Announced Care Inspection Report
27 February 2018

Edelweiss Dental Strangford

Type of Service: Independent Hospital (IH) – Dental Treatment
Address: 2 The Square, Strangford BT30 7ND
Tel No: 028 4488 1995
Inspector: Norma Munn

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered dental practice with one registered place.

3.0 Service details

Organisation/Registered Provider: Mr Klaus Viesteg	**Registered Manager:** Mr Klaus Viesteg
Person in charge at the time of inspection: Mr Klaus Viesteg	**Date manager registered:** 11 December 2014
Categories of care: Independent Hospital (IH) – Dental Treatment	**Number of registered places:** One

4.0 Inspection summary

An announced inspection took place on 27 February 2018 from 10.45 to 13.20.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003; 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).

The inspection assessed progress with any areas for improvement identified 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.

Examples of good practice were evidenced that related to patient safety in respect of staff recruitment, the management of medical emergencies and decontamination.

The previous inspection on 31 March 2017 resulted in a number of areas for improvement being made and also a failure to comply notice (FTC) was issued. An enforcement compliance inspection was carried out on 28 June 2017 and compliance with the FTC notice was achieved.

The actions taken to address the areas for improvement identified during the inspection of 31 March 2017 were reviewed during this inspection. It was good to note that the three areas for improvement made against the regulations had been met; and six of the nine areas for improvement against the standards had been fully met, and one had been partially met. However, the findings of this inspection, which resulted in a number of new areas for improvement against the regulations and standards, would indicate that the current governance and oversight arrangements within Edelweiss Dental Strangford are not robust enough to identify when improvements are needed and subsequently take action to address them. The area for improvement in relation to the governance and oversight arrangements at Edelweiss Dental Strangford, made during the previous inspection, has been stated for the second time.

During this inspection it was identified that overview arrangements, in respect of staff training and the General Dental Council (GDC) registration status for employed staff, had been implemented. However, there are currently no governance and oversight arrangements in

respect of these matters for staff working in the dental practice who are self-employed. In addition, there are no overview arrangements in place in respect of professional indemnity cover for employed or self-employed staff. Confirmation of professional indemnity in respect of employed staff was received following the inspection. The importance of ensuring that governance and oversight arrangements are in place in respect of these areas for all staff who work in the practice was discussed with Mr Viesteg. Two areas for improvement against the regulations have been made to ensure that current GDC registration and professional indemnity insurance are in place for self-employed staff; and three areas for improvement against the standards have been made to implement robust arrangements for checking the GDC registration and professional indemnity for all staff, and implementing a system to monitor that all staff are meeting their GDC Continuing Professional Development (CPD) requirements.

A review of radiation safety and protection identified that the recommendations made during the most recent Radiation Protection Advisor (RPA) visit had not been addressed. In addition there was no evidence to confirm that the gas boiler had been serviced in accordance with manufacturer's instructions, and a number of issues in respect of fire safety were identified. Three areas for improvement against the regulations have been made to address these matters.

The most recent staff appraisals had taken place during 2016 and confirmation that the practice was registered with the Information Commissioners Office (ICO) could not be located at the time of the inspection. Two areas for improvement against the standards have been made to address these matters.

Two areas for improvement against the standards in relation to the further development of the safeguarding policies and the legionella risk assessment have not been fully addressed and have been stated for the second time.

Patients who submitted questionnaire responses to RQIA indicated they were generally very satisfied or satisfied with all aspects of care in the practice. One patient indicated that they were unsatisfied in respect of safe, compassionate and well led care. There was no supporting information as to why the patient indicated this response and the patient did not leave any contact details. This was discussed with Mr Viesteg.

Comments provided included the following:

- "Lovely friendly staff."
- "Great atmosphere here, not at all like my previous dentists - I'm not as nervous as I used to be either!"
- "I am happy with my treatment at my dentist. Girls are great too."
- "I am very very happy with my care and treatment. The standard of my treatment has been second to none and I would highly recommend Edelweiss Dental Strangford."
- "Amazing dental practice. All staff so caring, professional, reassuring and understanding."
- "I like the fact that various treatments are outlined and discussed and I feel I can make an informed decision."

