Announced Care Inspection Report
22 April 2016

The Maypole Dental Practice

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Tel No: 028 9039 7782
Inspector: Norma Munn

1.0 Summary

An announced inspection of The Maypole Dental Practice took place on 22 April 2016 from 09:50 to 13:50.

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 Crawford, registered manager, demonstrated that some improvement is needed to ensure that care provided in the establishment is safe. Areas reviewed included staffing, recruitment and selection, safeguarding, management of medical emergencies, infection prevention control and decontamination, radiology and the general environment. A recommendation made during the previous inspection regarding the review of the legionella risk assessment had not been addressed and has been stated for a second time. Three recommendations have been made in relation to maintaining the staff register, the provision of emergency equipment and updating the safeguarding policy.

Is care effective?

Observations made, review of documentation and discussion with Ms Crawford 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 Crawford 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 person's understanding of their role and responsibility in accordance with legislation. As previously discussed, a recommendation made during the previous inspection in relation to the legionella risk assessment had not been addressed. Subsequently, a recommendation has been made that the registered person ensures that any requirements and/or recommendations made in a Quality Improvement Plan (QIP) are addressed within the stated time frame.

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 (DHSPPS) 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	5

Details of the QIP within this report were discussed with Ms Linzi Crawford, registered manager and Ms Jemaimah Morgan, clinical compliance auditor for the Oasis Group, as part of the inspection process. The findings of the inspection can be found in the main body of the report. 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

There were no further actions required to be taken following the most recent inspection.

2.0 Service details

Registered organisation/registered person: Oasis Dental Care Mr Andrew Relf	**Registered manager:** Ms Linzi Crawford
Person in charge of the service at the time of inspection: Ms Linzi Crawford	**Date manager registered:** 26 November 2015
Categories of care: Independent Hospital (IH) – Dental Treatment	**Number of registered places:** 2

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 Linzi Crawford, registered manager, Ms Jemaimah Morgan, clinical compliance auditor for the Oasis Group 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 10 August 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 10 August 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 14.2 **Stated:** First time	It is recommended that the legionella risk assessment is reviewed. A record should be retained to confirm that any recommendations made in the risk assessment have been addressed.	**Not Met**
	Action taken as confirmed during the inspection: A review of documentation confirmed that the legionella risk assessment had not been reviewed since 6 September 2011. A two year review date was specified on the risk assessment. Ms Crawford confirmed that the risk assessment had not been reviewed within the specified time frame. The risk assessment included recommendations to reduce the risk of legionella. Although Ms Crawford confirmed that the recommendations had been addressed documentation was not available to evidence this. This recommendation has not been addressed and has been stated for a second time.	
Recommendation 2 **Ref**: Standard 11.1 **Stated:** First time	It is recommended that the recruitment policy is further developed to include the procedure to be followed for undertaking enhanced AccessNI disclosure checks for newly recruited staff.	**Met**
	Action taken as confirmed during the inspection: A review of the recruitment policy and discussion with Ms Crawford confirmed that the policy had been developed to include the arrangements for enhanced AccessNI checks for newly recruited staff.	

Recommendation 3 **Ref**: Standard 11 **Stated:** First time	It is recommended that records of enhanced AccessNI checks should be retained in keeping with the AccessNI code of practice. The record should include the date the application was made, the date the certificate was received, the serial number on the certificate and the outcome of the review of the certificate.	**Met**
	Action taken as confirmed during the inspection: A review of the AccessNI log evidenced that disclosure numbers and dates the checks were received have been recorded. Discussion with Ms Crawford confirmed that the date the AccessNI check is undertaken and received and the outcome will be recorded for any new staff recruited in the future.	

4.3 Is care safe?

Staffing

Two dental surgeries are in operation in this practice. Discussion with Ms Crawford and staff and review of completed staff and patient questionnaires demonstrated that there are sufficient numbers of staff in various roles to fulfil the needs of the practice and patients. On the day of the inspection some staffing issues had arisen. Appropriate arrangements were being made to meet the needs of patients in an efficient and effective manner.

Induction programme templates were in place relevant to specific roles and responsibilities.

