's general health which may have impacted on treatment.

Dental care records showed that the dentists regularly checked gum health by use of the basic periodontal examination (BPE). This is a simple screening tool that indicates the level of treatment need in regard to gum health. Scores over a certain amount would trigger further, more detailed testing and treatment.

Screening of the soft tissues inside the mouth, as well as the lips, face and neck was carried out to look for any signs that could indicate serious pathology.

The dentists used current National Institute for Health and Care Excellence (NICE) guidelines to assess each patient's risks and needs and to determine how frequently to recall them. They also used NICE guidance to aid their practice regarding antibiotic prophylaxis for patients at risk of infective endocarditis (a serious complication that may arise after invasive dental treatments in patients who are susceptible to it), and removal of lower third molar (wisdom) teeth.

The decision to take X-rays was guided by clinical need, and in line with the Faculty of General Dental Practice directive.

Health promotion & prevention

Dental care records we saw indicated that an assessment was made of patient's oral health and risk factors. Medical history forms that patients were asked to fill in included information on nicotine use; this was used by dentists to introduce a discussion on oral health and prevention of disease.

We found a good application of guidance issued in the DH publication 'Delivering better oral health: an

evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is a toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Patients had access to a number of leaflets on oral health which were displayed in the reception area for patients to take away and read in their own time. This included leaflets on dental decay, smoking.

The practice kept stop smoking referral forms to assist in referrals for patients wishing to quit.

Staffing

The practice was staffed by two dentists, two dental hygienists, three dental nurses and two receptionists.

Prior to our inspection we checked that all appropriate clinical staff were registered with the General Dental Council and did not have any conditions on their registration.

The practice had started to offer direct access to one of the dental hygienists (meaning that a patient could see the dental hygienist without seeing the dentist). Although the dental hygienist was not using prescribed medicines for these patients they were not providing the patient with any written information on the limitations of this care. Following the inspection the practice implemented some written information.

Staff told us they had good access to on-going training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians, dental technicians, and orthodontic therapists.

Clinical staff were up to date with their recommended CPD as detailed by the GDC including medical emergencies, infection control and safeguarding training.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the treatment themselves.

Routine referrals made for example for: orthodontics, minor oral surgery or conscious sedation were made by using a template or writing a letter.

Are services effective?

(for example, treatment is effective)

Referrals for suspicious lesions were made by fast track email to the hospital and followed up by a telephone call to confirm receipt.

The practice did not keep a log of referrals, but had a system in place whereby the patient dental care record was kept aside by the dentist until they had received acknowledgement of the referral. This ensured that referrals could be easily chased up if contact had not been received from the receiving organisation within a suitable timeframe.

Consent to care and treatment

We spoke to clinicians about how they obtained full, educated and valid consent to treatment. Comprehensive discussions took place between clinicians and patients where the options for treatment were detailed. These discussions were recorded in the dental care records and patients commented that the dentist always took the time to explain the situation fully and detail all the options available to them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Staff demonstrated an understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment. Staff had undergone internal training on the MCA as part of the staff meeting in April 2016.

Similarly staff demonstrated an understanding of the situation in which a child under the age of 16 could legally consent for themselves. This is termed Gillick competence and relies on an assessment of the child's understanding of the treatment and the consequences of having/ not having the treatment. However some staff seemed less clear on how this would be applied in practice.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Comments we received from patients indicated that they were very happy with the level of care they received from the practice. Patients commented that the staff were friendly, helpful and professional and that they dealt particularly well with nervous patients. Some patients commented that they travelled back to attend this practice even when they had moved from the area.

We spoke to staff about how patient's confidential information was kept private. We were shown that computer screens were password protected and could not be overseen by patients standing at the reception desk. The waiting room was separate from the reception area which also aided patient privacy as they were less likely to be overheard at the reception desk.

These measures were underpinned by practice policy pertaining to data protection.

We witnessed patients being dealt with in a friendly and professional manner, both in person and over the telephone.

Involvement in decisions about care and treatment

Following examination and discussion with the clinician, patients were all given a copy of a treatment plan to consider. This included the costs of treatment.

Comments received from patients indicated that their conditions were explained well and they received advice and options in order to make decisions.