The findings of this report will provide the practice with the necessary information to assist them to fulfil their responsibilities, and enhance practice and patients' experience.

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.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	5	8

Details of the Quality Improvement Plan (QIP) were discussed with Mr Viesteg, registered person, 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.

4.2 Action/enforcement taken following the most recent care inspection dated 31 March 2017

Following the announced care inspection on 31 March 2017 a FTC notice was issued with regards to the recruitment and selection of staff. An enforcement compliance inspection was carried out on 28 June 2017 and at that time we were satisfied that full compliance had been achieved.

Areas for improvement identified at the last care inspection dated 31 March 2017 were not reviewed as part of the enforcement compliance inspection and were carried forward for review during this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the practice was reviewed. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the establishment
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report
- submitted staffing information
- submitted complaints declaration

Questionnaires were provided to patients and staff prior to the inspection by the practice on behalf of RQIA. Returned completed patient questionnaires were also analysed prior to the inspection.

A poster informing patients that an inspection was being conducted was displayed.

During the inspection the inspector met with Mr Viesteg, registered person and two dental nurses. A tour of the premises was also undertaken.

A sample of records was examined during the inspection in relation to the following areas:

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

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to Mr Viesteg, registered person, at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 28 June 2017

An enforcement compliance inspection was carried out on 28 June 2017 and at that time we were satisfied that full compliance had been achieved.

6.2 Review of areas for improvement from the last care inspection dated 31 March 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 9 A (1) **Stated:** First time	The registered provider must develop a policy and procedure for the prevention of blood borne virus exposure, including sharps and inoculation incidents in accordance with national guidance.	**Met**
	Action taken as confirmed during the inspection: Discussion with Mr Viesteg and a review of the policy manual confirmed that a policy and procedure for the prevention of blood borne virus exposure, including sharps and inoculation incidents had been developed in accordance with national guidance.	

Area for improvement 2 **Ref**: Regulation 21 (3) **Stated:** First time	The registered provider must ensure that a staff register is developed and maintained to include the names and details of all staff who have been employed and who are currently employed within Edelweiss Dental Strangford. The register must include the name; date of birth; position; dates of employment; and details of professional qualification and professional registration with the GDC, where applicable. This should also include associate dentists or other self-employed persons working in the practice.	**Met**
	Action taken as confirmed during the inspection: A review of documentation and discussion with Mr Viesteg confirmed that a staff register had been developed to include the names and details of all staff who have been employed and who are currently employed within Edelweiss Dental Strangford.	
Area for improvement 3 **Ref**: Regulation 15 (2) **Stated:** First time	The registered provider must ensure that pressure vessels are inspected under a written scheme of examination and records retained. A copy should be forwarded to RQIA on completion.	**Met**
	Action taken as confirmed during the inspection: A review of documentation and discussion with Mr Viesteg confirmed that pressure vessels have been inspected since the previous inspection and records retained.	
Action required to ensure compliance with The Minimum Standards for Dental Care and Treatment (2011)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 11.1 **Stated:** Second time	It is recommended that job descriptions should be developed in respect of each role within the practice and provided to staff. Contracts of employment/agreement should be developed and issued to staff. A copy of the contract should be retained in the personnel file.	**Met**

	Action taken as confirmed during the inspection: A review of documentation and discussion with Mr Viesteg confirmed that job descriptions have been developed in respect of each role within the practice and provided to staff. A review of documentation and discussion with staff confirmed that a contract/agreement has been issued to all staff and a copy retained on file.	
Area for improvement 2 **Ref**: Standard 11.1 **Stated:** Second time	It is recommended that AccessNI enhanced disclosure certificates should be handled in keeping with AccessNI's code of practice and a record retained of the date the check was applied for and received, the unique identification number and the outcome.	**Met**
	Action taken as confirmed during the inspection: A review of documentation confirmed that a record has been retained in relation to AccessNI disclosure checks carried out prior to the previous inspection. A review of the submitted staffing information and discussion with Mr Viesteg confirmed that no new staff have been recruited since the previous inspection. Mr Viesteg confirmed that all AccessNI enhanced disclosure certificates will be handled in keeping with AccessNI's code of practice for any new staff commencing work in the future.	
Area for improvement 3 **Ref**: Standard 11.3 **Stated:** First time	A record of staff induction should be completed for any staff recruited in the future and records should be retained.	**Met**
	Action taken as confirmed during the inspection: As discussed no new staff have been recruited since the previous inspection. Mr Viesteg confirmed that a record of staff induction for any staff recruited in the future will be retained.	

