Failure to Comply Notice Announced Compliance Inspection

Name of Establishment:	**Bradbury Dental Surgery**
Establishment ID No:	**11402**
Date of Inspection:	**30 June 2014**
Inspectors' Names:	**Lynn Long** **Elaine Connolly**

The Regulation and Quality Improvement Authority
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501

1.0 General Information

Name of establishment:	Bradbury Dental Surgery
Address:	46 Bradbury Place Belfast BT7 1RR
Telephone number:	028 9022 2444
Registered organisation / Responsible individual:	Dental World Limited Mr Robert A McMitchell
Registered manager:	Miss Jessica Larmour
Person in charge of the establishment at the time of Inspection:	Miss Jessica Larmour
Registration category:	IH-DT
Type of service provision:	Private dental treatment
Maximum number of places registered: (dental chairs)	3
Date and type of previous inspection:	Failure to Comply Notice - Announced Compliance Inspection 30 May 2014
Date and time of inspection:	30 June 2014 10.00-11.30
Name of inspectors:	Lynn Long Elaine Connolly

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect dental practices providing private dental care and treatment. A minimum of one inspection per year is required. The service is also inspected to determine compliance with the requirements of the Independent Health Care Regulations (Northern Ireland) 2005 and the Minimum Standards for Dental Care and Treatment March 2005.

This is a report of the announced inspection to assess the compliance against one of two Failure to Comply Notices, which were issued to Bradbury Dental Surgery on 28 March 2014. At the compliance inspection to the practice on 30 May 2014 it was evident that the necessary actions had been taken to comply with the Failure to Comply Notice in relation to the decontamination of reusable dental instruments.

The necessary actions had not been taken to comply with the second Failure to Comply Notice in relation to radiology and radiation safety and subsequently the Failure to Comply Notice was extended to 29 June 2014.

3.0 Purpose of the Inspection

The purpose of the inspection was to ascertain the progress made to address the actions outlined in the Failure to Comply Notice, in relation to radiology and radiation safety, issued on 28 March 2014 and extended on 30 May 2014 to 29 June 2014.

The breach of legislation identified in the Failure to Comply Notice was as follows:

Regulation 15 (1) (b)

(1)Subject to regulation 7 (3), the registered person shall provide treatment and any other services to patients in accordance with the statement of purpose, and shall ensure that the treatment and any other services provided to each patient –

(b)reflect published research evidence and guidance issued by the appropriate professional and expert bodies, as to good practice in the treatment of the condition from which the patient is suffering;

4.0 Inspection Focus

An announced follow-up inspection was undertaken to Bradbury Dental Surgery on 12 March 2014 as a number of issues in relation to radiology and radiation safety which did not meet with best practice had been identified during the inspection of 10 December 2013 and had still not been progressed. Subsequent to this, a Failure to Comply Notice was issued on 28 March 2014.

During an announced compliance inspection to Bradbury Dental Surgery on 30 May 2014 full compliance in relation to radiology and radiation safety had not been achieved and the Failure to Comply Notice was subsequently extended to 29 June 2014.

This inspection was undertaken to establish the progress made towards compliance with the Failure to Comply Notice.

5.0 Methods/Process

- review of the actions taken to comply with the failure to comply notice;
- discussion with Miss Jessica Larmour, registered manager;
- examination of relevant records;
- consultation with relevant staff;
- tour of the premises; and
- evaluation and feedback.

Any other information received by RQIA about this practice has also been considered by the inspector in preparing for this inspection.

6.0 Summary

This announced compliance inspection to Bradbury Dental Surgery was undertaken to establish the progress made towards compliance with the Notice of Failure to Comply which had been issued to Mr McMitchell, responsible individual, in respect of Bradbury Dental Surgery on 28 March 2014.

A previous compliance inspection had been undertaken to the practice on 30 May 2014. However, compliance in relation to radiology and radiation safety had not been achieved at this time and the Notice of Failure to Comply was subsequently extended to 29 June 2014.

