

Inspection Report

8 February 2024



Rosconnor Clinic Derry

Type of service: Independent Hospital (IH) – Dental Treatment
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Assurance, Challenge and Improvement in Health and Social Care

Information on legislation and standards underpinning inspections can be found on our website <https://www.rqia.org.uk/>, [The Independent Health Care Regulations \(Northern Ireland\) 2005](#) and the [Minimum Standards for Dental Care and Treatment \(March 2011\)](#)

1.0 Service information

Organisation/Registered Provider: Portman Healthcare Limited	Registered Manager: Miss Sharon Sweeney
Responsible Individual: Mr Robert Davidson	Date registered: 25 November 2021
Person in charge at the time of inspection: Miss Sharon Sweeney	Number of registered places: Three
Categories of care: Independent Hospital (IH) – Dental Treatment	
Brief description of how the service operates: Rosconnor Clinic Derry is registered with the Regulation and Quality Improvement Authority (RQIA) as an independent hospital (IH) with a dental treatment category of care. The practice has three registered dental surgeries and provides general dental services, private and health service treatment and offers conscious sedation. Portman Healthcare Limited is the registered provider for 13 dental practices registered with RQIA. Mr Robert Davidson is the responsible individual for Portman Healthcare Limited.	

2.0 Inspection summary

This was an announced inspection, undertaken by a care inspector on 8 February 2024 from 10.00 am to 1.00 pm.

It focused on the themes for the 2023/24 inspection year and assessed progress with any areas for improvement identified during or since the last care inspection.

There was evidence of good practice in relation to the recruitment and selection of staff; staff training; management of medical emergencies; management of conscious sedation; infection prevention and control; decontamination of reusable dental instruments; adherence to best practice guidance in relation to COVID-19; radiology and radiation safety; management of complaints and incidents; and governance arrangements.

No immediate concerns were identified regarding the delivery of front line patient care.

3.0 How we inspect

RQIA is required to inspect registered services in accordance with legislation. To do this, we gather and review the information we hold about the service, examine a variety of relevant records, meet and talk with staff and management and observe practices on the day of the inspection.

The information obtained is then considered before a determination is made on whether the practice is operating in accordance with the relevant legislation and minimum standards.

Examples of good practice are acknowledged and any areas for improvement are discussed with the person in charge and detailed in the quality improvement plan (QIP).

4.0 What people told us about the care and treatment?

We issued posters to the registered provider prior to the inspection inviting patients and members of the dental team to complete an electronic questionnaire.

No completed staff or patient questionnaires were received prior to the inspection.

5.0 The inspection

5.1 What action has been taken to meet any areas for improvement identified at or since last inspection?

The last inspection to Rosconnor Clinic Derry was undertaken on 29 March 2022; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 Do recruitment and selection procedures comply with all relevant legislation?

There were recruitment and selection policies and procedures in place that adhered to legislation and best practice guidance.

Portman Healthcare Limited have a corporate human resources (HR) shared services department. The corporate HR department supports the registered manager during the recruitment process. The HR department are responsible for developing job descriptions, induction templates and employment contracts bespoke to roles and responsibilities; and issuing reference requests.

The registered manager is responsible for ensuring all recruitment records have been sought and uploaded to the electronic HR system. Discussion with Miss Sweeney confirmed that she had a clear understanding of the legislation and best practice guidance.

A review of the staff register evidenced that a number of new staff had been recruited since the previous inspection. A review of a sample of personnel files of newly recruited staff evidenced that relevant recruitment records had been sought; reviewed and stored as required.

There was evidence of job descriptions and induction checklists for the different staff roles. A review of records confirmed that if a professional qualification is a requirement of the post, a registration check is made with the appropriate professional regulatory body.

Discussion with members of the dental team confirmed they have been provided with a job description, contract of employment/agreement and received induction training when they commenced work in the practice.

The recruitment of the dental team complies with the legislation and best practice guidance to ensure suitably skilled and qualified staff work in the practice.

5.2.2 Is the dental team appropriately trained to fulfil the duties of their role?

The dental team takes part in ongoing training to update their knowledge and skills, relevant to their role.

Policies and procedures are in place that outline mandatory training to be undertaken, in line with any professional requirements, and the [training guidance](#) provided by RQIA.

