Unannounced Follow-up Care Inspection Report
16 May 2018

Dundonald Dental Practice

Type of Service: Independent Hospital (IH) - Dental Treatment
Address: 1003 Upper Newtownards Road, Dundonald BT16 1RN
Tel No: 02890 483240
Inspectors: Norma Munn and Carmel McKeegan

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 provider 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 three registered places providing private and NHS dental care and treatment.

3.0 Service details

Organisation/Registered Provider: Dental World 1 Limited **Responsible Individual:** Ms Ritu Dhariwal	**Registered Manager:** Vacant
Person in charge at the time of inspection: Ms Megan Bell, practice lead	**Date manager registered:** Application not yet submitted
Categories of care: Independent Hospital (IH) - Dental Treatment	**Number of registered places:** 3

4.0 Inspection summary

An unannounced follow up inspection was undertaken to Dundonald Dental Practice on 16 May 2018 from 10.00 to 14.30.

The focus of the inspection was to ascertain the progress made to address the areas of improvement identified as a result of the unannounced inspection undertaken on 5 December 2017. Areas of improvement made as a result of the pre-registration inspection on 7 December 2016, which were not reviewed during the inspection on 5 December 2017, were also reviewed. Other areas reviewed included the management of medical emergencies; infection prevention and control; decontamination of reusable dental instruments; and radiology and radiation safety.

During the unannounced inspection on 5 December 2017, nine areas of improvement against the regulations and fourteen against the standards were made. As a result of the issues identified, a serious concerns meeting was held in RQIA on 12 January 2018. Mr Suken Shah, company director; Ms Monica Shah, compliance manager; and Ms Linda McVey, a registered manager of other practices within Dental World 1 Limited, attended the meeting in the absence of Ms Ritu Dhariwal, responsible individual. At the meeting the actions that had been taken to address the issues identified were discussed and assurances were given that the organisational governance and oversight arrangements in respect of Dundonald Dental Practice were robust.

During this inspection on 16 May 2018, a significant number of the areas for improvement which had been identified during the inspection on 5 December 2017 had not been addressed. There was no evidence that the previously identified issues in respect of the management and governance arrangements at this practice had been addressed, despite the assurances provided at the serious concerns meeting on 12 January 2018.

RQIA was very concerned that the necessary improvements had not been made. The lack of robust governance and oversight arrangements could have the potential to negatively impact on the provision of safe, effective and compassionate care.

Subsequently, an intention to issue a failure to comply notice meeting was held in RQIA on 30 May 2018. Ms Dhariwal, Mr Shah, and Ms Shah attended the meeting. At this meeting RQIA discussed concerns in relation to the lack of robust governance and oversight arrangements

within Dundonald Dental Practice. The actions that had been taken to address the identified issues were discussed and evidence was presented to support the actions taken. Assurances were given that the organisational governance and oversight arrangements in respect of Dundonald Dental Practice were robust. RQIA requested that the reports completed in accordance with Regulation 26 of The Independent Health Care Regulations (Northern Ireland) 2005 should be forwarded to RQIA on a monthly basis for a period of three months (from June 2018). Following a review of the evidence presented at the intention to issue a failure to comply meeting, a decision was made not to serve a failure to comply notice.

RQIA will continue to monitor and review the quality of service provided in Dundonald Dental Practice and will carry out a further unannounced inspection to assess progress. It should be noted that if RQIA find that sufficient improvements have not been made further enforcement action may be taken.

As a result of this inspection seven areas for improvement against the regulations and seven areas for improvement against the standards have been stated for the second time. In addition, five areas for improvement against the regulations and two areas for improvement against the standards have also been identified.

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 (DOH) Minimum Standards for Dental Care and Treatment (2011).

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

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	12	9

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Ms Bell, practice lead and Ms McVey, a registered manager in other practices within Dental World 1 Limited, as part of the inspection process. The findings of the inspection were also discussed at the failure to comply notice meeting held in RQIA on 30 May 2018. The timescales for completion commence from the date of inspection.

Enforcement action resulted from the findings of this inspection.

