J R P Jones & Associates Limited

JRP Jones & Associates Limited

Inspection report

4A Bridge Street
Morpeth
NE61 1NB
Tel: 01670517515

Date of inspection visit: 7 April 2022
Date of publication: 04/05/2022

Overall summary

We carried out this announced focused inspection on 7 April 2022 under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered practice was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a Care Quality Commission, (CQC), inspector who was supported by a specialist dental adviser.

To get to the heart of patients' experiences of care and treatment, we usually ask five key questions, however due to the ongoing COVID-19 pandemic and to reduce time spent on site, only the following three questions were asked:

• Is it safe?

• Is it effective?

• Is it well-led?

These questions form the framework for the areas we look at during the inspection.

Our findings were:

- Staff knew how to deal with medical emergencies. Appropriate medicines and life-saving equipment were available.
- The practice had infection control procedures which reflected published guidance.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.
- Staff and patients were asked for feedback about the services provided.

Summary of findings

- The dental clinic had information governance arrangements.
- The dental clinic was visibly clean; however improvements were needed to the storage arrangements of the cleaning equipment.
- Improvements were needed to the systems used to help the provider manage risks to patients and staff.
- The provider had staff recruitment procedures which reflected current legislation. However, improvements were needed to ensure important checks were carried out at the time of recruitment.

Background

The provider has 28 practices and this report is about JRP Jones and Associates Limited.

JRP Jones and Associates Limited is in Morpeth in Northumberland and provides NHS and private dental care and treatment for adults and children.

The practice is located over three floors, accessible only by stairs. It is close to local transport links and car parking spaces are available near the practice.

The dental team includes seven dentists, one foundation dentist, three dental nurses, five trainee dental nurses, one dental hygienist, one dental therapist, two receptionists and the practice manager. The practice has six treatment rooms.

During the inspection we spoke with one dentist, the foundation dentist, one dental nurse, the compliance manager and the regional manager. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Mondays, Wednesdays & Thursdays from 9am to 12:40pm and from 2pm to 5:40pm

Tuesdays from 8am to 4:40pm

Fridays from 9am to 12:40pm and from 2pm to 4:40pm

We identified regulations the provider was not complying with. They must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

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

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**No action** 
Are services effective?	**No action** 
Are services well-led?	**Requirements notice** 

Are services safe?

Our findings

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

Safety systems and processes, including staff recruitment, equipment and premises and radiography (X-rays)

The practice had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.

The practice had infection control procedures which reflected published guidance. The practice had introduced additional procedures in relation to COVID-19 in accordance with published guidance. Improvements could be made to the Infection Prevention and Control auditing protocol to ensure actions highlighted within the audit were actioned.

We saw the practice had some procedures to reduce the possibility of legionella and other bacteria developing in the water. We looked at the risk assessment carried out in May 2021. We noted that high risk recommendations had been made, relating to the servicing and maintenance of water storage units; however, there was no evidence these had been actioned. We discussed improvements that could be made to the water temperature monitoring protocols to ensure the temperature readings were recorded.

The practice had policies and procedures in place to ensure clinical waste was disposed of appropriately in line with guidance, however improvements were needed to the storage arrangements to ensure staff safety. On the day of the inspection, we noted used clinical waste bags were placed in a cupboard. They were stored in such a way that made accessing other items in the cupboard difficult and the risks to staff had not been considered and mitigated.

We saw the practice was visibly clean, however improvements were needed to the storage arrangements of the cleaning equipment to ensure this was fit for use.

The practice had a recruitment policy to help them employ suitable staff and had checks in place for agency and locum staff. These reflected the relevant legislation. We looked at six staff recruitment records. Enhanced Disclosure and Barring Services (DBS) checks had not been undertaken at the time of recruitment for four of staff, and there was no evidence the risks around this had been considered. Records were not available to show that satisfactory evidence of conduct in previous employment had been sought for three members of staff.

Improvements were also needed for the systems to ensure clinical staff had received appropriate vaccinations, including vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked. Vaccination logs and records to show the effectiveness of the vaccination were not available for four staff members.

Clinical staff were qualified, registered with the General Dental Council and had professional indemnity cover.

The practice ensured equipment was safe to use and maintained and serviced according to manufacturers' instructions, with the exception of the suction motor. On the day of the inspection there were no records available to demonstrate this had been serviced and maintained as required.

The practice ensured the facilities were maintained in accordance with regulations.

A fire risk assessment was carried out in May 2021 in line with the legal requirements. A subsequent fire department visit, was carried out in June 2021. There was no evidence recommendations made in these reports had been actioned, and the protocols for managing risks associated with fire, were being followed. During the inspection we noted the routine testing of the fire alarm was carried out inconsistently. There was no evidence that the emergency lighting was serviced and maintained nor that fire drills were carried out. Records were also not available to demonstrate that all staff undertook training in relation to fire safety.

Are services safe?

The practice had arrangements to ensure the safety of the X-ray equipment and we saw the required radiation protection information was available.

Risks to patients

The practice had implemented some systems to assess, monitor and manage risks to patient and staff safety; this included sepsis awareness. There was no evidence the practice had undertaken a risk assessment relating to the handling and disposal of dental sharps and the risks to staff considered and mitigated.

Emergency equipment and medicines were available and checked in accordance with national guidance.

Staff knew how to respond to a medical emergency and we were told staff had completed training in emergency resuscitation and basic life support every year; however, of the six staff records we looked at, evidence was not available to demonstrate this for five members of staff.

The practice had risk assessments to minimise the risk that could be caused from substances that are hazardous to health.

Information to deliver safe care and treatment

Dental care records we saw were very comprehensive, were kept securely and complied with General Data Protection Regulation requirements.

The practice had systems for referring patients with suspected oral cancer under the national two-week wait arrangements.

Safe and appropriate use of medicines

The practice had systems for appropriate and safe handling of medicines. Antimicrobial prescribing audits were carried out.

Track record on safety, and lessons learned and improvements

The practice had a system for receiving and acting on safety alerts.

The practice had limited systems for reviewing and investigating incidents and accidents. We looked at the records available and found no evidence that an accident was reviewed to use it as an opportunity for shared learning.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

The practice had systems to keep dental professionals up to date with current evidence-based practice.

Helping patients to live healthier lives

The practice provided preventive care and supported patients to ensure better oral health.

Consent to care and treatment

Staff obtained patients' consent to care and treatment in line with legislation and guidance.

Staff understood their responsibilities under the Mental Capacity Act 2005.

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

The practice kept detailed dental care records in line with recognised guidance.

Staff conveyed an understanding of supporting more vulnerable members of society such as patients with dementia, and adults and children with a learning difficulty.

We saw evidence the dentists justified, graded and reported on the radiographs they took. The practice carried out radiography audits following current guidance and legislation. We discussed some changes that could be made to the auditing protocol to drive continual improvement.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

The provider told us there were systems in place to ensure newly appointed staff received a structured induction. We looked at six staff records. Evidence was not available to demonstrate that the induction had been completed for three members of staff. The other three records lacked sufficient detail so as to provide assurance of the staff member's understanding of important protocols in the practice.

Clinical staff completed continuing professional development required for their registration with the General Dental Council.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

The dentists confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide.

Are services well-led?

Our findings

We found this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notice section at the end of this report).

We will be following up on our concerns to ensure they have been put right by the provider.

Leadership capacity and capability

We found the provider had the capacity, values and skills to deliver high-quality, sustainable care. The information and evidence presented during the inspection process was clear and well documented. The inspection however, highlighted some areas such as, risk management and adherence to published guidance where improvements were needed.

Culture

The practice had protocols in place to manage the service, however these did not always operate effectively.

Staff stated they felt respected, supported and valued. They were proud to work in the practice.

Staff told us they discussed their training needs during annual appraisals. They also discussed learning needs, general wellbeing and aims for future professional development. Improvements were needed to the monitoring of staff training to ensure that it was up-to-date and undertaken at the required intervals. For example, in relation to Basic Life Support and fire safety training.

Governance and management

Staff had clear responsibilities roles and systems of accountability to support the management of the practice.

The practice had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff. Important information and protocols were cascaded via the senior managers; however improvements could be made to ensure changes to protocol are adopted within the practice.

Improvements were needed to ensure processes for managing risks were effective. The practice did not have adequate systems in place for identifying, assessing and mitigating risks in areas such as managing incidents and accidents, fire safety and legionella.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

The practice had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information.

Engagement with patients, the public, staff and external partners

Staff gathered feedback from patients, the public and external partners and a demonstrated commitment to acting on feedback. We saw feedback gathered from patient surveys from January to April 2022. This demonstrated that over 94% of patients who participated in the survey would recommend the practice to others.

The practice gathered feedback from staff through meetings, surveys, and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

Continuous improvement and innovation

The practice had some systems and processes for learning, continuous improvement and innovation.

Are services well-led?

These included audits of dental care records, disability access, radiographs and infection prevention and control. We discussed some improvements could be made to the auditing protocols to ensure outcomes and any action plans are created to drive further improvement.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the Regulation was not being met The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • Protocols were not in place to adequately review and investigate accidents and incidents and share any learning. • Records were not available to demonstrate that the suction equipment had been serviced and maintained according to manufacturer's guidelines. • Clinical waste was not stored safely and the risks to staff had not been considered and mitigated. • The risks associated with all forms of sharps had not been considered nor had those risks to staff been mitigated. • Recommendations made as part of the fire safety risk assessment had not been carried out and the risks associated with fire had not been appropriately assessed and mitigated. • Fire safety equipment such as the emergency lighting were not tested and checked. • All staff had not undertaken fire safety training as recommended. • Recommendations made in the legionella risk assessments had not been implemented and the risks appropriately mitigated. • Cleaning equipment was not available and stored as required.

This section is primarily information for the provider

Requirement notices

The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to maintain securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity or activities. In particular:

- There was no system in place to ensure important recruitment checks had been carried out, for all members of staff, at the time of recruitment and that staff vaccinations had been carried out and the level of immunity checked.
- Records were not available to demonstrate comprehensive inductions were being carried out for all newly appointed members of staff.
- Not all members of staff had undertaken Basic Life Support training as required.

Regulation 17 (1)