A record is kept of all training (including induction) and professional development activities undertaken by staff, which is overseen by Miss Sweeney to ensure that the dental team is suitably skilled and qualified.

The care and treatment of patients is being provided by a dental team that is appropriately trained to carry out their duties.

5.2.3 Is the practice fully equipped and is the dental team trained to manage medical emergencies?

The British National Formulary (BNF) and the Resuscitation Council (UK) specify the emergency medicines and medical emergency equipment that must be available to safely and effectively manage a medical emergency. Systems were in place to ensure that emergency medicines and equipment are immediately available as specified and do not exceed their expiry dates.

There was a medical emergency policy and procedure in place and a review of this evidenced that it reflected legislation and best practice guidance. Protocols were available to guide the dental team on how to manage recognised medical emergencies.

Managing medical emergencies is included in the induction programme and refresher training is undertaken annually.

Members of the dental team were able to describe the actions they would take, in the event of a medical emergency, and were familiar with the location of medical emergency medicines and equipment.

Sufficient emergency medicines and equipment were in place and the dental team is trained to manage a medical emergency as specified in the legislation, professional standards and guidelines.

5.2.4 Does the dental team provide dental care and treatment using conscious sedation in line with the legislation and guidance?

Conscious sedation helps reduce anxiety, discomfort, and pain during certain procedures. This is accomplished with medications or medical gases to relax the patient.

Miss Sweeney confirmed that conscious sedation is offered if clinically indicated using intravenous (IV) sedation. IV sedation is only offered to patients over the age of 18.

There was a conscious sedation policy and procedure in place that was comprehensive and reflected the legislation and best practice guidance. Review of the environment and equipment evidenced that conscious sedation is being managed in keeping with the [Conscious Sedation in Dentistry, Dental Clinic Guidance, \(Third Edition\); Scottish Dental Clinical Effectiveness Programme \(SDCEP\)](#).

A review of records and discussion with the Miss Sweeney demonstrated that a full assessment of the patient to confirm the dental treatment required and the need for sedation is undertaken by the dentist providing the sedation.

Miss Sweeney confirmed that valid written consent is sought for the provision of dental care with sedation in accordance with the above best practice guidance.

It was demonstrated that clinical records of patients who had treatment using sedation includes a detailed record of the pre-sedation assessment, the patient's written consent, the patient's visit for sedation including monitoring, the treatment procedure and the recovery of each patient.

Information was available for patients in respect of the treatment provided and aftercare arrangements and a record is maintained to verify that post-treatment instructions were given and explained to the patient and their escort, as appropriate.

The dental team involved in the provision of conscious sedation must receive appropriate practical and clinical training. A review of training records evidenced that all relevant members of the dental team had completed 12 hours of sedation related verifiable continuing professional development (CPD) training in each five year CPD cycle.

A discussion took place regarding the life support training to be undertaken by all clinical team members involved in managing patients having sedation.

Immediate Life Support (ILS) training as laid down by the Resuscitation Council (UK) must be undertaken. A review of the content of the medical emergency refresher training undertaken on 11 December 2023 demonstrated that all the main elements of ILS training as outlined in Appendix 2 of [Conscious Sedation in Dentistry, Dental Clinic Guidance, \(Third Edition\); Scottish Dental Clinical Effectiveness Programme \(SDCEP\)](#) were included.

The medicines used during IV sedation are classified as controlled drugs (CDs). The arrangements for the management of the CDs were reviewed. It was demonstrated that CDs are securely stored at all times and systems were in place for the ordering, administration, reconciliation (stock check) and disposal of these medicines. It was identified that a standard operating procedure (SOP) for CDs was in place and had been signed by all relevant clinical staff.

There are arrangements in place to enable the dental team to safely provide dental care and treatment using conscious sedation, in keeping with legislation and guidance.

5.2.5 Does the dental team adhere to infection prevention and control (IPC) best practice guidance?

The IPC arrangements were reviewed throughout the practice to evidence that the risk of infection transmission to patients, visitors and staff was minimised.

There was an overarching IPC policy and associated procedures in place. Review of these documents demonstrated that they reflected legislation and best practice guidance. Miss Sweeney confirmed there was a nominated lead dental nurse who had responsibility for IPC and decontamination in the practice. The lead dental nurse had undertaken IPC and decontamination training in line with their continuing professional development and had retained the necessary training certificates as evidence.

