The Regulation and Quality Improvement Authority

Announced Care Inspection Report
05 February 2018

Aughnacloy Dental Practice

Type of service: Independent Hospital (IH) – Dental Treatment
Address: 139 Moore Street, Aughnacloy, BT69 6AR
Tel no: 028 8555 7275
Inspector: Carmel McKeegan

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the servicefrom their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered dental practicewith threeregistered places.

3.0 Service details

Organisation/Registered Provider: Aughnacloy Dental Practice Mr Denis Kelly	**Registered Manager:** Mr Denis Kelly
Person in charge at the time of inspection: Mr Denis Kelly	**Date manager registered:** 05 November 2011
Categories of care: Independent Hospital (IH) – Dental Treatment	**Number of registered places:** 3

4.0 Inspection summary

An announced inspection took place on 05 February 2018 from 11.30 to 13.45.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Independent Health Care Regulations (Northern Ireland) 2005, The Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011 and the Department of Health, Social Services and Public Safety (DHSSPS) Minimum Standards for Dental Care and Treatment (2011).

The inspection assessed progress with any areas for improvement identified during and since the last careinspection and to determine if the practice was delivering safe, effective and compassionate care and if the service was well led.

Examples of good practice were evidenced in all four domains. These related to patient safety in respect of staff development, recruitment, infection prevention and control and radiology. Other examples included health promotion, engagement to enhance the patients' experience and governance arrangements.

Five areas for improvement were identified against the standards in the following areas to ensue that; all staff should receive training in safeguarding children and adults at risk of harm; that the adult safeguarding policy is further developed; that the fire risk assessment is located and that any recommendations contained therein are implemented; to develop a written security policy to reduce the risk of prescription theft and misuse, and to undertake a patient satisfaction survey on an annual basis.

All of the patients who submitted questionnaire responses to RQIA indicated that a high level of satisfaction with all aspects of care in this service. The following comments were provided in submitted questionnaire responses:

- "My treatment is second to none."
- "Very happy."

The findings of this report will provide the practice with the necessary information to assist them to fulfil their responsibilities, enhance practice and patientsexperience.

While we assess the quality of services provided against regulations and associated DHSSPS care standards, we do not assess the quality of dentistry provided by individual dentists.

4.1Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	5

Details of the Quality Improvement Plan (QIP) were discussed with Mr Denis Kelly, registered person, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcementaction did not result from the findings of this inspection.

4.2Action/enforcementtaken following the most recent care inspection dated 08 March 2017

No further actions were required to be taken following the most recent inspection on 08 March 2018.

5.0 How we inspect

Prior to the inspection a range of information relevant to the practice was reviewed. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the establishment
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report
- submitted staffing information
- submitted complaints declaration

Questionnaires were provided to patients prior to the inspection by the establishment on behalf of RQIA. Returned completed patient questionnaires were also analysed prior to the inspection. Staff were invited to complete questionnaires electronically however none were received by RQIA. It is acknowledged that some difficulties have been experienced with the introduction of electronic questionnaires and RQIA continue to work to resolve the matter.

A poster informing patients that an inspection was being conducted was displayed.

During the inspection the inspector met with Mr Denis Kelly, registered person, an associate dentist and two dental nurses. A tour of the premises was also undertaken.

A sample of records was examined during the inspection in relation to the following areas:

- staffing
- recruitment and selection
- safeguarding
- management of medical emergencies
- infection prevention and control and decontamination
- radiography
- clinical record recording arrangements
- health promotion
- management and governance arrangements
- maintenance arrangements

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to Mr Kelly at the conclusion of theinspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 08 March 2017

The most recent inspection of the practice was an announced care inspection.The completed QIP was returned and approved by the care inspector.

6.2 Review of areas for improvement from the last care inspection dated 08 March 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Minimum Standards for Dental Care and Treatment (2011)		**Validation of compliance**
Recommendation 1 **Ref:** Standard 12.4 **Stated:** Second time	The registered person should consider provision of an automated external defibrillator (AED).	**Met**
	Action taken as confirmed during the inspection: It was confirmed that an AED had been provided and staff had received training in this regard.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Staffing

Three dental surgeries are in operation in this practice. Discussion with staff and a review of completed patient and staff questionnaires demonstrated that there was sufficient numbers of staff in various roles to fulfil the needs of the practice and patients.