Area for improvement 4 **Ref**: Standard 15.3 **Stated:** First time	Review and update the policies and procedures for the safeguarding of adults and children to fully reflect the regional policies and guidance documents.	**Partially met**
	Action taken as confirmed during the inspection: One overarching safeguarding policy for adults and children is in place. A review of the policy identified that, following the previous inspection, it had been revised. However, the revised policy was not reflective of the regional policies and procedural guidance in respect of safeguarding for adults and children. This area for improvement has not been fully addressed and has been stated for the second time.	
Area for improvement 5 **Ref**: Standard 13.4 **Stated:** First time	All records in relation to decontamination should be consistently recorded in keeping with HTM 01-05 Decontamination in primary care dental practices.	**Met**
	Action taken as confirmed during the inspection: Discussion with staff and a review of documentation confirmed that records in relation to decontamination have been consistently recorded in keeping with HTM 01-05 Decontamination in primary care dental practices.	
Area for improvement 6 **Ref**: Standard 13.2 **Stated:** First time	A six monthly audit of compliance with HTM 01-05 using the IPS audit tool should be undertaken and any deficits identified should be addressed.	**Met**
	Action taken as confirmed during the inspection: Discussion with staff and a review of documentation confirmed that the IPS audit had been completed during October 2017 and it was confirmed that the audit will be repeated six monthly.	

Area for improvement 7 **Ref**: Standard 8.3 **Stated:** First time	Ensure that all x-ray equipment is serviced and maintained in keeping with manufacturer's instructions. **Action taken as confirmed during the inspection**: Discussion with staff and a review of documentation evidenced that the intra-oral x-ray unit had been serviced during February 2018.	**Met**
Area for improvement 8 **Ref**: Standard 13.2 **Stated:** First time	Review the legionella risk assessment and address any recommendations made. **Action taken as confirmed during the inspection**: The legionella risk assessment undertaken during March 2017 could not be located during the inspection and it was not clear if the recommendations made have been addressed. Following the inspection a copy of the legionella risk assessment, undertaken by an external organisation during March 2017, was forwarded to RQIA. There was no supporting evidence confirming that the recommendations had been addressed. This area for improvement has not been addressed and has been stated for the second time.	**Not met**
Area for improvement 9 **Ref**: Standard 8 **Stated:** First time	Review current monitoring systems to ensure effective quality assurance and governance arrangements are in operation. **Action taken as confirmed during the inspection**: The findings of this inspection which have resulted in a number of areas of improvement against the regulations and standards indicate that the current governance and oversight arrangements within Edelweiss Dental Strangford are not robust enough to identify when improvements are needed and subsequently take action to address them. This area for improvement has not been addressed and has been stated for the	**Not met**

	second time.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Staffing

One dental surgery is in operation in this practice. Discussion with staff and a review of completed patient satisfaction questionnaires demonstrated that there was sufficient numbers of staff in various roles to fulfil the needs of the practice and patients.

No new staff have been recruited since the previous care inspection; however, induction programme templates were in place relevant to specific roles within the practice.

It was identified that overview arrangements, in respect of staff training and the GDC registration status for employed staff, had been implemented. Staff spoken with confirmed that they keep themselves updated with GDC CPD requirements, and training records were available for review in respect of employed staff. However, there are currently no governance and oversight arrangements in respect of these matters for staff working in the dental practice who are self-employed.

In addition there are no overview arrangements in place in respect of professional indemnity cover for employed or self-employed staff. Confirmation of professional indemnity, in respect of Mr Viesteg and employed staff, was received following the inspection.

The importance of ensuring that governance and oversight arrangements are in place in respect of these areas for all staff who work in the practice was discussed with Mr Viesteg. Two areas for improvement against the regulations have been made to ensure that current GDC registration and professional indemnity insurance are in place for self-employed staff, and three areas for improvement against the standards have been made to implement robust arrangements for checking the GDC registration and professional indemnity for all staff, and implementing a system to monitor that all staff are meeting their GDC CPD requirements.

