# Announced Care Inspection Report
# 18 July 2016

# Quigley & Martin

**Type of Service: Independent Hospital (IH) – Dental Treatment**
**Address: 73 - 75 Broughshane Street, Ballymena, BT43 6ED**
**Tel No: 028 2565 3800**
**Inspector: Stephen O'Connor**

## 1.0 Summary

An announced inspection of Quigley & Martin took place on 18 July 2016 from 09:55 to 12:05.

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 Mr David Martin, registered person and Mrs Anne Barkley, registered manager and staff demonstrated that in the main systems and processes were in place to ensure that care to patients was safe and avoids and prevents harm. Areas reviewed included staffing, recruitment and selection, safeguarding, management of medical emergencies, infection prevention control and decontamination, radiology and the general environment. Recommendations have been made in regards to the ventilation system in the decontamination room and undertaking a fire risk assessment.

**Is care effective?**

Observations made, review of documentation and discussion with Mr Martin, Mrs Barkley 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 Mr Martin, Mrs Barkley and staff demonstrated that arrangements are 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 in the main 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 provider'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 | 2 |

Details of the Quality Improvement Plan (QIP) within were discussed with Mr David Martin, registered person and Mrs Anne Barkley, 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.

## 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 provider:**<br>Mr David Martin | **Registered manager:**<br>Mrs Anne Barkley |
| **Person in charge of the service at the time of inspection:**<br>Mr David Martin | **Date manager registered:**<br>15 March 2012 |
| **Categories of care:**<br>Independent Hospital (IH) – Dental Treatment | **Number of registered places:**<br>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 patient and staff questionnaires.

During the inspection the inspector met with Mr David Martin, registered person, Mrs Anne Barkley, registered manager, an associate dentist and a dental nurse. A tour of some areas 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 23 April 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 23 April 2015

| Last care inspection recommendations | | Validation of compliance |
|---|---|---|
| **Recommendation 1**<br><br>**Ref: Standard 12.1**<br><br>**Stated: First time** | It is recommended that protocols outlining the local procedure for dealing with the various medical emergencies as specified in the BNF should be established. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Review of documentation demonstrated that protocols outlining the local procedures for dealing with the various medical emergencies are available for staff reference. It was also observed that information in regards to the management of medical emergencies and emergency medicines was displayed in the surgeries. | |

| | | |
|---|---|---|
| **Recommendation 2**<br><br>**Ref: Standard 11.1**<br><br>**Stated: First time** | It is recommended that recruitment and selection procedures should be further developed to ensure the following are obtained and details retained in staff personnel files on recruitment of new staff:<br><br>• evidence that an enhanced AccessNI check is undertaken and received prior to commencing work in the practice;<br>• two written references, one of which should be from the current/most recent employer; and criminal conviction declarations on application | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Mrs Barkley amended the recruitment policy during the inspection to include the information as outlined within this recommendation. | |
| **Recommendation 3**<br><br>**Ref**: **Standard 11.1**<br><br>**Stated: First time** | It is recommended that a staff register should be developed and retained containing details of all staff including, name, date of birth, position; dates of employment; and details of professional qualification and professional registration with the GDC, where applicable. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>A staff register has been developed. Review of the staff register demonstrated that it includes all information as outlined within this recommendation. | |

## 4.3 Is care safe?

**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 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. It was confirmed that the practice pays for clinical staff to attend core continuing professional development (CPD) days facilitated by the Northern Ireland Medical and Dental Training Agency (NIMDTA).

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 Martin and Mrs Barkley confirmed that two staff have been recruited since the previous inspection. A review of the personnel files for these staff 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 during June 2016.

It was confirmed that separate policies and procedures were in place for the safeguarding and protection of adults and children. 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.

A copy of the new regional guidance issued in July 2015 entitled 'Adult Safeguarding Prevention and Protection in Partnership' was available in the practice for staff reference and it was confirmed that the policy had been updated in keeping with the newly published guidance document.

**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.

As discussed previously 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 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. It was observed that the ventilation system in the decontamination room was not in keeping with best practice guidance as outlined in HTM 01-05 as make-up ventilation was not in place. This had been identified during the inspection undertaken on 16 July 2013 and Mr Martin was advised at that time to discuss the ventilation system with Health Estates at the Department of Health (DOH). A recommendation has been made in regards to the ventilation system. Mr Martin was advised that advice and guidance in this regard should be sought from a representative in the Sustainable Development Engineering Branch (SDEB) at the DOH. Following the inspection the contact information for SDEB was shared with Mr Martin.

Appropriate equipment, including a washer disinfector and two 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 during June 2016.

It was confirmed that 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.

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. The most recent RPA reports available in the radiation protection file were dated 11 July 2013. Mr Martin confirmed that the appointed RPA had completed the quality assurance check of the x-ray machines on 14 July 2016 and that the practice was awaiting the reports. Mr Martin confirmed that any recommendations within the RPA report will be addressed and records retained.