Induction programme templates were in place relevant to specific roles and responsibilities. A sample of one evidenced that induction programmes had been completed when new staff joined the practice.

Procedures were in place for appraising staff performance and staff confirmed that appraisals had taken place. Staff confirmed that they felt supported and involved in discussions about their personal development. There was a system in place to ensure that all staff receive appropriate training to fulfil the duties of their role.

A review of records confirmed that a robust system was in place to review the General Dental Council (GDC) registration status and professional indemnity of all clinical staff.

Recruitment and selection

A review of the submitted staffing information and discussion with Mr Kelly confirmed that one new staff member had been recruited since the previous inspection. A review of the personnel file for this staff member demonstrated that some of the information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 has been sought and retained.However the following information was not provided;

- a criminal conviction declaration
- a record of the individual’s employment history with reasons for leaving and any employment gaps explored
- a second written reference

Mr Kelly confirmed that he had sought a verbal reference for the staff member but had not recorded the reference.Discussion took place on how to record a verbal reference should a written reference not be forthcoming. Mr Kelly confirmed the applicant had provided a C.V. and gave assurances that the outstanding information would obtained at the earliest opportunity.

Following the inspection a template for recording a criminal conviction declaration and a recruitment record checklist were provided to Mr Kelly by email which, if used, will ensure that all the required recruitment documentation is obtained for new staff members.

There was a recruitment policy and procedure available. The policy was comprehensive and reflected best practice guidance.

Safeguarding

Staff were aware of the types and indicators of abuse and the actions to be taken in the event of a safeguarding issue being identified, including who the nominated safeguarding lead was.

It was identified that not all staff had received training in safeguarding children and adults as outlined in the Minimum Standards for Dental Care and Treatment 2011. An area of improvement has been made in this regard.

Mr Kelly is the safeguarding lead and has completed formal training; however it was not clear if the training had been formal level 2 training in safeguarding adults in keeping with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016). Mr Kelly agreed to follow this up and will ensure that if he is required to attend further training he will do so.

Policies and procedures were in place for the safeguarding and protection of adults and children at risk of harm. The policies included the types and indicators of abuse and distinct referral pathways in the event of a safeguarding issue arising with an adult or child. The relevant contact details for onward referral to the local Health and Social Care Trust should a safeguarding issue arise were included. The adult safeguarding policy needs to be further developed to fully reflect the regional 'Adult Safeguarding Prevention and Protection in Partnership policy' (July 2015) and 'Adult Safeguarding Operational Procedures' (2016). Advice and guidance was provided and an area for improvement against the standards has been made in this regard.

It was confirmed that copies of the regional policy entitled 'Co-operating to Safeguard Children and Young People in Northern Ireland' (March 2016) and the regional guidance document entitled 'Adult Safeguarding Prevention and Protection in Partnership' (July 2015) were both available for staff reference.

Management of medical emergencies

A review of medical emergency arrangements evidenced that emergency medicines were provided in keeping with the British National Formulary (BNF).The Glucagon medication was stored out of the fridge and the expiry date had not been revised on the packaging and the expiry date check list in accordance with the manufacturer's instruction. Mr Kelly confirmed a revised expiry date would be recorded in keeping with manufacturer's instruction.

Emergency equipment as recommended by the Resuscitation Council (UK) guidelines was retained. A robust system was in place to ensure that emergency medicines and equipment do not exceed their expiry date. There was an identified individual with responsibility for checking emergency medicines and equipment.

Review of training records and discussion with staff confirmed that the management of medical emergencies is included in the induction programme and training is updated on an annual basis in keeping with best practice guidance.

Discussion with staff demonstrated that they have a good understanding of the actions to be taken in the event of a medical emergency and the location of medical emergency medicines and equipment.

The policy for the management of medical emergencies reflected best practice guidance. Protocols were available for staff reference outlining the local procedure for dealing with the various medical emergencies.

Infection prevention control and decontamination procedures

Clinical and decontamination areas were tidy and uncluttered and work surfaces were intact and easy to clean. Fixtures, fittings, dental chairs and equipment were free from damage, dust and visible dirt.Staff were observed to be adhering to best practice in terms of the uniform and hand hygiene policies.

