

Mr. Nicholas Jones

Phillips Jones & Joseph

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 30 March 2016 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

Phillips Jones and Joseph is a dental surgery located in the Royal Borough of Greenwich and provides NHS dental services. The demographics of the local area were mixed and the practice served patients from a range of social, economic and ethnic backgrounds.

The practice staffing consists of four dentists, six dental nurses, one receptionist and a practice manager who also carried out reception duties.

The practice is open from 8.45am to 5.30pm Monday to Thursdays and 8.45am to 3.30pm on Fridays. The practice is set out over two levels with two surgeries on the first floor and two on the second floor. There is no step free access to the building and is therefore not wheelchair accessible. Other facilities include: two patient waiting rooms (one on each level), reception area, decontamination room and a staff office.

The principal dentist 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.

The inspection took place over one day and was carried out by a CQC inspector and a dentist specialist advisor.

We received feedback from 30 patients which included completed Care Quality Commission comment cards and speaking with patients during our inspection. Patient feedback was very positive about the service. They were

Summary of findings

also complimentary about the staff stating they were polite and courteous and provided excellent customer services. People referred to being treated with dignity and respect and receiving a high level of care and treatment. Information was given to patients appropriately and staff were helpful.

Our key findings were:

- Systems were in place for the provider to receive safety alerts from external organisations and they were shared appropriately with staff.
- Processes were in place for staff to learn from incidents and lessons learnt were discussed amongst staff.
- There were systems in place to reduce the risk and spread of infection. Dental instruments were decontaminated suitably.
- Patients' needs were assessed and care was planned in line with current guidance.
- Patients were involved in their care and treatment planning so they could make informed decisions.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained. However the compressor had not been serviced since 2011.
- The practice did not have access to an automated external defibrillator (AED) and the medical oxygen cylinder available on the premises was past its use by date.
- There were processes in place to safeguard patients.
- All clinical staff were up to date with their continuing professional development.
- The practice was carrying out risk assessments regularly.
- Governance arrangements were in place; however the practice were not always following their own policies and procedures.

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

- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society.
- Review stocks of medicines and equipment and the system for identifying, and replenishing out-of-date stock.
- Review the availability of equipment to manage medical emergencies giving due regard to guidelines issued by the British National Formulary, the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review the systems in place to assess, monitor and mitigate the various risks arising from undertaking of the regulated activities.

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.

Systems were in place for the provider to receive safety alerts from external organisations and they were shared appropriately with staff. Processes were in place for staff to learn from incidents and lessons learnt were discussed amongst staff. Pre-employment checks were carried out appropriately.

Dental instruments were decontaminated suitably. Medicines were available in the event of an emergency. Regular checks were however not being undertaken to monitor the usability of medicines and equipment. The medical oxygen cylinder was past its use by date staff did not have access to an automated external defibrillator (AED) in the event of a medical emergency.

Processes were not in place to ensure all equipment was serviced regularly and in correct working order. The practice was carrying out regular risk assessments.

Are services effective?

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

There were suitable systems in place to ensure patients' needs were assessed and care and treatment was delivered in line with published guidance. Patients were given relevant information to assist them in making informed decisions about their treatment and consent was obtained appropriately. Staff were aware of their responsibilities under the Mental Capacity Act (MCA) 2005.

The practice maintained appropriate dental care records and patient details were updated regularly. Information was available to patients relating to health promotion and maintaining good oral health.

Are services caring?

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

Feedback from patients was positive. We received feedback from 30 patients. Patients stated that they were involved with their treatment planning and were able to make informed decisions. Patients referred to staff as being caring, empathetic, and professional and treating them with dignity and respect. They felt involved in their treatment and gave examples of where staff had ensured they understood treatment.

Are services responsive to people's needs?

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

Patients had good access to the service which included information available via the practice leaflet. Urgent on the day appointments were available during opening hours. In the event of a dental emergency outside of opening hours patients were directed to their dentist, and the '111' out of hours' service. The building was not wheelchair accessible however the practice had arrangements to refer people to other dental surgeries close by. Information was available in accessible formats.

