

Announced Care Inspection Report

17 October 2016



Clear Dental Armagh

Type of service: Independent Hospital (IH) – Dental Treatment

Address: 12-14 Russell Street, Armagh, BT61 9AA

Tel no: 02837524958

Inspector: Carmel McKeegan

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An announced inspection of Clear Dental Armagh took place on 17 October 2016 from 11.00 to 13.45.

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

Is care safe?

Observations made, review of documentation and discussion with Mrs Roisin Donnelly, registered manager, and staff demonstrated that 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. One recommendation was made to ensure that both the fire risk assessment and legionella risk assessment are reviewed in keeping with best practice.

Is care effective?

Observations made, review of documentation and discussion with Mrs Donnelly 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 Mrs Donnelly 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 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. One requirement was made in relation to the six monthly monitoring visit of the practice by the registered person.

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	1	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Donnelly, 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

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

2.0 Service details

Registered organisation/registered person: Clear Dental Care (NI) Ltd Mr Mark Tosh	Registered manager: Mrs Roisin Donnelly
Person in charge of the practice at the time of inspection: Mrs Roisin Donnelly	Date manager registered: 17 July 2014
Categories of care: Independent Hospital (IH) – Dental Treatment	Number of registered places: 6

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 Mrs Donnelly, registered manager, two dentists, two dental nurses, a trainee nurse and a receptionist. 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 June 2015

The most recent inspection of the establishment was an announced care inspection. No requirements or recommendations were made during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 10 June 2015

As above.

4.3 Is care safe?

Staffing

Six 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. A review of a sample of two evidenced that appraisals had been completed on an annual basis. There was a system in place to ensure that all staff receive appropriate training to fulfil the duties of their role.

A review of records confirmed that a robust system was in place to review the General Dental Council (GDC) registration status and professional indemnity of all clinical staff.

Recruitment and selection

A review of the submitted staffing information and discussion with Mrs Donnelly 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, with the exception of written references. One written reference was provided for one staff member and there was written evidence to verify that written references had been requested from the nominated referees however this had not been forthcoming. Mrs Donnelly was advised that in the absence of a written reference, a verbal reference should be sought and a record kept in this regard. During the inspection, Mrs Donnelly contacted Clear Dental Care (NI) Ltd head office who confirmed that verbal references would be sought for each staff member.

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.

Policies and procedures were in place for the safeguarding and protection of adults and children. The adult safeguarding policy had been updated to reflect the new regional adult safeguarding guidance. 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.

The new regional policy entitled 'Co-operating to safeguard children and young people in Northern Ireland' issued during March 2016 and the regional guidance document entitled 'Adult Safeguarding Prevention and Protection in Partnership' issued during July 2015 were both available for staff reference.

Management of medical emergencies

A review of medical emergency arrangements evidenced that emergency medicines were, in the main, provided in keeping with the British National Formulary (BNF), however it was identified that Aspirin Dispersible 75mg tablets were provided, this medication was replaced with the recommended Aspirin Dispersible 300mg strength during the inspection.

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. Since the previous inspection, floors in all six dental surgeries have been replaced with flooring compliant with Health Technical Memorandum (HTM) 01-05 Decontamination in primary care dental practices. Wallpaper was noted in one of the dental surgeries, as wallpaper is not compliant with HTM 01-05, it was advised that during any future refurbishment wall coverings should be provided in keeping with HTM 01-05 guidance.

Staff were observed to be adhering to best practice in terms of the uniform and hand hygiene policies.

Discussion with staff demonstrated that they had an understanding of infection prevention and control policies and procedures and were aware of their roles and responsibilities. Staff confirmed that they have received training in infection prevention and control and decontamination in keeping with best practice. Training records were available for inspection.

There was a nominated lead 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 disinfecter, a DAC Universal and five 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 HTM 01-05.

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 July 2016.

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

Radiography

The practice has six 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, 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.

The radiation protection advisor (RPA) completes a quality assurance check every three years. Review of the report of the most recent visit by the RPA demonstrated that the recommendations made have been addressed.

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

Quality assurance systems and processes were in place to ensure that all matters relating to x-rays reflect legislative and best practice guidance.

Environment

The environment was maintained to a good standard of maintenance and décor.

Cleaning schedules were in place for all areas and a colour coded cleaning system was provided. The practice was observed to be spotlessly clean in all areas. Mrs Donnelly was advised to keep a signed record of all cleaning undertaken in the practice.

Records in relation to maintenance were retained in a systematic and organised manner and as a result of this robust system Mrs Donnelly was in a position to access information in a timely fashion.

A legionella risk assessment was last undertaken in July 2014, water temperature is monitored and recorded as recommended. The legionella risk assessment should be reviewed at least every two years

A fire risk assessment had also been undertaken in July 2014, this risk assessment should be reviewed annually.

A recommendation was made to ensure that both the fire risk assessment and legionella risk assessment are reviewed in keeping with best practice guidance.

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 had been established and the last pressure vessel examination was undertaken on 22 March 2016.