Discussion with staff demonstrated that they had an understanding of infection prevention and control policies and procedures and were aware of their roles and responsibilities. Staff confirmed that they have received training in infection prevention and control and decontamination in keeping with best practice.

There was a nominated lead with responsibility for infection control and decontamination.

A decontamination room, separate from patient treatment areas and dedicated to the decontamination process,was available.Appropriate equipment, including a washer disinfector and two steam steriliser, have been provided to meet the practice requirements. A review of documentation evidenced that equipment used in the decontamination process has been appropriately validated. A review of equipment logbooks evidenced that periodic tests are undertaken and recorded in keeping with Health Technical Memorandum (HTM) 01-05 Decontamination in primary care dental practices.

It wasconfirmed that the practice continues to audit compliance with HTM 01-05 using the Infection Prevention Society (IPS) audit tool. The most recent IPS audit was completed on 26 January 2018.

A range of policies and procedures were in place in relation to decontamination and infection prevention and control.

Radiography

The practice has threesurgeries, two of which have an intra-oral x-ray machine.

A dedicated radiation protection file containing the relevant local rules, employer's procedures and other additional information was retained. A review of the file confirmed that staff have been authorised by the radiation protection supervisor (RPS) for their relevant duties and have received local training in relation to these duties. It was evidenced that all measures are taken to optimise dose exposure. This included the use of rectangular collimation, x-ray audits and digital x-ray processing.

A copy of the local rules was on display near each x-ray machineand appropriate staff had signed to confirm that they had read and understood these. Staff spoken with demonstrated sound knowledge of the local rules and associated practice.

The radiation protection advisor (RPA) completes a quality assurance check every three years. Review of the report of the most recent visit by the RPA on 8 February 2018 demonstrated that the recommendations made have been addressed.

The x-ray equipment has been serviced and maintained on 26 April 2017 in accordance with manufacturer's instructions.

Quality assurance systems and processes were in place to ensure that all matters relating to x-rays reflect legislative and best practice guidance.

Environment

The environment was maintained to a good standard of maintenance and décor.

Detailed cleaning schedules were in place for all areas which were signed on completion. A colour coded cleaning system was in place.

Arrangements are in place for maintaining the environment. Portable appliance testing (PAT) of electrical equipment is undertaken every two years and is due be renewed in August 2018.

Staff confirmed that fire drills are routinely undertaken and recorded and all staff have completed fire safety awareness training.

Mr Kelly confirmed that a fire risk assessment had been undertaken, however it could not be located. An area for improvement against the standards was made in this regard.

It was confirmed that a legionella risk assessment had been completed by an external organisation on 10 January 2018, Mr Kelly confirmed that work has commenced to address the recommendations outlined in the risk assessment report. Legionella control measures to include the monitoring of water temperatures are in place and records retained.

Review of documentation evidenced that the pressure vessels in the practice have been inspected in keeping with the written scheme of examination of pressure vessels.

It was confirmed that robust arrangements are in place for the management of prescription pads/forms, however, a written security policy to reduce the risk of prescription theft and misuse had not been developed. An area of improvement against the standards was made in this regard.

Patient and staff views

Seventeen patients submitted questionnaire responses to RQIA. All indicated that they felt safe and protected from harm and indicated a high level of satisfaction with this aspect of care.

No staff questionnaire responses were received

Areas of good practice

There were examples of good practice found in relation to staff recruitment, induction, appraisal, infection prevention control and decontamination procedures, radiologyand the environment.

Areas for improvement

All staff should receive training in safeguarding children and adults as outlined in the Minimum Standards for Dental Care and Treatment 2011.

The policy and procedure for Adult Safeguarding should be in keeping with the regional 'Adult Safeguarding Prevention and Protection in Partnership policy' (July 2015) and 'Adult Safeguarding Operational Procedures' (2016).

Mr Kelly should locate the completed fire risk assessment and ensure that any recommendations contained therein are addressed.

A written security policy to reduce the risk of prescription theft and misuse should be developed

	Regulations	Standards
Total number of areas for improvement	0	4

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Clinical records

Mr Kelly and staff confirmed that clinical records are updated contemporaneously during each patient's treatment session in accordance with best practice.

Routine dental examinations include a review of medical history, a check for gum disease and oral cancers andthat treatment plans are developed in consultation with patients. It was confirmed that patients are informed about the cost of treatments, choices and options.

