Announced Care Inspection Report
10 January 2018

Gary McCleary & Co Ltd Dental Practice

Type of Service: Independent Hospital (IH) – Dental Treatment
Address: 21 Church Place, Lurgan
Tel No: 028 3832 5979
Inspector: Elizabeth Colgan

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 service from 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 practice with four registered places.

3.0 Service details

Organisation/Registered Provider: Gary McCleary and Co Limited **Responsible Individual** Mr. Gary McCleary	**Registered Manager:** Ms. Veronica McCann
Person in charge at the time of inspection: Ms. Veronica McCann	**Date manager registered:** 06 March 2012
Categories of care: Independent Hospital (IH) – Dental Treatment	**Number of registered places:** 4

4.0 Inspection summary

An announced inspection took place on 10 January 2018 from 10.15 to 12.45.

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 care inspection 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 training and development, safeguarding, the management of medical emergencies, radiology and the environment. Other examples included health promotion, engagement to enhance the patients' experience and governance arrangements.

One area for improvement has been identified against the regulations to ensure that information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 has been sought and retained.

An area for improvement has been stated for the second time in relation to undertaking six monthly audits to monitor compliance with HTM 01-05 using the Infection Prevention Society (IPS) audit tool. Two areas for improvement have also been identified against the standards in relation to undertaking yearly staff appraisals and completing an annual patient consultation process with a summative report provided for all interested parties.

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

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.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	1	3

Details of the Quality Improvement Plan (QIP) were discussed with Ms Veronica McCann, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent care inspection dated 7 February 2017

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 7 February 2017.

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 and staff prior to the inspection by the practice on behalf of RQIA. Returned completed patient and staff questionnaires were also analysed prior to the inspection.

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

During the inspection the inspector met with the registered manager, two dentists, and one dental nurse. 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 the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 7 February 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 07 February 2017

Quality Improvement Plan		
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005		**Validation of compliance**
Requirement 1 **Ref**: Regulation 17 (1) **Stated:** First time	The annual justification and clinical evaluation audit should be completed.	
	Review of documentation confirmed that an annual justification and clinical evaluation audit had been completed.	**Met**

Action required to ensure compliance with The Minimum Standards for Dental Care and Treatment (2011)		
Recommendation 1 **Ref**: Standard 13 **Stated:** First time	The six monthly Infection Prevention Society audit should be completed.	
	Review of documentation confirmed that the Infection Prevention Society audit had been completed yearly and not every six months This area for improvement has been stated for the second time.	**Partially met**

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

Four 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 two staff files evidenced that induction programmes had been completed when new staff joined the practice.

Procedures were in place for appraising staff performance; however staff appraisals had not been undertaken in the past year. This was an area identified for improvement against the standards. 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 Ms. McCann confirmed that two staff have been recruited since the previous inspection. A review of the personnel files for these staff demonstrated that not all the relevant information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 has been sought and retained. The following information was not available in both files, two written references, one of which should be from the current/most recent employer and employment history. In one file evidence of a contract of employment was not available. This was an area identified for improvement against the regulations.

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.

Review of records demonstrated that all staff had received training in safeguarding children and adults as outlined in the Minimum Standards for Dental Care and Treatment 2011. A safeguarding lead has been identified and confirmation of a date to complete formal training on 24 January 2018 in safeguarding adults in keeping with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016) was forwarded to RQIA by electronic mail on 19 January 2018.

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.

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), and that 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. Training records were available for inspection.

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, a DAC Universal and a 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 was confirmed that the practice audits compliance with HTM 01-05 using the IPS audit tool yearly. This audit should be completed on a six monthly basis. This was an area identified for improvement against the standards at the previous care inspection which has been stated for the second time.

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

Radiography

The practice has four surgeries, each of which has an intra-oral x-ray machine and an orthopan tomogram machine (OPG), which is located in a separate room.

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, and x-ray audits.

A copy of the local rules was on display near each x-ray machine and 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 demonstrated that the recommendations made have been addressed.

The x-ray equipment has been serviced and maintained 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.

Ms McCann confirmed that arrangements are in place for maintaining the environment.

A legionella risk assessment was last undertaken in 2016 and is reviewed annually. Water temperatures are monitored and recorded as recommended.

A fire risk assessment had been undertaken and staff confirmed fire training and fire drills had been completed. Staff demonstrated that they were aware of the action to take in the event of a fire. A written scheme of examination of pressure vessels has been undertaken.

It was confirmed that robust arrangements are in place for the management of prescription pads/forms and that written security policies are in place to reduce the risk of prescription theft and misuse.

Patient and staff views

Twenty patients submitted questionnaire responses to RQIA. All indicated that they felt safe and protected from harm. All patients indicated they were very satisfied with this aspect of care. One comment was included in submitted questionnaire responses.

- "Excellent dental practice with great staff."

Seven staff submitted questionnaire responses. All indicated that they felt that patients are safe and protected from harm. Five staff indicated they were very satisfied with this aspect of care and two indicated they were satisfied. Staff spoken with during the inspection concurred with this. One comment was included in submitted questionnaire responses.

- "No appraisals in over three years."

Areas of good practice

There were examples of good practice found in relation to induction, training, safeguarding, management of medical emergencies, decontamination procedures, radiology and the environment.