Patient and staff views

Seven patients submitted questionnaire responses to RQIA. All indicated that they felt safe and protected from harm. Comments provided included the following:

- 'All Good'
- 'Yeah, seems grand'

Ten 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. The following comment was included in submitted questionnaire responses:

- 'We all work well together as a team to make sure patients are safe and protected from harm.'

Areas for improvement

The fire risk assessment and legionella risk assessment should be reviewed in keeping with best practice guidance.

Number of requirements	0	Number of recommendations	1
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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 confirmed that patients are informed about the cost of treatments, choices and options.

Electronic records are maintained and have different levels of access afforded to staff dependent on their role and responsibilities. Appropriate systems and processes were in place for the management of records and maintaining patient confidentiality.

Policies were available in relation to records management, data protection and confidentiality and consent. The records management policy includes the arrangements in regards to the creation, storage, recording, retention and disposal of records and data protection. The policy is in keeping with legislation and best practice guidance.

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

Health promotion

The practice has a strategy for the promotion of oral health and hygiene. Clinical staff confirmed that oral health is actively promoted on an individual basis during treatment sessions by both the dentists and the dental hygienist.

A range of oral health promotion leaflets were available at reception and the patients' waiting area. A range of oral healthcare products were also available to purchase.

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
- clinical waste management
- clinical records
- review of complaints/accidents/incidents

Communication

Staff confirmed that arrangements are in place for onward referral in respect of specialist treatments. A policy and procedure and template referral letters have been established.

Staff meetings are held on a regular basis to discuss clinical and practice management issues. Review of documentation demonstrated that minutes of staff meetings are retained. Staff spoken with confirmed that meetings also facilitated informal and formal in house training sessions.

Staff confirmed that there are good working relationships and there is an open and transparent culture within the practice.

A breaking bad news policy in respect of dentistry was in place.

Patient and staff views

All of the seven patients who submitted questionnaire responses indicated that they get the right care, at the right time and with the best outcome for them. The following comment was provided:

- ' More than helpful'

All of the ten 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. No comments were included in submitted questionnaire responses.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0
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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 ensured 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 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 submitted patient questionnaire responses indicated that they are treated with dignity and respect and are involved in decision making affecting their care. The following comments were provided:

- 'No problems'
- 'Listens to your concerns, answers appropriately'

All submitted staff questionnaire responses indicated that they feel 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. No comments were included in submitted questionnaire responses.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0
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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.

Mrs Donnelly is the nominated individual with overall responsibility for the day to day management of the practice. Mrs Donnelly confirmed that Mr Mark Tosh, registered person undertakes a visit to the premises at least every two weeks and is in regular contact by telephone and electronic mail. However, as Mr Tosh is not in the practice on a daily basis, in accordance with legislation, he must undertake an unannounced monitoring visit to the practice on a six monthly basis. A written report of the visit should be prepared on the conduct of the establishment and be available in the establishment for inspection. Guidance on the content of this report was provided to the practice following the inspection and a requirement was made in this regard.

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.

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.

Staff 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.

Mrs Donnelly demonstrated a clear understanding of her role and responsibility in accordance with legislation. Information requested by RQIA has been submitted within specified timeframes. It was confirmed that the Statement of Purpose and Patient's Guide are kept under review, revised and updated when necessary and available on request.

The RQIA certificate of registration was up to date and displayed appropriately.

Observation of insurance documentation confirmed that current insurance policies were in place.

Patient and staff views

All submitted patient questionnaire indicated that they feel that the service is well managed. The following comment was provided:

- 'Satisfactory'

All submitted staff questionnaire responses indicated that they feel that the service is well led. Staff spoken with during the inspection concurred with this. No comments were included in submitted questionnaire responses.

Areas for improvement

The registered person must undertake an unannounced monitoring visit to the practice on a six monthly basis. A written report of the visit should be prepared on the conduct of the establishment and be available in the establishment for inspection.

Number of requirements	1	Number of recommendations	0
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5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Roisin Donnelly, 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/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to independent.healthcare@rqia.org.uk for assessment 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	
Statutory requirements	
Requirement 1 Ref: Regulation 26 Stated: First time To be completed by: 30 November 2016	<p>The registered person must undertake an unannounced monitoring visit to the practice on a six monthly basis. A written report of the visit should be prepared on the conduct of the establishment and be available in the establishment for inspection.</p> <p>Response by registered provider detailing the actions taken: I Already visit the practice very regularly evry 3-4weeks, i need to put in place a way of documenting the visits.</p>
Recommendations	
Recommendation 1 Ref: Standard 14.2 Stated: First time To be completed by: 30 November 2016	<p>The fire risk assessment and legionella risk assessment should be reviewed in keeping with best practice guidance.</p> <p>Response by registered provider detailing the actions taken: we will review the named risks assessments and add the review of them to our governance checklist so it is done at regular intervals. Fire risk assessment and legionella risk assessment was carried out on 27/10/16.</p>

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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