Both manual and computerised records are maintained. Electronic records have different levels of access afforded to staff dependent on their role and responsibilities. Appropriate systems and processes were in place for the management of records and maintaining patient confidentiality.

Policies were available in relation to records management, data protection and confidentiality and consent. The records management policy includes the arrangements in regards to the creation, storage, recording, retention and disposal of records and data protection. The policy is in keeping with legislation and best practice guidance.

The practice is registered with the Information Commissioner's Office (ICO) and a Freedom of Information Publication Scheme has been established.

Health promotion

The practice has a strategy for the promotion of oral health and hygiene. Mr Kelly and staff confirmed that oral health is actively promoted on an individual basis during treatment sessions by the dentist and the dental hygienist. A range of oral health promotion leaflets were available at reception and the patients' waiting area. A range of oral healthcare products were also available to purchase.

Audits

There were arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to patients at appropriate intervals which included:

- x-ray quality grading
- x-ray justification and clinical evaluation recording
- IPS HTM 01-05

Communication

Mr Kelly confirmed that arrangements are in place for onward referral in respect of specialist treatments. A policy and procedure and template referral letters have been established.

Staff meetings are held on a monthly basis to discuss clinical and practice management issues. Review of documentation demonstrated that minutes of staff meetings are retained. Staff spoken with confirmed that meetings also facilitated informal in house training sessions.

Staff confirmed that there are good working relationships and there is an open and transparent culture within the practice.

A breaking bad news policy in respect of dentistry was in place.

Patient and staff views

All of the patients who submitted questionnaire responses indicated that they get the right care, at the right time and with the best outcome for them and indicated a high level of satisfaction with this aspect of care.

No staff questionnaire responses were received.

Areas of good practice

There were examples of good practice found in relation to the management of clinical records, the range and quality of audits, health promotion strategies and ensuring effective communication between patients and staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Dignity, respect and involvement in decision making

Staff demonstrated a good understanding of the core values of privacy, dignity, respect and patient choice. Staff confirmed that if they needed to speak privately with a patient that arrangements are provided to ensure the patient's privacy is respected. Staff were observed to conduct telephone enquiries in a professional and confidential manner, patients were not present during the inspection.

The importance of emotional support needed when delivering care to patients who were very nervous or fearful of dental treatment was clear.

It was confirmed that treatment options, including the risks and benefits, were discussed with each patient. This ensured patients understood what treatment is available to them and can make an informed choice. Mr Kelly and staffdemonstrated how consent would be obtained.

Mr Kelly confirmed that a patient satisfaction survey had not been undertaken recently. Mr Kelly was advised that a patient satisfaction survey that includes the quality of treatment and other services provided and should be undertaken on at least an annual basis. A summary report should be collated and made available to patients.An area for improvement against the standards has been made in this regard.

A policy and procedure was in place in relation to confidentiality which included the arrangements for respecting patient's privacy, dignity and providing compassionate care and treatment.

Patient and staff views

All of thepatients who submitted questionnaire responses indicated that they are treated with dignity and respect and are involved in decision making affecting their care and indicated a high level of satisfaction with this aspect of care.

No staff questionnaire responses were received.

Areas of good practice

There were examples of good practice found in relation to maintaining patient confidentiality ensuring the core values of privacy and dignity were upheld and providing the relevant information to allow patients to make informed choices.

Areas for improvement

Patient satisfaction surveys to include the quality of treatment and other services provided should be undertaken on at least an annual basis. A summary report should be collated and made available to patients.

	Regulations	Standards
Total number of areas for improvement	0	1

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Management and governance arrangements

There was a clear organisational structure within the practice and staff were able to describe their roles and responsibilities and were aware of who to speak to if they had a concern. Staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Mr Kelly is the nominated individual with overall responsibility for the day to day management of the practice.

Policies and procedures were available for staff reference. Observations made confirmed that policies and procedures were indexed, dated and systematically reviewed on an annual basis. Staff spoken with were aware of the policies and how to access them.

Arrangements were in place to review risk assessments.

A copy of the complaints procedure was available in the practice. Staff demonstrated a good awareness of complaints management. A complaints questionnaire was forwarded by RQIA to the practice for completion.The returned questionnaire indicated that no complaints have been received for the period 1 April 2016 to 31 March 2017.

A system was in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies as appropriate. A system was also in place to ensure that urgent communications, safety alerts and notices are reviewed and where appropriate, made available to key staff in a timely manner.

Mr Kelly confirmed that arrangements were in place to monitor, audit and review the effectiveness and quality of care delivered to patients at appropriate intervals. If required an action plan is developed and embedded into practice to address any shortfalls identified during the audit process.

A whistleblowing/raising concerns policy was available. Discussion with staff confirmed that they were aware of who to contact if they had a concern.

Mr Kelly demonstrated a clear understanding of his role and responsibility in accordance with legislation. It was confirmed that the statement of purpose and patient's guide are kept under review, revised and updated when necessary and available on request.

The RQIA certificate of registration was up to date and displayed appropriately.

Observation of insurance documentation confirmed that current insurance policies were in place.

Patient and staff views

All of the patients who submitted questionnaire responses indicated that they felt that the service is well led and indicated a high level of satisfaction with this aspect of the service.

No staff questionnaire responses were received.

Areas of good practice

There were examples of good practice found in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaininggood working relationships.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of theQIP were discussed with Mr Denis Kelly, registered person,as part of the inspection process. The timescales commence from the date of inspection.

The registered person/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standardsthis may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person to ensure that all areas for improvementidentified within the QIP are addressed within the specified timescales.

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

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and The Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011 and the Department of Health, Social Services and Public Safety (DHSSPS) Minimum Standards for Dental Care and Treatment (2011).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered providershould confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

<table>
<tr><th colspan="2">Quality Improvement Plan</th></tr>
<tr><td colspan="2">Action required to ensure compliance with The Minimum Standards for Dental Care and Treatment (2011)</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 15

Stated: First time

To be completed by:
01 May 2018</td><td>The registered person shall ensure all staff receive training in safeguarding children and adults at risk of harm as outlined in the Minimum Standards for Dental Care and Treatment 2011.

Ref: 6.4</td></tr>
<tr><td>Response by registered persondetailing the actions taken:
I have checked to ensure that all staff have recieved training in safeguarding of adults and children at rtisk of harm .of at least 2hrs inthe last 2 year period . I have made them aware of the updated safeguarding policies. I have checked with 352 Trainig Acadamey and can confirm that my own training with them was at level 2.</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 15

Stated: First time

To be completed by:
01 May 2018</td><td>The registered person shall ensure the adult safeguarding policy is updated to fully reflect the regional ‘Adult Safeguarding Prevention and Protection in Partnership policy’ (July 2015) and ‘Adult Safeguarding Operational Procedures’ (2016).

Ref: 6.4</td></tr>
<tr><td>Response by registered persondetailing the actions taken:
.The adult safeguarding policy has been fully updated to reflect the regional Adult safeguarding prevention and Protection in Partnership policy [July 2015] and Adult Safeguarding Operational procedures[2016]</td></tr>
</table>

Area for improvement 2 **Ref:** Standard 14 **Stated:** First time **To be completed by**: 01 May 2018	The registered person should locate the fire risk assessment and address any recommendations contained therein. Ref: 6.4
	Response by registered persondetailing the actions taken: I have checked and although we have an Annual Fire Safety inspection and maintainance of equipment, we do not have a Formal Fire risk Assessment . This has now been arranged with Fire Plus. Once it has been completed it will be fully implemented.
Area for improvement 3 **Ref**: Standard 14 **Stated:** First time **To be completed by:** 01 May 2018	The registered person shall ensure that a written security policy to reduce the risk of prescription theft and misuse is developed and shared with staff. Ref: 6.4
	Response by registered persondetailing the actions taken: Awritten security policy to reduce the risk of prescription theft and abuse has been developed and shared with staff.
Area for improvement4 **Ref**: Standard 9 **Stated:** First time **To be completed by:** 01 May 2018	The registered person shall ensure that apatient satisfaction survey to include the quality of treatment and other services provided are undertaken on at least an annual basis. A summary report should be collated and made available to patients. Ref: 6.6
	Response by registered persondetailing the actions taken: Apatient satisfaction survey to include the quality of treatment and other services provided has been done and will be repeated annually.A summary report has been collated and displayed on the noticeboard where it can be seen by patients.

Please ensure this document is completed in full and returned via Web Portal

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