The enforcement policies and procedures are available on the RQIA website:

https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

4.2 Action/enforcement taken following the most recent care inspection dated 5 December 2017

As previously discussed, as a result of the issues identified during the inspection on 5 December 2017, a serious concerns meeting was held on 12 January 2018. Mr Shah, Ms Shah, and Ms McVey attended the meeting on behalf of Ms Dhariwal, responsible individual.

At this meeting, Mr Shah, Ms Shah, and Ms McVey provided an account of the actions taken to ensure the minimum improvements necessary to achieve compliance with the areas for improvement identified. RQIA was assured that the appropriate actions to address the issues identified were being taken. At the conclusion of the meeting it was agreed that a follow up unannounced inspection would be undertaken to assess compliance with the areas for improvement identified.

5.0 How we inspect

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

- notifiable events since the pre-registration care inspection
- the registration status of the establishment
- written and verbal communication received since the pre-registration care inspection
- the pre-registration care inspection report
- the returned QIP from the pre-registration care inspection

During the inspection the inspectors met with Ms Bell, one dental nurse, and one trainee dental nurse. Ms McVey attended the practice after the commencement of the inspection and facilitated the inspection. 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
- management of medical emergencies
- training
- infection prevention and control
- decontamination
- radiography
- management and governance arrangements

Areas for improvement carried forward from the pre-registration inspection on 7 December 2016 and the inspection on 5 December 2017 were reviewed, and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to Ms Bell and Ms McVey at the conclusion of the inspection and were also discussed at the failure to comply notice meeting held in RQIA on 30 May 2018.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 5 December 2017

The most recent inspection of the establishment was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

6.2 Review of areas for improvement from the care inspections dated 7 December 2016 and 5 December 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 26 **Stated:** First time	The registered person shall ensure that six monthly unannounced visits by the responsible individual or their nominated representative, as outlined in Regulation 26 of The Independent Health Care Regulations (Northern Ireland) 2005, as amended, are carried out. Written reports of the unannounced visits should be available for inspection.	**Not met**
	Action taken as confirmed during the inspection: Ms McVey confirmed that an unannounced visit had recently been carried out by a representative of Ms Dhariwal; however, the report of the visit was not available for review. RQIA raised this matter during the inspection on 5 December 2017, and at the serious concerns meeting on 12 January 2018. RQIA was concerned that the necessary improvements had not been made and the lack of robust governance and oversight arrangements could have the potential to impact on care provision. Subsequently an intention to issue a Failure to Comply Notice meeting was held in RQIA on	

	30 May 2018. At this meeting RQIA discussed concerns in relation to the lack of robust governance and oversight arrangements within the practice. Evidence to confirm the actions taken to address the identified issues was presented and during discussion assurances were given that the organisational governance and oversight arrangements in respect of the practice were robust. RQIA acknowledged the improvements that have been made and a decision not to serve a failure to comply notice was made. This area for improvement has not been addressed and has been stated for the second time. In addition, RQIA has requested that the reports completed in accordance with Regulation 26 of The independent Health Care Regulations (Northern Ireland) 2005 are forwarded to RQIA on a monthly basis for a period of three months (from June 2018). These should include a clear focus on the actions to be taken in respect of the quality improvement plan within this report. A separate area for improvement against the regulations has been made in this regard.	
Area for improvement 2 **Ref:** Regulation 11 **Stated:** First time	The registered person shall ensure that RQIA is formally notified of the acting management arrangements until such time as a registered manager is appointed. The application for a registered manager should be submitted to RQIA at the earliest opportunity.	**Not Met**
	Action taken as confirmed during the inspection: Following the inspection in December 2017, RQIA was formally notified of the acting management arrangements and a registered manager application was submitted to RQIA. However, during April 2018 the applicant registered manager informed RQIA that she was resigning from Dental World 1 Limited. During this inspection it was established that a practice lead had been appointed and commenced working in the practice on 1 May	