Staff spoken with confirmed that they felt supported and involved in discussions about their personal development. Procedures were in place for appraising staff performance; however, a review of records and discussion with staff confirmed that appraisals had not taken place since 2016. An area for improvement against the standards has been made in this regard.

Recruitment and selection

A review of the submitted staffing information and discussion with Mr Viesteg confirmed that no new staff have been recruited since the previous inspection. 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 is sought and retained for inspection.

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

Safeguarding

Staff 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.

Mr Viesteg confirmed that all staff had received training in safeguarding children and adults, as outlined in the Minimum Standards for Dental Care and Treatment 2011. It was confirmed that the safeguarding lead has completed formal training in safeguarding adults, in keeping with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016).

One overarching policy was in place for the safeguarding and protection of adults and children at risk of harm. The policy had been reviewed since the previous inspection; however; it did not include all of the types and indicators of abuse in respect of children and adults, and did not fully reflect regional policies and procedural guidance. As discussed in section 6.2 this area for improvement against the standards has been stated for the second time.

Following the inspection, safeguarding information was forwarded to Mr Viesteg in respect of both adults and children, including links to the regional safeguarding policies and procedural guidance.

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 with the exception of an automated external defibrillator (AED). A discussion took place in relation to the Resuscitation Council (UK) guidelines and recommendations regarding the accessibility of an AED. Mr Viesteg confirmed that the practice has an arrangement in place to access a public AED in a timely manner. The arrangements for access have been incorporated into the medical emergency policy.

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. As outlined previously, training records in respect of self-employed staff also need to be retained.

Discussion with staff demonstrated that they have a good understanding of the actions to be taken in the event of a medical emergency and the location of medical emergency medicines and equipment.

The policy for the management of medical emergencies reflected best practice guidance. Protocols were available for staff reference outlining the local procedure for dealing with the various medical emergencies.

Infection prevention control and decontamination procedures

Clinical and decontamination areas were tidy and uncluttered and work surfaces were intact and easy to clean. Fixtures, fittings, dental chairs and equipment were free from damage, dust and visible dirt. Staff were observed to be adhering to best practice in terms of the uniform and hand hygiene policies.

There was a nominated lead with responsibility for infection control and decontamination.

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. Review of training records and discussion with staff confirmed that they have received training in infection prevention and control and decontamination in keeping with best practice. Training records in respect of self-employed staff also need to be retained.

A decontamination room separate from patient treatment areas and dedicated to the decontamination process was available. Appropriate equipment, including a washer disinfector, a DAC Universal and a steam steriliser, has 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 October 2017.

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

Radiography

The practice has one surgery, which has an intra-oral x-ray machine.

The RPA completes a quality assurance check every three years. The most recent visit by the RPA was on 13 November 2017. A review of the report of that visit confirmed that a number of recommendations had been made. However, Mr Viesteg confirmed that these recommendations had not been addressed. There was no evidence that staff have been authorised by the radiation protection supervisor (RPS) for their relevant duties or received local training in relation to these duties. In addition, rectangular collimation was not in use and x-ray audits had not been completed. The most recent local rules were not on display; however, they were replaced during the inspection with the most up to date version. Appropriate staff had not signed to confirm that they had read and understood the most recent local rules. An area for improvement against the regulations has been made in this regard.

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

Environment

The environment was maintained to a good standard of maintenance and décor. Mr Viesteg agreed to investigate a large crack on the wall in the decontamination room and ensure this is made good.

Detailed cleaning schedules were in place for all areas which were signed on completion. A colour coded cleaning system was in place.

The most recent gas safety certificate was dated July 2016 and there was no evidence that the gas boiler had been serviced since then. An area for improvement against the regulations has been made in this regard.

A legionella risk assessment had been undertaken during March 2017 by an external provider and during the previous inspection an area for improvement had been made to review the legionella risk assessment and address any recommendations made. During this inspection the legionella risk assessment could not be located and Mr Viesteg was unsure if the risk assessment had been reviewed or if the recommendations made had been addressed. Following the inspection a copy of the legionella risk assessment was forwarded to RQIAl; however, there was no evidence that the recommendations made had been addressed. As discussed in section 6.2 this area for improvement has not been addressed and has been stated for the second time.