There were systems in place for patients to make a complaint about the service if required. Information about how to make a complaint was readily available to patients.

Summary of findings

Are services well-led?

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

Staff meetings were held informally but regularly and information was shared and opportunities existed for staff to develop. Audits were being conducted and demonstrated they were being used as a tool for continuous improvements. Staff told us they were confident in their work and felt well-supported.

Governance arrangements were in place for effective management of the practice however the practice were not always following their policies and procedures. Risk assessments and servicing of equipment were not being carried out in line with their governance arrangements. Monitoring to ensure availability of essential equipment to manage medical emergencies was not being effectively undertaken.

Phillips Jones & Joseph

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.

The inspection took place on the 30 March 2016 and was undertaken by a CQC inspector and a dental specialist adviser. Prior to the inspection we reviewed information submitted by the provider and information available on the provider's website.

The methods used to carry out this inspection included speaking with the dentists, dental nurses, the practice

manager, reception staff and patients on the day of the inspection, reviewing documents, completed patient feedback forms and observations. We received feedback from 30 patients.

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

Staff we spoke with were aware of reporting procedures including who and how to report an incident to. There had not been any incidents or accidents in the practice in the last 12 months. We did however review the accident/incident book and saw the last recorded accident which had occurred. We saw that the incident was recorded appropriately. We spoke with the practice manager about the handling of incidents and the duty of candour. The explanation was in line with the duty of candour expectations. [Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity].

There were systems in place to receive safety alerts by email. Alerts were received by one of the principal dentist and the practice manager and shared with staff working in the practice. This included forwarding them to relevant staff and also printing them off for distribution. Examples of alerts we saw were from the Medicines and Healthcare products Regulatory Agency (MHRA) and NHS England updates.

The practice manager demonstrated an understanding of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 2013) and had the appropriate documentation in place to record if they had an incident. There had not been any RIDDOR incidents, within the past 12 months.

Reliable safety systems and processes (including safeguarding)

One of the principal dentists was the safeguarding lead. The practice had policies and procedures in place for safeguarding adults and children protection. We reviewed staff training records and saw that all dentists were up to date but some of the dental nurses had last received formal training in 2011. The principal dentist who was also the safeguarding lead advised us that they had completed a refresher session in February 2016 for all staff to update them on new legislation and refresh their knowledge in the area. We were also shown evidence that training was

booked for all staff to complete face to face safeguarding training between April and September 2016. Staff we spoke with demonstrated sufficient knowledge of safeguarding issues.

The relevant safeguarding escalation flowcharts and diagrams for recording incidents were available to staff as well as the local safeguarding teams contact details in the staff area.

Some of the dentists in the practice were following guidance from the British Endodontic Society relating to the use of rubber dam for root canal treatment. [A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured]. The dentists who were not using the number dam were using other preventative measures when performing root canal treatment and recording this in the notes.

Medical histories were reviewed at each subsequent visit and updated if required. During the course of our inspection we checked dental care records to confirm the findings and saw that medical histories had been updated appropriately.

Medical emergencies

There were emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice and these were stored securely. The last check we saw was in April 2015. Staff did not have access to suitable emergency equipment on the premises. There was no automated external defibrillator (AED) in line with Resuscitation Council UK guidance and the General Dental Council (GDC) standards for the dental team. [An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm]. Medical oxygen cylinder was past its use by date of November 2011.

All clinical staff had completed recent basic life support training which was repeated annually. All staff were aware of where medical equipment was; however not all staff were confident in the use of medical oxygen.

Are services safe?

Staff recruitment

There was a full complement of the staffing team. The team consists of four dentists, six dental nurses and two receptionists.