	2018. However, despite numerous requests, RQIA had not been formally notified of the management arrangements within the practice in the absence of a registered manager. This area for improvement has not been addressed and has been stated for the second time.	
Area for improvement 3 **Ref:** Regulation 19 (1) (c) **Stated:** First time	The registered person shall ensure that a system is established to review the GDC registration status of clinical staff. Records should be retained.	**Not Met**
	Action taken as confirmed during the inspection: Review of records evidenced that a system had still not been established to review the GDC registration status of clinical staff. Several records had not been retained. This area for improvement has not been addressed and has been stated for the second time.	
Area for improvement 4 **Ref:** Regulation 19 (3) **Stated:** First time	The registered person shall ensure that a system is established to review the professional indemnity of staff who required individual professional indemnity. Records should be retained.	**Not Met**
	Action taken as confirmed during the inspection: Review of records evidenced that a system had still not been established to review the professional indemnity of staff who required individual professional indemnity. Several records had not been retained. This area for improvement has not been addressed and has been stated for the second time.	
Area for improvement 5 **Ref:** Regulation 18 (2) **Stated:** First time	The registered person shall ensure that a system is established to ensure that all staff receive appropriate training to fulfil the duties of their role. Training records should also be retained including any training provided in house.	**Not Met**

	Action taken as confirmed during the inspection: Review of records confirmed that the management of medical emergencies training was attended on 13 January 2018. However, records were not available to evidence that all staff had received training in respect of infection prevention and control, the decontamination of dental instruments and the safeguarding of adults and children, commensurate with their roles and responsibilities. Ms McVey confirmed that fire training had been undertaken and fire drills carried out; however, there were no records to evidence this. This area for improvement has not been addressed and has been stated for the second time.	
Area for improvement 6 **Ref:** Regulation 19 (2) Schedule 2 **Stated:** First time	The registered person shall ensure that two written references, one of which should be from the current/most recent employer, a criminal conviction declaration and a physical and mental health assessment are obtained prior to any new staff commencing employment. Records should be retained in staff personnel files.	**Partially Met**
	Action taken as confirmed during the inspection: Ms McVey stated that staff personnel files were stored in another Dental World 1 practice. Ms McVey was advised that personnel records in respect of Dundonald Dental Practice should be retained in the premises. During the inspection Mrs McVey arranged for the relevant staff personnel files to be delivered. A review of these files evidenced that all staff personnel files were available with the exception of the most recent member of staff employed. Prior to the conclusion of the inspection Ms McVey provided recruitment documentation for this staff member. However, not all	

	information as outlined in the regulations had been sought and retained. There was no evidence that a criminal conviction declaration or a physical and mental health assessment had been obtained. In addition, there was no evidence that an enhanced AccessNI check had been undertaken. On enquiry, Ms McVey shared a copy of the enhanced AccessNI certificate from an electronic device. Ms McVey was advised that this AccessNI certificate should be disposed of in keeping with AccessNI's code of practice. This area for improvement has not been fully addressed and the unaddressed component has been stated for the second time.	
Area for improvement 7 **Ref:** Regulation 19 (2) Schedule 2 **Stated:** First time	The registered person shall ensure that enhanced AccessNI checks are obtained in respect of any new staff prior to their commencement of employment. **Action taken as confirmed during the inspection**: A review of one personnel file evidenced that an AccessNI certificate had been obtained prior to their commencement of employment.	**Met**
Area for improvement 8 **Ref:** Regulation 18 (2) **Stated:** First time	The registered person shall ensure that induction programmes specific to the role are further developed to provide meaningful induction and mentorship arrangements. **Action taken as confirmed during the inspection**: Discussion with a recently recruited staff member confirmed that an induction had been provided by Mr Shah, one day per week. However, a record of this had not been retained. This area for improvement has not been addressed and has been stated for the second time.	**Not Met**