NHS and private price lists were displayed in the waiting area for patients' information.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

As part of our inspection we conducted a tour of the practice and found the premises and facilities were appropriate for the services delivered.

We examined appointments scheduling, and found that adequate time was given for each appointment to allow for assessment and discussion of patients' needs. Patients commented that they were usually seen on time.

At the time of the inspection the practice were accepting child patients on the NHS and adult patients privately funded.

The waiting room had a range of children's books and toys.

Tackling inequity and promoting equality

Staff we spoke with expressed that they welcomed patients from all backgrounds and cultures, and all patients were treated according to their individual needs. This was underpinned by the practice's equality and diversity policy.

We spoke to staff about the ways in which they met the needs of patients with individual needs. The receptionist detailed the ways in which they would help patients with limited mobility. The practice had stairs from the front door leading up to the practice on the first floor; patients known to the practice were advised to call from the bottom of the stairs and staff would assist them. The receptionist made sure all new patients that telephoned to make an appointment were aware of the limitations in access.

The practice had carried out a disability audit in March 2016, this had resulted in a list of actions that the practice

could look into to ensure that the accessibility was as good as possible. We saw that some of these actions (such as hand rails on both sides of the stairs) had been put into place, and others (such as a possible stair lift) discounted due to the width of the staircase.

Comments received from patients indicated that the practice strived to meet the individual needs of patients.

Access to the service

The practice was open between 8 am and 5 pm on Monday to Thursday and 8 am to 4 pm on a Friday.

Emergency slots were set aside daily and the practice endeavoured to see any patient in pain on the day they contacted the service.

Out of hours arrangements were detailed on the answerphone.

Concerns & complaints

The practice had a complaints policy in place which was displayed in the reception area. As well as directing patients on how to raise a complaint within the service it also gave contact details for external agencies that a complaint could be escalated to.

This was displayed behind the reception desk and would be difficult for a patient to read whilst stood at the desk. We raised this with the practice principal who moved it to the waiting room immediately following the inspection.

The practice kept a log of complaints received and had not received a complaint in the year preceding our visit. We were shown the evidence that an investigation would be undertaken and apologies issued to the patients where necessary.

Are services well-led?

Our findings

Governance arrangements

The principal dentist took responsibility for the day to day running of the practice. Staff we spoke with felt supported by the principal dentist both professionally and personally. We noted clear lines of responsibility and accountability across the practice team.

The receptionist had a checklist which listed a number of governance procedures including weekly and monthly checks and when equipment needed servicing.

Practice meetings were held monthly and alternated between being held on a Tuesday or Thursday to ensure that all staff could attend at least every other month. The minutes of these meetings were available to staff and the principal dentist ensured that staff who were not able to attend were kept up to date.

Leadership, openness and transparency

Staff we spoke with reported an open and honest culture across the practice and they felt fully supported to raise concerns with the principal dentist.

Staff we spoke with felt supported in their roles and commented on what a nice place it was to work.

A whistleblowing policy was available which guided staff in how to raise concerns about a colleague's actions or behaviours. It detailed the practice's expectations of candour in this regard. Contact details for external agencies that staff could raise concerns to, were available in the policy.

Learning and improvement

The practice sought to continuously improve standards by use of quality assurance tools, and continual staff training.

Staff were supported in achieving the General Dental Council's requirements in continuing professional development (CPD). We saw evidence that all clinical staff were up to date with the recommended CPD requirements of the GDC.

Staff received annual appraisals, and personal development plans were drawn up to aid their career progression and highlight any training needs.

Clinical audits were used to identify areas of practice which could be improved. Infection control audits had been carried out six monthly, most recently in November 2016 and had highlighted action points.

Audits on the quality of X-rays taken were carried out six monthly and had listed areas for continued improvement. Other audits that had been completed in the year preceding our inspection included waste, cleaning, access and prescription drugs.

Practice seeks and acts on feedback from its patients, the public and staff

The practice obtained feedback from patients from several pathways. They completed the NHS friends and family test. Feedback forms were available in reception.

Staff felt supported to approach the principal dentist with ideas or concerns either formally or informally and gave examples of situations where their contributions have led to a change.