Areas for improvement

The IPS audit should be completed six monthly in accordance with HTM 01-05.

All information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 should be sought and retained for any new staff member.

An annual appraisal should be undertaken for all staff members with a record maintained.

	Regulations	Standards
Total number of areas for improvement	1	2

6.5 Is care effective?

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

Clinical records

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

Ms McCann confirmed that routine dental examinations include a review of medical history, a check for gum disease and oral cancers and that 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. A range of health promotion information leaflets were available in the reception area and the practice has a health promotion outreach programme which they deliver in schools and community centres. Ms McCann confirmed that oral health is actively promoted on an individual level with patients during their consultations.

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

As stated in the report, IPS HTM 01-05 compliance should be undertaken every six months and patient consultation surveys completed every year.

Communication

Ms McCann 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 regular 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 and formal 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 20 patients who submitted questionnaire responses indicated that they get the right care, at the right time and with the best outcome for them. Nineteen patients indicated that they were very satisfied with this aspect of care and one indicated they were satisfied. No comments were included in submitted questionnaire responses.

Seven submitted staff questionnaire responses indicated that they felt that patients get the right care, at the right time and with the best outcome for them. Five staff indicated they were very satisfied with this aspect of care and two indicated they were satisfied. Staff spoken with during the inspection concurred with this. No comments were included in submitted questionnaire responses.

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 converse with patients and conduct telephone enquiries in a professional and confidential manner.

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. Staff demonstrated how consent would be obtained.

The practice has not undertaken a patient satisfaction survey since September 2016; this should be completed on an annual basis. This was an area identified for improvement against the standards.

Review of the most recent patient satisfaction report in September 2016 demonstrated that the practice pro-actively seeks the views of patients about the quality of treatment and other services provided. Patient feedback whether constructive or critical, is used by the practice to improve, as appropriate.

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 the 20 patients who submitted questionnaire responses indicated that they are treated with dignity and respect and are involved in decision making affecting their care. All patients indicated they were very satisfied with this aspect of care. No comments were included in submitted questionnaire responses.

Seven submitted staff questionnaire responses indicated that they felt that patients are treated with dignity and respect and are involved in decision making affecting their care. Five staff indicated they were very satisfied with this aspect of care and two indicated they were satisfied. Staff spoken with during the inspection concurred with this. One comment was included in submitted questionnaire responses.

- "There are no suggestion boxes for patients in our practice, which could be rectified,"

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

An annual patient consultation process should be completed and a summative report made available for all interested parties.

	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.

Ms McCann 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 a yearly 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.

Ms McCann 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. As stated previously, IPS HTM 01-05 compliance should be undertaken every six months and patient surveys every year.

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

Ms McCann demonstrated a clear understanding of her role and responsibility in accordance with legislation. Information requested by RQIA has been submitted within specified timeframes. 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 20 patients who submitted questionnaire responses indicated that they felt that the service is well led. All patients indicated they were very satisfied with this aspect of the service. No comments were included in submitted questionnaire responses.

Six submitted staff questionnaire responses indicated that they felt that the service is well led, one indicated that they didn't think the service was well led. Five staff indicated they were very satisfied with this aspect of the service and one indicated they were satisfied and one indicated that were unsatisfied. Staff spoken with during the inspection concurred that they felt the service was well led. Comments provided included the following:

- "Extremely well led."
- "Very well."
- "No clear admin and clinical lead. Issues are raised but no action taken. Few audits are carried out-no learning outcomes identified- procedures not updated.

Areas of good practice

There were examples of good practice found in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good 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 the QIP were discussed with Ms McCann, registered manager, 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 standards this 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 improvement identified 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 provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan	
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 19 Schedule (2) as amended **Stated:** First time **To be completed by:** 8 February 2018	The registered person shall ensure that staff personnel files for newly recruited staff includes all relevant documentation as specified in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005. Ref: 6.4
	Response by registered person detailing the actions taken: all relevant documentation has been added to file
Action required to ensure compliance with The Minimum Standards for Dental Care and Treatment (2011)	
Area for improvement 1 **Ref**: Standard 13 **Stated:** Second time **To be completed by:** 8 February 2018	The registered person shall ensure that six monthly audits to monitor compliance with HTM 01-05 using the Infection Prevention Society (IPS) audit tool are undertaken. Ref. 6.4
	Response by registered person detailing the actions taken: IPS completed on 30/01/2018 and protocol set for 6 monthly audits
Area for improvement 2 **Ref**: Standard 11 **Stated:** First time **To be completed by:** 8 February 2018	The registered person shall ensure that, staff appraisals are undertaken on a yearly basis. Ref: 6.4
	Response by registered person detailing the actions taken: protocol is now in place for yearly audits

Area for improvement 3 **Ref**: Standard 9 **Stated:** First time	The registered person shall ensure that a patient satisfaction survey is undertaken yearly and a summative report made available of all interested parties. Ref: 6.4
To be completed by: 8 February 2018	**Response by registered person detailing the actions taken:** A survey has now been completed

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

The Regulation and Quality Improvement Authority

9th Floor

Riverside Tower
5 Lanyon Place
BELFAST

BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews