Announced Care Inspection Report
22 June 2016

18 Dental

Service type: Dental Practice
Address: **18 Lodge Road, Coleraine, BT52 1NB**
Tel No: 028 7032 7057
Inspector: Philip Colgan

1.0 Summary

An announced inspection of 18 Dental took place on 22 June 2016 from 08:45 to 11:00.

The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the service was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

Observations made, review of documentation and discussion with Ms Laura Neill, practice manager and staff, demonstrated that systems and processes were in place to ensure that care provided in the establishment was safe. Areas reviewed included staffing, recruitment and selection, safeguarding, management of medical emergencies, infection prevention control and decontamination, radiology and the general environment. One recommendation in relation to emergency medicines has been made.

Is care effective?

Observations made, review of documentation and discussion with Ms Neill and staff demonstrated that systems and processes were in place to ensure that care provided in the establishment was effective. Areas reviewed included clinical records, health promotion, audits and communication. No requirements or recommendations have been made.

Is care compassionate?

Observations made, review of documentation and discussion with Ms Neill and staff demonstrated that arrangements were in place to promote patients' dignity, respect and involvement in decision making. No requirements or recommendations have been made.

Is the service well led?

Information gathered during the inspection evidenced that there was effective leadership and governance arrangements in place which creates a culture focused on the needs of patients in order to deliver safe, effective and compassionate care. Areas reviewed included organisational and staff working arrangements, the arrangements for policy and risk assessment reviews, the arrangements for dealing with complaints, incidents and alerts, insurance arrangements and the registered person's understanding of their role and responsibility in accordance with legislation. No requirements or recommendations have been made.

This inspection was underpinned by 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).

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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	1

Details of the QIP within this report were discussed with Ms Laura Neill, practice 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.

1.2 Actions/enforcement taken following the most recent care inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last inspection.

2.0 Service details

Registered organisation/registered person: Ms Ursula Mulholland	**Registered manager:** Ms Ursula Mulholland
Person in charge of the service at the time of inspection: Ms Laura Neill	**Date manager registered:** 5 February 2012
Categories of care: Independent Hospital (IH) – Dental Treatment	**Number of registered places:** 4

3.0 Methods/processes

Questionnaires were provided to patients and staff prior to the inspection by the practice on behalf of the RQIA. Prior to inspection we analysed the following records: staffing information, complaints declaration and returned completed staff and patient questionnaires.

During the inspection the inspector met with Ms Laura Neill, Practice Manager, and two dental nurses. A tour of the premises was also undertaken.

Records were examined during the inspection in relation to the following areas:

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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 24 July 2015

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

4.2 Review of requirements and recommendations from the last care inspection dated 24 July 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref: Regulation 25 (2) (b)** **Stated: First time**	The registered person must address the ventilation in the decontamination room to ensure the provision of make-up air in the interest of health and safety for staff. Extract ventilation should be provided at the 'dirty' side of the decontamination room and make up air at the 'clean' side.	**Met**
	Action taken as confirmed during the inspection: Observation during the inspection evidenced that this requirement has been met.	

Last care inspection statutory requirements		Validation of compliance
Requirement 2 **Ref: Regulation 19 (2) Schedule 2** **Stated: First time**	The registered person must address the following issues in relation to Access NI checks: • enhanced Access NI checks must be undertaken and received prior to any new staff commencing work in the practice; and • enhanced Access NI disclosure certificates must be handled in keeping with the Access NI code of practice	**Met**
	Action taken as confirmed during the inspection: Discussion with Ms Neill and a review of documentation in respect of one staff member recruited since the previous inspection evidenced that this requirement has been met.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 13 **Stated: Second time** **To be Completed by:** **7 August 2015**	The daily automatic control test (ACT) specifics of the sterilisation temperature and hold time and the pressure reading should be recorded in the steriliser logbooks.	**Met**
	Action taken as confirmed during the inspection: Discussion with staff and a review of decontamination records evidenced that this recommendation has been met.	
Recommendation 2 **Ref**: Standard 12.4 **Stated: First time**	It is recommended that the system for checking emergency equipment is further developed to include all emergency equipment in the practice.	**Met**
	Action taken as confirmed during the inspection: Discussion with Ms Neill and staff and a review of documentation evidenced that this requirement has been met.	

Recommendation 3 **Ref**: Standard 11.1 **Stated: First time**	It is recommended that staff personnel files for newly recruited staff should include a criminal conviction declaration and two written references as indicated in regulation 19 (2) Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005.	**Met**
	Action taken as confirmed during the inspection: Discussion with Ms Neill and a review of the personnel file for one newly recruited staff member evidenced that this requirement has been met	

4.3 Is care safe?

Staffing

Four dental surgeries are in operation in this practice. Discussion with staff and review of completed staff and patient 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. Review of the personnel files for recently employed staff members 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 is a system in place to ensure that all staff receives 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 Neill confirmed that one staff member has been recruited since the previous inspection. A review of the personnel file for this staff member demonstrated that all the relevant information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 has been sought and retained.

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

Safeguarding

Staff spoken with 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. This training is provided annually. The frequency of this training exceeds best practice.