Fire-fighting equipment was being serviced on the day of the inspection. Staff demonstrated that they were aware of the action to take in the event of a fire, and discussion with the staff and a review of the training records confirmed that fire training had taken place, with the exception of self-employed staff. Fire training must be undertaken by all staff and a record should be retained.

There was no evidence that fire drills had taken place and the system for recording weekly and monthly fire safety checks was not in keeping with best practice. An area for improvement against the regulations has been made in relation to fire safety.

A review of the written scheme of examination confirmed that pressure vessels had been inspected since the previous inspection and records retained.

It was confirmed that arrangements were in place for the management of prescription pads/forms. However written security policies had not been developed. This was discussed during the inspection and RQIA received confirmation that a policy to reduce the risk of prescription theft and misuse had been developed. This will be reviewed during the next inspection.

Patient and staff views

Twenty patients submitted questionnaire responses to RQIA. Nineteen patients indicated they were very satisfied with this aspect of safe care.

No staff returned questionnaires to RQIA.

Areas of good practice

There were examples of good practice found in relation to staff recruitment, induction, management of medical emergencies and decontamination procedures.

Areas for improvement; I have listed these according to the summary.

Ensure that current GDC registration is in place for self-employed staff. Copies should be forwarded to RQIA.

Ensure that professional indemnity is in place for self-employed staff. Copies should be forwarded to RQIA.

Implement robust arrangements to check the GDC registration status of all clinical staff. Records should be available for inspection.

Implement robust arrangements to check the professional indemnity cover of all clinical staff. Records should be available for inspection.

Implement a system to monitor and ensure that the GDC CPD requirements are met by all clinical staff in the practice, including self-employed staff. Records of training are to be retained.

Ensure that the recommendations outlined in the most recent RPA report of November 2017 are addressed.

The gas boiler should be serviced annually in accordance with the manufacturer's guidance and the gas service certificate. A record of the service certificate should be retained.

Ensure that routine fire safety checks are carried out and recorded accurately and that all staff attend fire safety training and fire drills annually.

All staff should receive an annual appraisal and records should be retained.

The safeguarding policies should be further developed to ensure they fully reflect regional and best practice guidance in respect of adults and children. The updated policies should be shared with staff.

Review the legionella risk assessment undertaken by an external organisation during March 2017. Address the issues identified by the risk assessor.

	Regulations	Standards
Total number of areas for improvement	5	6

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Clinical records

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

Staff 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. It was 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.

Mr Viesteg confirmed that the practice is registered with the ICO and a Freedom of Information Publication Scheme has been established. However, a copy of the ICO certificate was not available to review during the inspection. An area for improvement against the standards has been made in this regard.

Health promotion

The practice has a strategy for the promotion of oral health and hygiene. Mr Viesteg and staff confirmed that oral health is actively promoted on an individual level with patients during their consultations. A monthly dental hygienist service is available.

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 IPS HTM 01-05 compliance and a patient satisfaction audit.

As discussed, x-ray quality grading, x-ray justification and clinical evaluation recording had not been completed.

Communication

Mr Viesteg 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. Review of documentation demonstrated that minutes of staff meetings are retained.

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

Patient and staff views

Eighteen patients indicated they were very satisfied with this aspect of effective care and two indicated they were satisfied.

No staff questionnaires were returned to RQIA.

Areas of good practice

There were examples of good practice found in relation to ensuring effective communication between patients and staff.

Areas for improvement

A copy of the ICO certificate confirming that the practice is registered should be obtained and available for inspection.

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Dignity, respect and involvement in decision making

Staff 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 aware of the importance of conversing with patients and conducting 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 that patients understand what treatment is available to them and can make an informed choice. Staff demonstrated how consent would be obtained.

It was confirmed that the practice undertakes patient satisfaction surveys on an annual basis. The most recent patient satisfaction report was not reviewed during this inspection. Staff demonstrated that the practice pro-actively seeks the views of patients about the quality of treatment and other services provided. It was confirmed that 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.

Patient and staff views

Nineteen patients indicated they were very satisfied with this aspect of compassionate care.