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. A system was 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 Crawford confirmed that one member of staff had been recruited since the previous inspection. The member of staff was no longer working in The Maypole Dental Practice and had been transferred to another practice within the Oasis group and the personnel records were no longer held within this practice. The details of this staff member had not been recorded in the staff register and the register had not been updated since the previous inspection. Ms Crawford agreed to update the staff register on the day of the inspection. Ms Crawford was reminded that the staff register is a live document and should be kept up to date. A recommendation has been made.

It was confirmed that should staff be recruited in the future robust systems and processes have been developed to ensure that all recruitment documentation as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 would be sought and retained for inspection.

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. A copy of the new regional guidance issued in July 2015 entitled "Adult Safeguarding Prevention and Protection in Partnership" was available for staff reference.

Policies and procedures were in place for the safeguarding and protection of adults and children. The safeguarding policy for adults was reviewed and identified the previous registered manager as the nominated lead, incorrect contact details for onward referral, was dated 2010, and had not been updated in line with current legislation. A recommendation has been made.

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.

Management of medical emergencies

A review of medical emergency arrangements evidenced that emergency medicines were provided in keeping with the British National Formulary (BNF). It was observed that the format of Buccal Midazolam retained was not the format recommended by the Health and Social Care Board (HSCB). Ms Crawford was advised that when the current format of Buccal Midazolam expires it should be replaced with Buccolam pre-filled syringes as recommended by the HSCB. Emergency equipment as recommended by the Resuscitation Council (UK) guidelines was retained. A self-inflating bag with reservoir had been provided suitable for use with a young adult. However, the Resuscitation Council (UK) guidelines recommend that two self-inflating bags with reservoirs are provided; one suitable for use with a child and one suitable for use with an adult. A recommendation has been made. 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. However, the different sections of the policy were not retained together and were difficult to locate. The benefits of having one overarching policy which is easily accessible to staff was discussed. Ms Crawford agreed to address this issue on the day of the inspection. 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. The plastic cover on one dental chair was ripped and was removed on the day of the inspection. Signage in clinical areas had not been laminated. Ms Crawford agreed to ensure that all signage displayed is laminated in keeping with best practice guidance. Staff were observed to be adhering to best practice in terms of uniform policy and were aware of good practice regarding hand hygiene.

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. 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 February 2016.

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

Radiography

The practice has two 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 is 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 machine. 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 any 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. However, the colour coded mops had not been stored in the correct colour coded buckets. Ms Crawford agreed to address this issue with the relevant staff.

Arrangements are in place for maintaining the environment. Documents reviewed included the fire risk assessment dated November 2015. As outlined previously, the legionella risk assessment had not been reviewed since 6 September 2011and there was no record to evidence that the recommendations made following the assessment had been addressed. This recommendation has been stated for a second time.

Patient and staff views

Eighteen patients submitted questionnaire responses to RQIA. Seventeen indicated that they felt safe and protected from harm and one patient did not comment.

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

Areas for improvement

The legionella risk assessment should be reviewed and a record should be retained to confirm that any recommendations made in the risk assessment have been addressed.

The staff register should be kept up to date.

The safeguarding policy for adults should be developed in line with current legislation.

A self-inflating bag with reservoir suitable for use with an adult and a self- inflating bag suitable for use with a child should also be provided.

Number of requirements:	0	Number of recommendations:	4

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.

Ms Crawford 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. Discussion with staff and observations made evidenced that appropriate systems and processes were in place for the management of records and maintaining patient confidentiality.

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. An extensive range of health promotion information leaflets were available in the reception area. These included information on types and costs of treatment, types of fillings, information on gum disease, oral health, cosmetic teeth alignment services, information on mouth cancer, smoking and a leaflet for children giving information on oral care, brushing tips and activities for children to make dental visits easier.

Audits

There were arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to patients at appropriate intervals. Ms Morgan and Ms Crawford discussed routine audits undertaken which included:

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

Communication

Ms Crawford confirmed that arrangements are in place for onward referral in respect of specialist treatments.

Staff meetings are held on a regular basis to discuss clinical and practice management issues. The most recent staff meeting was held in April 2016. 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 excellent working relationships and there is an open and transparent culture within the practice.

A breaking bad news policy in respect of dentistry was not in place. However, staff were able to demonstrate how breaking bad news to patients was managed.