During a tour of some areas of the practice, it was observed that clinical and decontamination areas were clean, tidy and uncluttered. All areas of the practice observed were equipped to meet the needs of patients.

The arrangements for personal protective equipment (PPE) were reviewed and it was noted that appropriate PPE was readily available for the dental team in accordance with the treatments provided.

Using the Infection Prevention Society (IPS) audit tool, IPC audits are routinely undertaken by members of the dental team to self-assess compliance with best practice guidance. The purpose of these audits is to assess compliance with key elements of IPC, relevant to dentistry, including the arrangements for environmental cleaning; the use of PPE; hand hygiene practice; and waste and sharps management. This audit also includes the decontamination of reusable dental instruments which is discussed further in the following section of this report. A review of these audits evidenced that they were completed on a six monthly basis and, where applicable, an action plan was generated to address any improvements required.

Hepatitis B vaccination is recommended for clinical members of the dental team as it protects them if exposed to this virus. A system was in place to ensure that relevant members of the dental team have received this vaccination. A review of a sample of staff personnel files

confirmed that vaccination history is checked during the recruitment process and vaccination records are retained in personnel files.

Discussion with members of the dental team confirmed that they had received IPC training relevant to their roles and responsibilities and they demonstrated good knowledge and understanding of these procedures. Review of training records evidenced that the dental team had completed relevant IPC training and had received regular updates.

Review of IPC arrangements evidenced that the dental team adheres to best practice guidance to minimise the risk of infection transmission to patients, visitors and staff.

5.2.6 Does the dental team meet current best practice guidance for the decontamination of reusable dental instruments?

Robust procedures and a dedicated decontamination room must be in place to minimise the risk of infection transmission to patients, visitors and staff in line with [Health Technical Memorandum 01-05: Decontamination in primary care dental practices, \(HTM 01-05\)](#), published by the Department of Health (DoH).

There was a range of policies and procedures in place for the decontamination of reusable dental instruments that were comprehensive and reflected legislation, minimum standards and best practice guidance.

There was a designated decontamination room separate from patient treatment areas and dedicated to the decontamination process. The design and layout of this room complied with best practice guidance and the equipment was sufficient to meet the requirements of the practice. Records evidencing that the equipment for cleaning and sterilising instruments was inspected, validated, maintained and used in line with the manufacturers' guidance were reviewed. Review of equipment logbooks demonstrated that all required tests to check the efficiency of the machines had been undertaken.

Discussion with members of the dental team confirmed that they had received training on the decontamination of reusable dental instruments in keeping with their role and responsibilities. They demonstrated good knowledge and understanding of the decontamination process and were able to describe the equipment treated as single use and the equipment suitable for decontamination.

Decontamination arrangements demonstrated that the dental team are adhering to current best practice guidance on the decontamination of dental instruments.

5.2.7 Are arrangements in place to minimise the risk of COVID-19 transmission?

There were COVID-19 policies and procedures in place which were in keeping with the Health and Social Care Public Health Agency guidance [Infection Prevention and Control Measures for Respiratory illnesses March 2023](#) and the [Infection Prevention and Control Manual for Northern Ireland](#).

The management of operations in response to the pandemic was discussed with members of the dental team. These discussions included the application of best practice guidance, and focused on, training of staff, and enhanced cross-infection control procedures. There is an identified COVID-19 lead staff member and arrangements are in place to ensure the dental team is regularly reviewing COVID-19 advisory information, guidance and alerts.

A review of the COVID-19 arrangements evidenced that procedures are in place to ensure the staff adhere to best practice guidance to minimise the risk of COVID-19 transmission.

5.2.8 How does the dental team ensure that appropriate radiographs (x-rays) are taken safely?

The arrangements regarding radiology and radiation safety were reviewed to ensure that appropriate safeguards were in place to protect patients, visitors and staff from the ionising radiation produced by taking an x-ray.

Dental practices are required to notify and register any equipment producing ionising radiation with the Health and Safety Executive Northern Ireland (HSENI). A review of records evidenced the practice had registered with the HSENI.

The practice has three surgeries each of which has an intra-oral x-ray machine and the equipment inventory reflected this. In addition, there is a cone beam computed tomography (CBCT) machine, which is located in a separate room.