No submitted staff questionnaire responses were returned to RQIA.

Areas of good practice

There were examples of good practice found in relation to maintaining patient confidentiality, ensuring the core values of privacy and dignity were upheld and providing the relevant information to allow patients to make informed choices.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

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 whom 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 Viesteg, registered person, is the nominated individual with overall responsibility for the day to day management of the practice.

Policies and procedures were available for staff reference. Observations made confirmed that policies and procedures were indexed and dated. Mr Viesteg confirmed that policies will be reviewed on a three yearly basis. Staff spoken with were aware of the policies and how to access them.

A copy of the complaints procedure was available in the practice. Staff demonstrated a good awareness of complaints management. A complaints questionnaire was forwarded by RQIA to the practice for completion. The returned questionnaire indicated that no complaints have been received for the period 1 April 2016 to 31 March 2017.

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.

A whistleblowing/raising concerns policy was available. Discussion with staff confirmed that they were aware of whom to contact if they had a concern.

The findings of this inspection have resulted in a number of areas of improvement against the regulations and standards being made. This indicates that the current governance and oversight arrangements within Edelweiss Dental Strangford are not robust enough to identify when improvements are needed and subsequently take action to address them. The area for improvement in relation to the governance and oversight arrangements at Edelweiss Dental Strangford, made during the previous inspection, has been stated for the second time.

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.

Employers and public liability insurance documentation on display was out of date. On enquiry, the practice did not have evidence that this had been renewed. However, following the inspection, evidence confirming current insurance was forwarded to RQIA.

Patient and staff views

Eighteen patients indicated they were very satisfied with the well led aspect of care.

No submitted staff questionnaire responses were returned to RQIA.

Areas of good practice

There were examples of good practice found in relation to maintaining good working relationships.

Areas for improvement

Review current monitoring systems to ensure effective quality assurance and governance arrangements are in operation.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mr Viesteg, registered person, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with 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).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan	
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 19 (2) Schedule 2 **Stated:** First time **To be completed by:** 27 March 2018	The registered person shall ensure that current General Dental Council (GDC) registration is in place for self-employed staff. Copies should be forwarded to RQIA. Ref: 6.4
	Response by registered person detailing the actions taken: A self employed member of staff has presented proof of GDC registration to Edelwiess Dental (27/03/18). A copy will be emailed to the RQIA immediately and a copy retained in a personal folder available for inspection.
Area for improvement 2 **Ref**: Regulation 19 (2) Schedule 2 **Stated:** First time **To be completed by:** 27 March 2018	The registered person shall ensure that professional indemnity is in place for self-employed staff. Copies should be forwarded to RQIA. Ref: 6.4
	Response by registered person detailing the actions taken: A self employed member of staff has presented proof of professional Indemnity to Edelwiess Dental (27/03/18) A copy will be emailed to the RAIQ immediately and a copy kept in a personal folder available for inspection.

Area for improvement 3 **Ref**: Regulation 25 (2) (d) **Stated:** First time **To be completed by:** 27 April 2018	The registered person shall ensure that the recommendations outlined in the most recent Radiation Protection Advisor's (RPA) report of November 2017 are addressed. Ref:6.4
	Response by registered person detailing the actions taken: Radiation Protection Advisors recommendations were addressed and it is available for inspection
Area for improvement 4 **Ref**: Regulation 15 (2) (b) **Stated:** First time **To be completed by:** 27 April 2018	The registered person shall ensure that the gas boiler is serviced on an annual basis in accordance with manufacturer's instructions Ref: 6.4
	Response by registered person detailing the actions taken: A copy of the service information regarding the gas boiler was received and a copy was emailed to RQIA. Another copy is available for inspection.
Area for improvement 5 **Ref:** Regulation 25 (4) **Stated:** First time **To be completed by:** 27 April 2018	The registered person shall review the fire risk assessment and address the following: • ensure that routine fire safety checks are carried out and recorded accurately • ensure that all staff attend fire safety training annually • ensure all staff attend fire drills annually Ref: 6.4
	Response by registered person detailing the actions taken: A new fire risk assessment was developed and more robust. There are aspects of the checks carried out daily, weekly, monthly and annually. These are kept in the Fire Safety Risk Assessment file and are available for inspection.
Action required to ensure compliance with The Minimum Standards for Dental Care and Treatment (2011)	
Area for improvement 1 **Ref**: Standard 11.2 **Stated:** First time **To be completed by:** 27 March 2018	The registered person shall implement robust arrangements to check the General Dental Council (GDC) registration status of all clinical staff. Records should be available for inspection. Ref: 6.4
	Response by registered person detailing the actions taken: I am aware I can check the GCD website to ensure all staff members are registered, as well as seeing the original copy of the annual updated registration certificate issued by the GDC. Copies are made and kept in each staff members personal file for inspection. A self employed member of staff has presented proof of