The provider had an appropriate policy in place for the selection and employment of staff. This included requiring applicants to provide proof of address, proof of identification, references, and proof of professional qualifications and registrations (where applicable). All of the staff team were experienced and had worked in the practice for a number of years. We saw that appropriate checks had been carried out at their time of employment. All staff had a Disclosure and Barring Services check on file. DBS checks were renewed at regular intervals. (The DBS checks identify whether a person has a criminal record or is 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 saw confirmation of all clinical staffs' registration with the General Dental Council (GDC).

Monitoring health & safety and responding to risks

The practice had a health and safety policy and appropriate business continuity plan in place to deal with foreseeable emergencies. The health and safety policy covered accident, electrical and fire safety.

The practice had a general risk assessment carried out in 2011 and COSHH risk assessment carried out in 2009. Both documents were reviewed annually however we noted that only the date of the review was amended on the risk assessment. We discussed this with one of the principal dentists and they told us that they recognised that the risk assessments were not comprehensive and did not provide sufficient evidence of the risks being reviewed. They assured us that future risk assessments would be carried out appropriately.

There was a fire safety policy that covered maintenance of fire extinguishers, smoke alarms, electrical testing and fire drills. The servicing of fire equipment had taken place on 26 October 2015. Actions and recommendations had been made to improve fire safety.

There was a business continuity plan that outlined the intended purpose to help staff overcome unexpected

incidents and their responsibilities and duties. The plan outlined potential problems such as loss of computer system, loss of telephone and loss of electricity. Procedures were in place to enable them to respond to each situation.

Infection control

The practice had an infection control policy that outlined the procedure for all issues relating to minimising the risk and spread of infections. The principal dentist was the infection control lead.

There was a separate decontamination room. There were three sinks in the decontamination room in accordance with current guidelines; one for hand washing and two were used for cleaning and rinsing dental instruments. One of the dental nurses gave a demonstration of the decontamination process which was in line with guidance issued by the Department of Health, namely 'Health Technical Memorandum 01-05 -Decontamination in primary care dental practices (HTM 01-05)'. This included manually cleaning; inspecting under an illuminated magnifying glass to visually check for any remaining contamination (and re-washed if required); placing in the autoclave; pouching and then date stamping, so expiry date was clear. Staff wore the correct personal protective equipment, such as apron and gloves during the process.

There were three autoclaves. We saw records of all the daily and weekly checks and tests that were carried out on the autoclave to ensure it was working effectively.

Staff were immunised against blood borne viruses and we saw evidence of when they had received their vaccinations. The practice had blood spillage and mercury spillage kits. Clinical waste bins were assembled and labelled correctly in each surgery and were stored appropriately until collection by an external company, every week.

There were appropriate stocks of personal protective equipment such as gloves and disposable aprons for both staff and patients. There were enough cleaning materials for the practice. Wall mounted paper hand towels was available.

The surgeries were visibly clean and tidy. We were told the dental nurses were responsible for cleaning all surfaces and the dental chair in the surgery in-between patients and at the beginning and end of each session of the practice in the mornings/ evenings. External cleaning staff undertook

Are services safe?

the domestic cleaning at the practice. Daily and weekly cleaning schedules were in place outlining what areas needed to be cleaned. We reviewed a sample of completed schedules and they were up to date.

The practice had an external Legionella risk assessment carried out on the 23 March 2016. Actions were identified which the practice told us they would be implementing. [Legionella is a bacterium found in the environment which can contaminate water systems in buildings]. Taps were flushed daily in line with recommendations.

The practice carried out infection control audits every six months. We reviewed the last audit conducted in March 2016. No additional activity was required to be undertaken from the most recent audit.

Equipment and medicines

There were appropriate arrangements in place to ensure the maintenance of some equipment. Service contracts were in place for the maintenance of equipment including the autoclaves and washer disinfectors. The autoclaves were serviced on the 8 March 2016 and the washer disinfectors (which was not being currently used) was serviced on the 28 October 2015. There were two compressors. We saw records of the certificate for one which was dated 17

September 2011. There was no certificate for the other machine. We discussed this with the principal dentists and they confirmed that they would arrange for this to be completed as a matter of urgency.