Area for improvement 9 **Ref:** Regulation 15 (1) b **Stated:** First time	The registered person shall ensure that recommendations made by the Radiation Protection Advisor (RPA) are addressed and confirmation recorded in the radiation protection file.	**Met**
	Action taken as confirmed during the inspection: Review of the RPA report evidenced that all recommendations made by the RPA had been signed off as having been completed.	
Action required to ensure compliance with The Minimum Standards for Dental Care and Treatment (2011)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 9 **Stated:** Second time	The complaints policies and procedures should be further developed to reflect that patients who remain dissatisfied with the outcome of the complaints investigation, in respect of NHS dental care and treatment, can refer to the Northern Ireland Public Services Ombudsman only and in respect of private dental care and treatment, the Dental Complaints Service only. In addition, the details of the Health and Social Care Board (HSCB) and the General Dental Council (GDC) should be included as other agencies that may be utilised within the complaints investigation at local level. The details of RQIA should also be included as a body who take an oversight view of complaints management.	**Met**
	Action taken as confirmed during the inspection: Review of the complaints policies and procedures evidenced that this area for improvement has been addressed.	
Area for improvement 2 **Ref**: Standard 12.5 **Stated:** First time	The registered person shall ensure that fire safety awareness training is provided and fire drills are carried out on an annual basis. Records should be retained.	**Not Met**
	Action taken as confirmed during the inspection: It was confirmed that a fire drill had been completed during March 2018; however, there was no record retained to evidence this. There were no records to evidence that staff	

	had completed fire training in the past 12 months. This area for improvement has not been addressed and has been stated for the second time.	
Area for improvement 3 **Ref**: Standard 11.1 **Stated:** First time	The registered person shall ensure that enhanced AccessNI disclosure certificates are disposed of in keeping with AccessNI's code of practice and a record retained of the dates the check was applied for and received, the unique identification number and the outcome of the assessment of the check.	**Not Met**
	Action taken as confirmed during the inspection: As previously discussed Ms McVey shared a copy of the enhanced AccessNI certificate from an electronic device. Ms McVey was advised that this AccessNI certificate should be disposed of in keeping with AccessNI's code of practice. A record had not been retained of the dates the check was applied for and received, the unique identification number and the outcome of the assessment of the check. This area for improvement has not been addressed and has been stated for the second time.	
Area for improvement 4 **Ref**: Standard 11 **Stated:** First time	The registered person shall ensure that contracts of employment/agreement and written induction programmes are provided for any new staff recruited. Copies should be retained in staff personnel files.	**Partially Met**
	Action taken as confirmed during the inspection: A copy of the contract of employment was observed in the newly recruited staff member's personnel file. As discussed, an induction had been provided to this staff member by Mr Shah one day per week. However, a record of this had not been retained. This area for improvement has not been fully	

	addressed and the unaddressed component has been stated for the second time.	
Area for improvement 5 **Ref**: Standard 11 **Stated:** First time	The registered person shall establish a staff register containing the following staff details: • name • date of birth • position • date of commencement of employment • date of leaving employment • details of professional qualifications and professional registration with the GDC, where applicable The staff register should be kept updated and be available for inspection.	**Partially Met**
	Action taken as confirmed during the inspection: Review of the staff register evidenced that not all the names of staff who were currently employed in Dundonald Dental Practice were included in the register. Ms McVey was advised that the staff register is a live document which should be kept up to date. This area for improvement has not been fully addressed and the unaddressed component has been stated for the second time.	
Area for improvement 6 **Ref**: Standard 13.1 **Stated:** First time	The registered person shall ensure that cleaning schedules are further developed to detail the arrangements for all areas of the practice and include the frequency of cleaning and who is responsible.	**Met**
	Action taken as confirmed during the inspection: A review of cleaning schedules evidenced that this area for improvement has been addressed.	
Area for improvement 7 **Ref**: Standard 13.4 **Stated:** First time	The registered person shall ensure that the upholstery of the dental chair in surgery 3 and the operators chair in surgery 1 is repaired/re-up holstered.	**Met**