	GDC registration and indemnity registration as requested and copies are available for inspection. Proof was emailed to RQIA.
Area for improvement 2 **Ref**: Standard 11.2 **Stated:** First time **To be completed by:** 27 March 2018	The registered person shall implement robust arrangements to check the professional indemnity cover of all clinical staff. Records should be available for inspection. Ref: 6.4
	Response by registered person detailing the actions taken: A chart was drawn up and placed in the staff register for all members of staff to sign and date the document when they receive their annual GDC registration certificate and indemnity certificate. A copy will be made of each certificate for each member of staff and placed in the staff register as proof and will be available for inspection.
Area for improvement 3 **Ref**: Standard 11.4 **Stated:** First time **To be completed by:** 27 March 2018	The registered person shall implement a system to monitor and ensure that the General Dental Council (GDC) continuing professional development (CPD) requirements are met by all clinical staff in the practice, including self-employed staff. Records of training are to be retained. Ref: 6.4
	Response by registered person detailing the actions taken: Each member of staff has their own folder in which all CPD certificates are kept in the Practice available for inspection. It has been arranged that a review of all CPD training will be held on days when we have scheduled our staff meetings.
Area for improvement 4 **Ref**: Standard 11 **Stated:** First time **To be completed by:** 27 April 2018	The registered person shall ensure that all staff receive an appraisal on an annual basis. Ref: 6.4
	Response by registered person detailing the actions taken: Appraisals are being completed today (we have a scheduled staff meeting today 21/3/18) and staff will be given a copy available for inspection and kept in their personal folders.
Area for improvement 5 **Ref**: Standard 10 **Stated:** First time **To be completed by:** 27 March 2018	The registered person shall ensure that a copy of the Information Commissioners Office (ICO) certificate confirming that the practice is registered is obtained and available for inspection. Ref: 6.4
	Response by registered person detailing the actions taken: A copy of the ICO certificate was scanned and emailed to the RQIA on 09/03/2018. The original certificate is kept in the Practice and

	available for inspection.
Area for improvement 6 **Ref**: Standard 15.3 **Stated:** Second time **To be completed by:** 27 April 2018	The registered person shall review and update the policies and procedures for the safeguarding of adults and children to fully reflect the regional policies and guidance documents. Ref: 6.2 and 6.4
	Response by registered person detailing the actions taken: Two separate safeguarding policies for adults and children were developed to reflect the regional policies and guidance documents. The new policies are available for inspection in Edelweiss Dental policy and procedures folder.
Area for improvement 7 **Ref**: Standard 13.2 **Stated:** Second time **To be completed by:** 27 April 2018	The registered person shall review the legionella risk assessment and address any recommendations made. Ref: 6.2 and 6.4
	Response by registered person detailing the actions taken: A copy of the Legionella Risk Assessment was received by email, printed and all recommendations were addressed. A copy of the risk assessment is in the Legionella Risk Assessment folder available for inspection.
Area for improvement 8 **Ref**: Standard 8 **Stated:** Second time **To be completed by:** 27 April 2018	The registered person shall review current monitoring systems to ensure effective quality assurance and governance arrangements are in operation. Ref: 6.2 and 6.4
	Response by registered person detailing the actions taken: At Edelweiss Dental Strangford we aim to promote and maintain the highest standard of treatment. We strive to prevent mistakes or problems when delivering treatments to our patients and aim to increase patient confidence and the Practices' credibility, while also improving work processes and efficiency and complying with local rules and regualtions

Please ensure this document is completed in full and returned via Web Portal

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