The practice had portable appliances and carried out PAT (portable appliance testing). Appliances were last tested in September 2015.

Radiography (X-rays)

The practice had a radiation protection file. One of the principal dentists was the radiation protection supervisor (RPS) and the practice had an external radiation protection adviser (RPA).

The radiation protection file was well maintained. There was an inventory of equipment and a personnel list of all dentists and nurses who were qualified to take X-rays. All relevant staff were up to date with IRMER training. An X-ray risk assessment had been carried out in February 2016. We saw records to confirm this was conducted annually. There were detailed local rules and equipment had been serviced in September 2013. The critical examination had been completed in January 2016.

The practice were carrying out annual auditing of X-rays, the last audit being completed in February 2016.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists used current guidelines such as those from the National Institute for Health and Care Excellence (NICE) to assess each patient's risks. We saw that they were following guidance; for example their recall rates were in line with current recommendations.

We spoke with the principal dentists and saw evidence of comprehensive assessments to establish individual patient needs. The assessment included completing a medical history, outlining medical conditions and allergies (which was reviewed at each visit), a social history recording habits such as eating and activity and an extra- and intra-oral examination. The reason for visit was documented and a full clinical assessment was completed. An assessment of the periodontal tissue was taken and recorded using the basic periodontal examination (BPE) tool. The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums.

Health promotion & prevention

We saw evidence that clinicians in the practice were proactive with giving patients health promotion and prevention advice. Dentists told us that they gave health promotion and prevention advice to patients during consultations. Clinical staff gave us explanations of the advice they gave to patients. This ranged from teeth brushing techniques and dietary advice.

Health promotion leaflets were available to patients. This included smoking cessation, mouth cancer and child oral health posters.

Staffing

All clinical staff had current registration with their professional body, the General Dental Council. We saw

example of staff working towards their continuing professional development requirements, working through their five year cycle. [The GDC require all dentists to carry out at least 250 hours of CPD every five years and dental nurses must carry out 150 hours every five years]. We saw some examples of opportunities that existed for staff for further training and courses that were outside the core and mandatory requirements.

Working with other services

The practice had processes in place for effective working with other services. Information relating to patients' relevant personal details, reason for referral and medical history was contained in the referral. Copies of all referrals made were kept on the patients' dental care records. Referrals were made for procedures such as complex periodontal, orthodontic and endodontic treatment. Fast track referrals were seen within two weeks and details were faxed and followed up with a telephone call to ensure it was received.

Consent to care and treatment

Consent was usually obtained verbally and recorded in patients' dental care records. We reviewed patient dental care records and saw confirmation of this. Treatment plans were also completed appropriately.

We did not see evidence that staff had received training in consent and mental capacity however all clinical staff whom we spoke with demonstrated understanding of Gillick competency and the requirements of the Mental Capacity Act (MCA) 2005, including the best interest principle. [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 them]. Dental care records we checked demonstrated that consent was obtained and recorded appropriately.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We received feedback from 30 patients via Care Quality Commission comment cards and speaking with patients on the day. Patients gave examples of how they were treated with dignity and respect. This included staff ensuring they maintained privacy during consultations by keeping the treatment room doors closed, keeping their personal information confidential and speaking to them respectfully.

During our inspection we observed staff being respectful by ensuring that when patients were receiving treatment the door to the treatment rooms was closed and conversations could not be overheard in the surgery. We saw that reception staff made efforts to speak with lowered voices so conversations could not be overheard.

Patients' information was held securely electronically. All computers were password protected with individual login requirements

Involvement in decisions about care and treatment

The patient feedback we received confirmed that patients felt involved in their treatment planning and received enough information about their treatment. Patients commented that things were explained well, often with the use of models and aids, and they were provided with treatment options.

Information relating to costs was always given and explained including details about the different NHS band charges. The practice also displayed costs in the waiting area.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had an appropriate appointments system that responded to the needs of their patients. The practice is open from 8.45am to 5.30pm on Monday to Thursday and 8.45am to 3.30pm on Fridays.