	Action taken as confirmed during the inspection: Discussion with staff confirmed that the dental chair had been reupholstered and the operators chair repaired. However, it was observed that two operator's stools were ripped/damaged and an area for improvement has been made in this regard.	
Area for improvement 8 **Ref**: Standard 13.4 **Stated:** First time	The registered person shall ensure that decontamination log books are further developed to include the equipment information and that the details of the steriliser daily automatic control test (ACT) are recorded.	**Not Met**
	Action taken as confirmed during the inspection: A review of the equipment logbooks evidenced that periodic tests had been undertaken and recorded in keeping with HTM 01-05 up until 30 April 2018. On enquiry, staff could not explain why the recording of periodic tests had ceased from that date. This area for improvement has not been addressed and an area for improvement has been made against the regulations.	
Area for improvement 9 **Ref**: Standard 13.4 **Stated:** First time	The registered person shall provide portals for the washer disinfector to facilitate the processing of dental handpieces. Any compatible dental handpieces should be decontaminated using this method. A sufficient supply of handpieces should be provided to facilitate processing through the washer disinfector.	**Not Met**
	Action taken as confirmed during the inspection: During discussion it was confirmed that some dental handpieces were being processed in the washer disinfector. However, staff were unclear which handpieces were compatible with an automated validated process. Staff were unable to confirm if a sufficient supply of handpieces had been provided to	

	facilitate processing through the washer disinfector. This area for improvement has not been addressed and an area for improvement has been made against the regulations.	
Area for improvement 10 **Ref**: Standard 13.4 **Stated:** First time	The registered person shall seek clarification regarding the shelf life of pouches used for storing sterilised instruments with the manufacturer.	**Met**
	Action taken as confirmed during the inspection: Staff confirmed that all sterile instruments are stored in keeping with best practice guidance.	
Area for improvement 11 **Ref**: Standard 13.4 **Stated:** Second time	The registered person shall make arrangements to ensure staff can access the switch for the extract ventilation and that extract ventilation is used during the decontamination process.	**Met**
	Action taken as confirmed during the inspection: Staff confirmed that they can access the switch for the extract ventilation and that extract ventilation is used during the decontamination process.	
Area for improvement 12 **Ref**: Standard 12.4 **Stated:** First time	The registered person shall provide automated external defibrillator (AED) pads suitable for use with a child.	**Met**
	Action taken as confirmed during the inspection: Review of the emergency equipment evidenced that this area for improvement has been addressed.	
Area for improvement 13 **Ref**: Standard 12.3 **Stated:** First time	The registered person shall provide training in the management of a medical emergency for all staff and establish arrangements to ensure training is updated on an annual basis.	**Met**
	Action taken as confirmed during the inspection: Discussion with staff and review of documentation confirmed that all staff attended medical emergency training on 13	

	January 2018.	
Area for improvement 14 **Ref**: Standard 12 **Stated:** First time	A management of medical emergencies policy should be developed in accordance with legislative and best practice guidance.	**Met**
	Action taken as confirmed during the inspection: The management of medical emergencies policy was reflective of legislative and best practice guidance.	
Areas for improvement carried forward for review from the previous inspection dated 7 December 2016		
Area for improvement 1 **Ref**: Standard 1 **Stated:** First time	The statement of purpose (SOP) should be further developed to include the following as outlined in Regulation 7, Schedule 1 of The Independent Health Care Regulations (Northern Ireland) 2005: • name and address of the registered provider and registered manager • relevant qualification and experience of the registered provider and registered manager • the number, relevant qualifications and experience of the staff working in the practice • revised information of the facilities available for patients with a disability • the arrangements in the event of a patient being dissatisfied with the outcome of a complaints investigation The revised copy of the SOP should be submitted to RQIA upon return of the QIP.	**Not Met**
	Action taken as confirmed during the inspection: The SOP had not been further developed as outlined in Regulation 7, Schedule 1 of The Independent Health Care Regulations (Northern Ireland) 2005. This area for improvement has not been addressed and has been stated for the second time.	