A radiation protection advisor (RPA), medical physics expert (MPE) and radiation protection supervisor (RPS) have been appointed in line with legislation.

Two dedicated radiation protection files containing the relevant local rules, employer's procedures and other additional information were retained. One file included information concerning the intra-oral x-ray machines and the second file included information concerning the CBCT machine.

A review of the files confirmed that the Employer had entitled the dental team to undertake specific roles and responsibilities associated with radiology and ensured that these staff had completed appropriate training. The RPS oversees radiation safety within the practice and regularly reviews the radiation protection files to ensure that it is or they are accurate and up to date.

The appointed RPA must undertake a critical examination and acceptance test of all new x-ray equipment; thereafter the RPA must complete a quality assurance test every three years as specified within the legislation.

A new intra-oral machine had been installed in surgery one and it was evidenced that a critical examination and acceptance test for the new intra-oral x-ray machine was undertaken on 21 July 2023.

The three yearly quality assurance tests for the two existing intra-oral machine and the CBCT had been completed. The most recent reports generated by the RPA (27 September 2022 and 25 May 2023) evidenced that all x-ray equipment had been examined and any recommendations made had been actioned.

A copy of the local rules was on display near each x-ray machine observed and appropriate staff had signed to confirm that they had read and understood these. The dental team demonstrated sound knowledge of radiology and radiation safety including the local rules and associated practice.

Quality assurance systems and processes were in place to ensure that all matters relating to x-rays reflect legislation and best practice guidance. It was evidenced that all measures are taken to optimise radiation dose exposure. This included the use of rectangular collimation, x-ray audits and digital x-ray processing.

The radiology and radiation safety arrangements evidenced that procedures are in place to ensure that appropriate x-rays are taken safely.

5.2.9 Are complaints and incidents being effectively managed?

The arrangements for the management of complaints and incidents were reviewed to ensure that they were being managed in keeping with legislation and best practice guidance.

The complaints policy and procedure provided clear instructions for patients and staff to follow. Patients and/or their representatives were made aware of how to make a complaint by way of the patient's guide and information on display in the practice.

Arrangements were in place to record any complaint received in a complaints register and retain all relevant records including details of any investigation undertaken, all communication with complainants, the outcome of the complaint and the complainant's level of satisfaction.

A review of records confirmed that no complaints had been received since the previous inspection.

Discussion with Miss Sweeney confirmed that an incident policy and procedure was in place which includes the reporting arrangements to RQIA. Miss Sweeney confirmed that incidents are effectively documented and investigated in line with legislation. All relevant incidents are reported to RQIA and other relevant organisations in accordance with legislation and RQIA [Statutory Notification of Incidents and Deaths](#). Arrangements are in place to audit adverse incidents to identify trends and improve service provided.

The dental team was knowledgeable on how to deal with and respond to complaints and incidents in accordance with legislation, minimum standards and the DoH guidance.

Arrangements were in place to share information with the dental team about complaints and incidents including any learning outcomes, and also compliments received.

Systems were in place to ensure that complaints and incidents were being managed effectively in accordance with legislation and best practice guidance.

5.2.10 How does a registered provider who is not in day to day management of the practice assure themselves of the quality of the services provided?

Where the business entity operating a dental practice is a corporate body or partnership or an individual owner who is not in day to day management of the practice, unannounced quality monitoring visits by the registered provider must be undertaken and documented every six months; as required by Regulation 26 of The Independent Health Care Regulations (Northern Ireland) 2005.

Miss Sweeney is the nominated individual with overall responsibility for the day to day management of the practice and is responsible for reporting to the registered provider. A person acting on behalf of the responsible individual monitors the quality of services and undertakes a visit to the premises at least every six months in accordance with legislation. Reports of the unannounced monitoring visits along with any identified actions were available for inspection.

Arrangements were in place to provide copies of these reports to the registered provider to enable them to monitor progress with the identified actions.

5.3 Does the dental team have suitable arrangements in place to record equality data?

The arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients was discussed with Miss Sweeney.

Discussion and review of information evidenced that the equality data collected was managed in line with best practice.

6.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Miss Sweeney, Registered Manager, as part of the inspection process and can be found in the main body of the report.



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