The practice accommodated emergency and non-routine appointments every day during opening times. If a patient had a dental emergency they were asked to attend the surgery, and would be seen as soon as possible.

If required information could be produced in other formats such as large print for patients who required it.

Tackling inequity and promoting equality

The local population was diverse with a mix of patients from various cultures and background. The staff team was diverse as well and staff spoke different languages which included Swedish and Farsi. Staff also had access to NHS translation services if patients spoke another language that staff could not speak.

The practice was set out over two levels. All consulting rooms were upstairs on the first and second floors. Patients who had mobility problems were directed to other practices with step free access in the local area.

Access to the service

The practice opening times were advertised in the practice leaflet. Appointments were available from 8.45am to 5.30pm Monday to Thursday and 8.45am to 3.30pm on Fridays.

Appointments were booked by calling the practice or in person by attending the practice.

If a patient needed to see a dentist outside of normal opening times they were directed to contact the "111" out of hours services. They were informed of the service via the recorded message on the practice answer machine and a poster in the waiting rooms.

Concerns & complaints

At the time of our visit there had not been any complaints made in the past 12 months. Whilst no complaints had been made the practice manager demonstrated knowledge of their complaints procedure, including knowing timescales for responding, and what to do in the event of a patient needing to make a complaint. One of the principal dentists was responsible for handling complaints and staff were aware of this and knew to direct complaints to the principal dentist or the practice manager.

Complaint forms were available from reception.

Are services well-led?

Our findings

Governance arrangements

The practice had a range of policies and procedures for the smooth running of the service which were available electronically or in paper format. Staff were required to sign and date when they had read a policy of an updated version. We saw that staff had signed a recent update in 2016.

We saw instances of where procedures were not always followed. For example risk assessments were carried out annually however this was not always documented. We reviewed the risk assessment document and the last full documented audit was completed in 2011. Staff told us that risk assessments had been completed since however they did not have the documentation to support this. This was also the same with the COSHH folder. The last full document completed was in 2009. We discussed this issue with the principal dentists and they acknowledged that the appropriate paperwork needed to be completed in order to follow their procedures and evidence actions they had taken. There were also issues with the servicing of the compressor which was last serviced in 2011. There were no arrangements in place to monitor or identify when this was required.

Staff told us that audits completed over the past 12 months included audits on infection control, record keeping, X-rays and dental customer service. We reviewed the audits and saw that the aim of the audit was clearly outlined along with learning outcomes.

Leadership, openness and transparency

Staff in the practice were clear about the lines of responsibilities and were confident in approaching the principal dentists to discuss issues if they needed to. There were staff with lead role such as complaints, infection control and radiation protection. Leadership was also clear with the principal dentists having a clear presence.

We discussed the duty of candour requirement in place on providers with both of the principal dentists and they demonstrated understanding of the requirement. They gave us explanations of how they ensured they were open and transparent with patients and staff. The explanations were in line with the expectations under the duty of candour.

Learning and improvement

Training was planned on an individual basis with staff. The principal dentist told us that certain training such as life support/ CPR was conducted as a practice wide team, however staff were also encouraged to let them know what other training they wanted to attend.

The practice held informal meetings on a frequent basis. Due to the fact that a lot of staff worked part-time, we were told that the practicalities of holding meetings that all staff could attend was difficult. This meant that meetings tended to be held informally in smaller groups. Meeting minutes were not always maintained; however the staff team were very experienced and we were given examples of learning and development through the informal meeting, from staff. We reviewed the minutes of a team meeting held on 9 March 2016 and saw that topics such as staffing and policy updates were discussed.

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

The practice participated in the NHS Friends and Family Test (FFT). Results from the FFT were collected monthly and analysed to pick up any patient feedback. We reviewed the results of the FFT carried out in February 2016 and they were positive. The practice displayed the results of each month's surveys including giving patients feedback on the results and any changes made as a result of the survey.

The practice also carried out patient surveys. Audits were carried out on the surveys periodically to look for themes and trends.