Area for improvement 2 **Ref**: Standard 1 **Stated:** First time	The patient guide should be further developed to fully reflect the key areas and themes specified in Regulation 8 of The Independent Health Care Regulations (Northern Ireland) 2005. The revised copy should be submitted to RQIA upon return of the QIP.	**Not Met**
	Action taken as confirmed during the inspection: The patient guide had not been further developed to fully reflect the key areas and themes specified in Regulation 8 of The Independent Health Care Regulations (Northern Ireland) 2005. This area for improvement has not been addressed and has been stated for the second time.	
Area for improvement 3 **Ref**: Standard 8 **Stated:** First time	The following policies and procedures should be further developed in accordance with legislative and best practice guidance as discussed in the body of the report: • safeguarding children and adults at risk of harm • recruitment and selection • records management – retention schedule • health and safety • underperforming and whistleblowing • infection control Policies should be indexed in topical areas such as infection control, records management, human resources et cetera, to ensure that staff have easy access to all relevant policies within a specific topic area or be cross referenced to associated relevant policies.	**Partially Met**
	Action taken as confirmed during the inspection: The inspectors reviewed several safeguarding children and adults policies that were not in keeping with regional guidance. On enquiry Ms McVey produced a safeguarding policy that had been updated in keeping with regional guidance held on the practice	

	computer. It was advised that all out of date policies should be removed from the policy file. The whistle blowing/raising concerns policy did not include the details of the RQIA. To ensure that staff have easy access to all relevant policies it was suggested that only the current policies and procedures are available for staff reference, and older documents should be archived. This area for improvement has not been fully addressed and the unaddressed component has been stated for the second time.	

6.3 Management of medical emergencies

Management of medical emergencies

A review of arrangements in respect of the management of a medical emergency evidenced that emergency medicines in keeping with the British National Formulary (BNF) and emergency equipment as recommended by the Resuscitation Council (UK) guidelines were retained. The Glucagon medication was stored out of the fridge and the expiry date had been amended. However, the staff could not confirm if the expiry date recorded was in accordance with manufacturer's instructions. Ms McVey agreed to check this and has given assurances that the Glucagon medicine will be stored according to the manufacturer's instructions.

A system was in place to ensure that emergency medicines and equipment do not exceed their expiry date. However, the size zero oropharyngeal airway had passed its expiry date. This was discussed and Ms McVey agreed to replace this airway.

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. The most recent occasion staff completed medical emergency refresher training was during January 2018.

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.

Areas of good practice

The review of the arrangements in respect of the management of a medical emergency confirmed that this dental practice takes a proactive approach to this key patient safety area. This includes ensuring that staff have the knowledge and skills to react to a medical emergency, should it arise.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Areas for improvement	**0**	**0**

6.4 Infection prevention and control

Infection prevention and control (IPC)

During a tour of the premises, it was evident that the practice, including the clinical and decontamination area, was generally clean, tidy and uncluttered. As discussed two of the operators stools in the surgeries were observed to be ripped/damaged. An area for improvement against the standards has been made.

The practice continues to audit compliance with Health Technical Memorandum (HTM) 01-05: Decontamination in Primary Care Dental Practices using the Infection Prevention Society (IPS) audit tool. The most recent IPS audit had been completed during February 2018.

Records were not available to evidence that all staff had received training in respect of IPC commensurate with their roles and responsibilities. This issue was previously discussed in section 6.2 of this report and an area for improvement against the regulations has been made for the second time.

Cleaning chemicals were observed to be stored in unlocked cupboards in toilet areas and not in keeping with the Control of Substances Hazardous to Health Regulations (COSHH) 2002. An area for improvement against the regulations has been made.

Areas for improvement

The upholstery on the dental operator stools in the identified surgeries should be repaired/ re-upholstered.

A system should be established to ensure that all staff receive appropriate training to fulfil the duties of their role.

Cleaning chemicals should be stored in keeping with the COSHH regulations 2002.

	Regulations	Standards
Areas for improvement	**2**	**1**

6.5 Decontamination of reusable dental instruments

Decontamination of reusable dental instruments

A decontamination room separate from patient treatment areas and dedicated to the decontamination process was available. The decontamination room facilitates the flow from dirty through to clean areas for the cleaning and sterilising of reusable instruments.

The processes in respect of the decontamination of reusable dental instruments are being audited in line with best practice outlined in HTM 01-05 using the IPS audit tool. As discussed the most recent IPS audit had been completed during May 2018.