The announced compliance inspection was undertaken by Elaine Connolly and Lynn Long on 30 June 2014 between the hours of 10.00am and 11.30am. Miss Jessica Larmour, Registered Manager, was available throughout the inspection and was provided with verbal feedback at the conclusion of the inspection.

During the course of the inspection the inspectors also met with a dental nurse, discussed operational issues, examined a selection of records and carried out a general inspection of the establishment.

The breach of legislation identified in the Failure to Comply Notice was as follows:

The Independent Health Care Regulations (Northern Ireland) 2005

Regulation 15 (1)(b)

> *(1)Subject to regulation 7 (3), the registered person shall provide treatment and any other services to patients in accordance with the statement of purpose, and shall ensure that the treatment and any other services provided to each patient –*
>
> *(b)reflect published research evidence and guidance issued by the appropriate professional and expert bodies, as to good practice in the treatment of the condition from which the patient is suffering;*

Review of documentation, discussion with Miss Larmour and staff, and observations made evidenced that the necessary actions have not been taken to comply with the Failure to Comply Notice.

The findings of this inspection, including the detail of where compliance has not been achieved, are detailed in the main body of the report below.

Following the inspection, this matter was reported to senior management in RQIA, following which a decision was taken to hold an intention meeting to issue a Notice of Proposal. Mr McMitchell was invited to attend a meeting at RQIA on 3 July 2014. Mr McMitchell informed RQIA that he was unable to attend the meeting and the meeting was rescheduled to 2 July 2014.

During the intention meeting no significant information in relation to compliance was provided during the meeting.

RQIA have taken an overview of inspection activity, together with the information provided by Mr McMitchell at the meeting on 2 July 2014. RQIA acknowledged that some progress has been made to address the issues identified in the Failure of Comply Notice relating to radiology and radiation safety. However, the necessary actions have not been undertaken in relation to radiology and radiation safety at this practice. RQIA are concerned in relation to the potential risk that could be posed to patients in relation to radiology and radiation safety at this practice and subsequently a Notice of Proposal to impose the following condition to the registration of Bradbury Dental Surgery was issued:

Dental x-rays must not be undertaken at Bradbury Dental Surgery until such times as the matters set out in the Failure to Comply Notice have been assessed as compliant.

The inspectors wish to thank Miss Larmour and staff for their assistance and cooperation throughout the inspection process.

7.0 Inspection Findings of Action Required to Comply with Regulations:

7.1 FTC/IHC-DT/11402/2013-2014/02

Appoint a Radiation Protection Supervisor (RPS) for the practice. The Radiation Protection Supervisor must be made known to all staff and a record confirming the appointment must be retained in the radiation protection file;

A review of the records and discussion with Miss Larmour confirmed that one of the dentists had been appointed as the RPS for the practice. The RPS was not on duty during the inspection and had not been on duty during the previous compliance inspection. This was discussed with Miss Larmour who confirmed that the dentist who is appointed as the RPS for the practice regularly travels abroad to treat patients. Miss Larmour stated that the dentist was absent one week each month. During the meeting on 2 July 2014 Mr McMitchell advised those present that the RPS was absent for approximately four days each month and not one week.

There was no evidence retained in the radiation protection file that the RPS had provided training to or entitled staff in relation to their relevant duties in relation to radiology.

A number of issues were identified with the x-ray quality and the justification and clinical evaluation recording audits. This included that the percentages of x-rays with a grade two quality rating had increased since the previous inspection and was above the national average. Miss Larmour advised inspectors during discussions that the reason for the increase in the percentage of grade two x-rays was due to the condition of the phosphor plates. The RPS had not identified, as part of the audit, the need to replace the damaged phosphor plates.

A review of the justification and clinical evaluation recording audits identified a number of issues. However, the quality of the information contained on the audit was not clear and again there was no evidence to indicate what actions had been taken to address the deficits identified.