Patient and staff views

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

The four submitted staff questionnaire responses indicated that they felt that patients get the right care, at the right time and with the best outcome from them. Staff spoken with during the inspection concurred with this. The following comment was provided:

- "Emergency patients are being offered appointments as soon as possible."

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

Treatment options including the risks and benefits were discussed with each patient. This ensured patients understood what treatment is available to them in order that they can make an informed choice. Discussion with staff demonstrated how consent would be obtained.

The practice undertakes patient satisfaction surveys on an annual basis. The most recent patient satisfaction report was not reviewed. However, discussion with Ms Morgan and Ms Crawford 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 patients who submitted questionnaire responses indicated that they felt that they are treated with dignity and respect and are involved in decision making affecting their care.

The four 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 excellent working relationships and that management were responsive to any suggestions or concerns raised. Ms Crawford is the nominated individual with overall responsibility for the day to day management of the practice.

Mr Relf, registered person monitors the quality of services and undertakes a visit to the premises at least every six months in accordance with legislation. A report of the most recent unannounced monitoring visit was available for inspection. As previously discussed the recommendation made in relation to the legionella risk assessment during the previous inspection had not been addressed. The registered person should ensure that any recommendations and/or requirements made in a QIP are addressed within the stated time frame. A recommendation has been made.

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. As previously discussed the policy for safeguarding adults should be to be reviewed in line with current legislation.

A copy of the complaints procedure was available in the practice. Staff spoken with 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 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.

Arrangements were in place to monitor, audit and review the effectiveness and quality of care delivered to patients at appropriate intervals and 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.

Ms Crawford demonstrated a clear understanding of her role and responsibility in accordance with legislation.

A review of the Statement of Purpose evidenced that it had not been updated to reflect that Ms Crawford was the new registered manager. Ms Crawford agreed to amend the Statement of Purpose to reflect the change and has agreed keep this document under review and revised when necessary. Confirmation was obtained via the telephone on 28 April 2016 that this had been addressed. Discussion with Ms Crawford confirmed that the Patient's Guide is 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

Seventeen out of 18 patients who submitted questionnaire responses indicated that they felt that the service is well managed and one did not comment.

The four submitted staff questionnaire responses indicated that they felt that the service is well led. Staff spoken with during the inspection concurred with this. The following comment was provided:

- "The staff are very approachable and ready to help."

Areas for improvement

The registered person should ensure that any requirements and/or recommendations made in a QIP are addressed within the stated time frame.

Number of requirements:	0	Number of recommendations:	1

5.0 Quality improvement plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Crawford, registered manager and Ms Morgan, clinical compliance auditor as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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/s meets legislative requirements based on 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.

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(s) 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 14.2 **Stated:** Second time **To be completed by:** 22 June 2016	It is recommended that the legionella risk assessment is reviewed. A record should be retained to confirm that any recommendations made in the risk assessment have been addressed. **Response by registered person detailing the actions taken:** We are undergoing a change in contractor within the company I have raised this a s a priority and we are top of the list for Northern Irealnd
Recommendation 2 **Ref**: Standard 11.1 **Stated:** First time **To be completed by:** 22 May 2016	The staff register should be kept up to date. **Response by registered person detailing the actions taken:** This has been updated on day of inspection and we will continue to keep it going as a dynamic document
Recommendation 3 **Ref**: Standard 15.3 **Stated:** First time **To be completed by:** 22 June 2016	The adult safeguarding policy should be further developed in keeping with current legislation and should include the following: • name of the nominated person for safeguarding • onward referral arrangements in the event of a concern being identified, including local contact numbers **Response by registered person detailing the actions taken:** Local contact numbers updated and Philip boles now named
Recommendation 4 **Ref**: Standard 12.4 **Stated:** First time **To be completed by:** 22 May 2016	Two self-inflating bags with reservoirs should be provided as recommended in the Resuscitation Council (UK) guidelines on minimum equipment list for cardiopulmonary resuscitation in primary dental care (November 2013). One self-inflating bag should be suitable for use with children and one suitable for use with an adult. **Response by registered person detailing the actions taken:** Both now available
Recommendation 5 **Ref**: Standard 8.5 **Stated:** First time **To be completed by:** 22 June 2016	The registered person should ensure that any requirements and/or recommendations made in a Quality Improvement Plan (QIP) are addressed within the stated time frame. **Response by registered person detailing the actions taken:** This time round they have been

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