The x-ray equipment has been serviced and maintained in accordance with manufacturer's instructions during February 2016.

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 to include the annual servicing of oil central heating burner, inspection of the gas tank and pipelines and servicing of the firefighting equipment. It was confirmed that portable appliance testing (PAT) in respect of electrical appliances is completed every two years and fixed wiring installations are inspected every five years.

A legionella risk assessment was undertaken by an external organisation during July 2015 and remedial works completed to address recommendations made within the risk assessment. Water temperatures are monitored and recorded as recommended. Dipslides in respect of Dental Unit Water Lines (DUWLs) are undertaken quarterly, this exceeds best practice guidance.

Staff demonstrated that they were aware of the action to take in the event of a fire. As discussed previously firefighting equipment is serviced annually and routine checks are undertaken in respect of the emergency break glass points and emergency lighting. Review of a generic risk assessment which is completed annually evidenced that it included a section on fire risk. However, an overarching fire risk assessment for the premises could not be located. This was discussed with Mr Martin and Mrs Barkley and a recommendation has been made to address this.

Review of documentation evidenced that the pressure vessels in the practice had been inspected in keeping with the written scheme of examination of pressure vessels during August 2015.

**Patient and staff views**

Ten patients submitted questionnaire responses to RQIA. All indicated that they felt safe and protected from harm. No comments were included under this domain.

Eleven staff submitted questionnaire responses. All indicated that they felt that patients are safe and protected from harm. The following comment was included:

- "Patients are always protected from harm and kept safe"

**Areas for improvement**

A ventilation system in keeping with HTM 01-05 should be installed in the decontamination room.

A fire risk assessment must be undertaken by a competent person and an action plan developed to address any issues identified. The fire risk assessment should be retained in the practice for inspection by relevant bodies.

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|---|---|---|---|
| **Number of requirements** | **0** | | **2** |

## 4.4 Is care effective?

**Clinical records**

Staff spoken with 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 and it was confirmed that treatment plans are developed in consultation with patients. It was also 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 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. It was confirmed that oral health is actively promoted on an individual basis with patients during their consultations. A hygienist is available in the practice and patients are referred to the hygienist were appropriate. A range of resources were available within the practice when promoting oral health to include information leaflets and disclosing tablets. A range of oral health products were available for purchase in the practice and samples of oral health products are freely distributed to patients.

**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

**Communication**

Mr Martin and Mrs Barkley 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 every four to six weeks 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.

**Patient and staff views**

All 10 patients who submitted questionnaire responses indicated that they get the right care, at the right time and with the best outcome for them. No comments were provided under this domain.

All 11 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. The following comment was included:

- "The right care is always provided to patients"

**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.

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 ensures patients understood what treatment is available to them and can make an informed choice. 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 dated November 2015 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.

**Patient and staff views**

All 10 patients who submitted questionnaire responses indicated that they are treated with dignity and respect and are involved in decision making affecting their care. No comments were provided under this domain.

All 11 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. The following comment was included under this domain:

- "This is well maintained throughout the practice at all times"

**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. Mr Martin, registered person has 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 displayed 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.

Mr Martin and Mrs Berkley 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 Martin and Mrs Berkley demonstrated a clear understanding of their role and responsibilities 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 10 patients who submitted questionnaire responses indicated that they felt that the service is well managed. The following comment was included:

- "This is a very well managed practice. Never had any problems"

All 11 submitted staff questionnaire responses indicated that they felt that the service is well led. The following comment was included under this domain:

- "Within this practice I feel all the above points are met"

**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

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mr David Martin, registered person and Mrs Anne Barkley, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager 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 provider 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 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.

## 5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider 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 DHSSPS Minimum Standards for Dental Care and Treatment (2011). They promote current good practice and if adopted by the registered provider may enhance service, quality and delivery.

## 5.3 Actions taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return completed QIP to independent.healthcare.@rqia.org.uk for review 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 provider 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 provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

| Quality Improvement Plan | |
|---|---|
| **Recommendations** | |
| **Recommendation 1**<br><br>**Ref**: Standard 13<br><br>**Stated:** First time<br><br>**To be completed by:**<br>19 October 2016 | A ventilation system in keeping with best practice guidance as outlined in the 2013 edition of HTM 01-05 to include extract ventilation on the 'dirty side' and make-up ventilation on the 'clean side' should be installed in the decontamination room. |
| | **Response by registered provider detailing the actions taken:**<br>Assessment of ventilation system carried out and installation of make-up and extract ventilation will be completed by 19/10/2016 |
| **Recommendation 2**<br><br>**Ref**: Standard 14.2<br><br>**Stated:** First time<br><br>**To be completed by:**<br>19 August 2016 | A fire risk assessment must be undertaken by a competent person and an action plan developed to address any issues identified. The fire risk assessment should be retained in the practice for inspection by relevant bodies. |
| | **Response by registered provider detailing the actions taken:**<br>Fire risk assessment completed by 19/8/2016 |


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