Policies and procedures were in place for the safeguarding and protection of adults and children. The policy 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.

Management of medical emergencies

A review of medical emergency arrangements evidenced that emergency medicines were provided in keeping with the British National Formulary (BNF) with the exception of the retention of Epistatus for the treatment of Status Epilepticus, contrary to the guidance given by the Health and Social Service Board (HSCB). A recommendation was made that when the Epistatus medication has reached its expiry date it should be replaced with Buccolam as advised by the HSCB.

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 uniform and hand hygiene policies.

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 who had responsibility for infection control and decontamination in the practice.

A decontamination room separate from patient treatment areas and dedicated to the decontamination process was available. Appropriate equipment, including washer disinfectors and steam sterilisers 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 continues to audit compliance with HTM 01-05 using the Infection Prevention Society (IPS) audit tool. The most recent IPS audit was completed within the last six months.

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. In addition the practice has an orthopan tomogram machine (OPG) and CT scanner, which is located in a separate room.

The practice had a dedicated radiation protection file containing the relevant local rules, employer's procedures and other additional information. Records retained in the radiation protection 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. Review of the radiation protection file and discussion with staff 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 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.

A review of the radiation protection file evidenced that 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 no recommendations were made.
A review of documentation demonstrated that the x-ray equipment has been serviced and maintained in accordance with manufacturer's instructions.

It was demonstrated during the inspection that 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 high 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 were in place for maintaining the environment. The documents reviewed included: servicing of boiler, fire detection systems, fire-fighting equipment, fixed electrical wiring installation and a legionella risk assessment.

The legionella risk assessment had been undertaken and water temperatures are monitored and recorded as recommended.

A fire risk assessment had been undertaken and staff confirmed that 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 was also examined.

Patient and staff views

Thirteen patients submitted questionnaire responses to RQIA. All indicated that they felt safe and protected from harm.

Seven staff submitted questionnaire responses. All indicated that they felt that patients are safe and protected from harm. Staff spoken with during the inspection concurred with this.

Areas for improvement

When the Epistatus medication has reached its expiry date it should be replaced with Buccolam, as advised by the HSCB.

Number of requirements:	0	Number of recommendations:	1

4.4 Is care effective?

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

Ms Neill 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. Staff 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.

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

Health promotion

The practice has a strategy for the promotion of oral health and hygiene and it was confirmed that oral health is actively promoted on an individual level with patients during their consultations. There are two dental hygienists working in the practice. The practice actively promotes oral health by undertaking school visits, the annual children's day and the tooth brush amnesty scheme run by the practice. A range of health promotion information leaflets were available in the waiting area.

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 compliance
- records
- review of complaints/accidents/incidents
- the annual review of policies and procedures
- clinical waste disposal.

The range and frequency of audits carried out exceeds best practice.

Communication

Ms Neill 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 both 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 13 patients who submitted questionnaire responses indicated that they get the right care, at the right time and with the best outcome for them.

All 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. Staff spoken with during the inspection concurred with this.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements:	0	Number of recommendations:	0

4.5 Is care compassionate?

Dignity, respect and involvement in decision making

Staff spoken with 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.

Staff were clear about the importance of emotional support needed when delivering care to patients who were very nervous or fearful of dental treatment and the practice provides sedation for those patients who require additional care.

Clinical staff confirmed that treatment options, risks and benefits were discussed with each patient to ensure they understood what treatment was available in order that they could make an informed choice. Discussion with staff demonstrated how consent would be obtained.

The practice undertakes patient satisfaction surveys on an annual basis. Review of the most recent patient satisfaction report 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 13 patients who submitted questionnaire responses indicated that they are treated with dignity and respect and are involved in decision making affecting their care.

All 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. Staff spoken with during the inspection concurred with this.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements:	0	Number of recommendations:	0

4.6 Is the service well led?

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 Neill is the nominated person 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 three 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 displayed and 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 2015 to 31 March 2016.

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 Neill 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.

Information requested by RQIA has been submitted within specified timeframes. 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 13 patients who submitted questionnaire responses indicated that they felt that the service is well managed.

All submitted staff questionnaire responses indicated that they felt that the service is well led. Staff spoken with during the inspection concurred with this.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements:	**0**	**Number of recommendations:**	**0**

5.0 Quality improvement plan

The issue identified during this inspection is detailed in the QIP. Details of this QIP were discussed with Ms Laura Neill, Practice Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered person should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person to ensure that all requirements and recommendations contained 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 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person meets legislative requirements based on The Independent Health Care Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and the DHSSPS Minimum Standards for Dental Care and Treatment (2011). They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed by the registered manager. Once fully completed, the QIP will be returned to Independent.Healthcare@rqia.org.uk and assessed by the inspector.

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 registered person/manager from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered person/manager with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 12.4 **Stated:** First time **To be completed by:** 22 July 2016	The Epistatus medication should be replaced with Buccolam, as advised by the HSCB, when it has reached its expiry date.
	Response by registered person detailing the actions taken: The prinicipal dentist and Senior dental nurse has been informed of this recommendation. As suggested the existing Epistatus medication will be replaced with Buccolam when it reaches its expiry date.

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