A review of the records identified that the RPS had signed the documentation following the most recent inspection visit by the Radiation Protection Advisor (RPA). A number of recommendations had been made during the visit by the RPA. A number of the recommendations made had not been addressed. This issue had been raised during previous inspections. Again there was no evidence that the RPS was taking responsibility to address the issues identified in relation to radiology and radiation safety.

Given the issues identified during this inspection in relation to radiology and radiation safety inspectors are concerned in relation to the competency of the appointed RPS to fulfil this role. It is the view of the inspectors that the RPS identified in this practice is in name only and that they are not fulfilling their legal responsibilities.

The lack of governance arrangements in relation to radiology and radiation safety at this practice are concerning. RQIA are concerned in relation to the potential risk that could be posed to patients in relation to radiology and radiation safety at this practice.

Audits of x-ray quality must be undertaken and recorded on a six monthly basis. Issues identified as a result of the audit must be addressed. All dentists' x-ray quality ratings must be included in the audit;

A review of the records identified that audits of x-ray quality had been undertaken. However, the review identified that the percentages of x-rays with a grade two quality rating had increased since the previous inspection and was above the national average. Miss Larmour advised inspectors during discussion that the reason for the increase in the percentage of grade two x-rays was due to the condition of the phosphor plates. Miss Larmour stated she thought this may be due to the phosphor plates being damaged causing

"curling" around the edges of the film. There was no evidence that actions had been taken to address the deficits identified.

Audits of justification and clinical evaluation recording must be undertaken and recorded on an annual basis. Audits should incorporate review of all dentists' justification and clinical evaluation recording;

There was evidence retained that two dentists had undertaken an audit of a number of x-rays. Miss Larmour confirmed that these were the justification and clinical evaluation recording audits. A review of the audits identified that the information contained within them was not meaningful and it was difficult to ascertain what the dentists had audited or the deficits which the audit had identified. This could not be discussed with the dentists as the RPS was on leave and the other dentist was engaged treating patients. Again there was no evidence that actions had been taken to address the deficits identified.

The recommendations made by the appointed Radiation Protection Advisor must be addressed and a record retained to confirm the actions taken;

A review of the records identified that some actions have been taken to address the recommendations made by the RPA. However, it was evident that a number of the recommendations have not been addressed. Some of the recommendations made included that collimators should be fitted to the intra-oral x-ray machines and to ensure isolator switches were fitted in the orthopan tomogram (OPG) room and in surgeries two and three. Miss Larmour informed the inspectors that a remote control switch had been fitted to the OPG to allow staff to isolate the machine when outside of the room. However, there were no records to confirm that staff are aware of how to use this new piece of equipment or records to confirm who had supplied and fitted this isolator to the machine or trained staff in its use.

One inspector observed an x-ray being taken in surgery three. There was no evidence that staff were using a remote isolator switch. The inspector discussed this with the dental nurse on duty. The dental nurse was unaware of a remote isolator switch for this surgery. Miss Larmour informed the inspectors that it had been in the surgery the previous week when she had visited the practice. It could not be located on the day of the inspection. On completion of the x-ray one inspector observed that the collimator had been removed from the intra-oral machine and was resting on the work surface in the surgery.

Miss Larmour informed the inspectors that the x-ray equipment in surgery two was currently out of use. Miss Larmour confirmed that a new intra-oral machine had been installed Miss Larmour confirmed that the equipment was reconditioned and that it had been purchased and installed by a local supplier. However, there was no evidence retained at the practice to confirm installation and there was no manufacturer's guidance available in relation to the piece of equipment installed. This was discussed with Miss Larmour who agreed to contact the supplier to obtain the relevant paperwork.

Following the inspection, paperwork was forwarded to the inspectors in the form of a service report. The service report indicated that the equipment was the customers own and had not been supplied by the local company. The report also confirmed that a collimator and an isolation switch are needed in order for the x-ray equipment to be safe to use and goes on to indicate that these items are to be supplied by Mr McMitchell. The report also indicated that a critical examination needs to be undertaken on the equipment. Miss Larmour informed the inspectors that the critical examination had been undertaken and that they were awaiting paperwork from the appointed RPA confirming this.

Routine testing must be undertaken by the appointed Radiation Protection Advisor at intervals not exceeding three years and any recommendations made must be addressed and a record retained;

There was evidence retained to confirm that routine testing of three intra-oral x-ray machines and one orthopan tomogram had been undertaken since the previous visit. However, one of the machines which had been tested has now been replaced. As discussed Miss Larmour confirmed that it had been subject to a critical examination by the appointed RPA. However, there were no records retained to confirm this.

The inspectors also observed that the serial numbers on the x-ray equipment did not match the serial numbers on various different pieces of documentation. Different serial numbers were observed on the local rules, on information retained in the surgery beside the x-ray equipment, which outlined dosages recommended by the appointed RPA, on one set of local rules and also on information retained in the radiation protection file. This issue had been identified during the previous inspection and had not been rectified.

All staff, including the dentists must sign to confirm that they have read and understood the local rules for radiology;

A review of the records identified that staff including the dentists had signed to confirm that they had read and understood the local rules. However, it was identified that two different sets of local rules were available at the practice.

A review of the local rules identified that one set outlined information in relation to chemical processing of x-rays. Bradbury Dental Surgery x-ray processing is now digitalised. This information had not been updated despite being raised previously.

Employer's procedures must be established for the practice and include all aspects as required under the Ionising Radiation (Medical Exposure) Regulations (Northern Ireland) 2000 as amended.

Two sets of employer's procedures were available on request. One of the sets of employer's procedures was a template which had not been localised to reflect the arrangements in place at the practice.

The second set did not contain all of the information required in a set of employer's procedures. Records were retained on the radiation protection file advising what each member of staff's duties were and it was also recorded on the file that staff had been instructed regarding how to undertake their relevant duties. However, there were no records retained of who had entitled staff in relation to their relevant duties.

Miss Larmour confirmed that this information had been recorded by her and not by the RPS. There was no evidence retained on file that the RPS had been included in entitling staff and ensuring they are trained and competent.

The radiation protection file must be reviewed to ensure it reflects that x-rays are now digital, reflects current staff and that information which is no longer applicable is removed and filed appropriately.

The radiation protection file has been updated.

8.0 Inspection outcome

Review of documentation, discussion with Miss Larmour and a dental nurse and observations made during the inspection evidenced that the necessary actions have not been taken to comply with the matters outlined in the Failure to Comply Notice.

Following the inspection, this matter was reported to senior management in RQIA, following which a decision was taken to hold an intention meeting to issue a Notice of Proposal. Mr McMitchell was invited to attend a meeting at RQIA on 3 July 2014. Mr McMitchell informed RQIA that he was unable to attend this meeting and the meeting was rescheduled to 2 July 2014.

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9.0 Quality Improvement Plan

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

Enquiries relating to this report should be addressed to:

Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

_____ _____

Lynn Long **Date**
Inspector

_____ _____

Elaine Connolly **Date**
Senior Inspector

The Regulation and Quality Improvement Authority

I agree/~~do not agree~~* with the content of the Failure to Comply Notice Announced Compliance Inspection report of Bradbury Dental Surgery undertaken on 30 June 2014.

**** Please delete as appropriate***

Please provide any additional comments or observations you may wish to make:

SIGNED: _____ **SIGNED:** _____
Registered Provider **Registered Person in Control (or Designated Person in Control)**

NAME: Robert McMitchell **NAME:** Jessica Lamar
(PRINT) **(PRINT)**

DATE: 3.9.14 **DATE:** 03.09.14

The registered provider/manager is required to sign this declaration and return to:

The Regulation and Quality Improvement Authority
9th floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

DATE RECEIVED	APPROVED	SIGNATURE OF INSPECTOR
19/9/14.	Yes	