Records were not available to evidence that all staff had received training in respect of the decontamination of reusable dental instruments commensurate with their roles and responsibilities. This issue was previously discussed in section 6.2 of this report and an area for improvement against the regulations has been made for the second time.

A review of current practice evidenced that arrangements are in place to ensure that reusable dental instruments are appropriately cleaned, sterilised and stored following use in keeping with best practice guidance as outlined in HTM 01-05 with the exception of some of the dental handpieces, which are manually cleaned prior to sterilisation. On enquiry, staff were unsure whether the dental handpieces were compatible with the washer disinfector. Staff were unable to confirm if the supply of dental handpieces had increased since the previous inspection. Processing of handpieces was discussed and staff were advised to refer to the manufacturer's instruction and the Professional Estates Letter (PEL) (13) 13, dated 24 March 2015 which was issued to all dental practices by the DOH. This issue was previously discussed in section 6.2 of this report and an area for improvement against the regulations has now been made.

Appropriate equipment, including a washer disinfector and a steam steriliser, had been provided to meet the practice requirements. The equipment used in the decontamination process had been appropriately validated and inspected in keeping with the written scheme of examination. Equipment logbooks evidenced that periodic tests had been undertaken and recorded in keeping with HTM 01-05 up until 30 April 2018. On enquiry staff could not explain why the recording had ceased from that date. This issue was previously discussed in section 6.2 of this report and an area for improvement against the regulations has now been made.

Areas for improvement

A system should be established to ensure that all staff receive appropriate training to fulfil the duties of their role.

All compatible dental handpieces should be decontaminated in keeping with manufacturer's instructions and Professional Estates Letter (PEL) (13) 13. Compatible handpieces should be processed in the washer disinfector.

Periodic testing as outlined in HTM 01-05 should be undertaken and recorded for all equipment used in the decontamination process. Records are to be retained in the log books provided for each piece of equipment.

	Regulations	Standards
Areas for improvement	**3**	**0**

6.6 Radiology and radiation safety

Radiology and radiation safety

The practice has four surgeries, each of which has an intra-oral x-ray machine. Three of the surgeries are registered with RQIA to provided private dental care and treatment and the fourth surgery is not operational. In addition, there is an orthopan tomogram machine (OPG), which is located in a separate area. Staff confirmed that the OPG was not in operation.

A radiation protection advisor (RPA) and medical physics expert (MPE) have been appointed.

A dedicated radiation protection file containing all relevant information was in place. A review of the file evidenced that a new intra-oral x-ray machine had been recently installed in surgery 4. However, staff confirmed that surgery 4 was non-operational and they were unsure which surgery the new intra oral x-ray machine had been installed in. This led to confusion in relation to the identification of the surgery room numbers and the location of the x-ray equipment. There were no room numbers or names on the surgery doors to identify them. A critical examination of the new x-ray machine had been carried out by the installer; however; there was no evidence that the appointed RPA had endorsed the report. Staff were advised that the identified newly installed x-ray machine must not be operational until the critical examination report has been reviewed and endorsed by the RPA and any recommendations made addressed. An area for improvement against the regulations has been made to ensure that the RPA reviews the report of the critical examination check carried out by the installer for the newly installed x-ray unit prior to use, and any recommendations made by the RPA should be actioned and a record retained to evidence this. In addition, the dental surgeries should be clearly labelled/numbered to ensure that staff can identify the surgeries referenced in the RPA report.

The appointed RPA completes a quality assurance check every three years. A review of the report of the most recent visit by the RPA demonstrated that any recommendations made had been addressed.

Staff spoken with demonstrated knowledge of radiology and radiation safety in keeping with their roles and responsibilities.

It was confirmed that a range of audits, including x-ray quality grading and justification and clinical evaluation recording, are undertaken.

Areas for improvement

The RPA must review the report of the critical examination check carried out by the installer for the newly installed x-ray unit prior to use. On receipt of the RPA report, any recommendations made by the RPA should be actioned and a record retained to evidence this. In addition the surgery rooms should be clearly labelled/numbered to ensure that staff can identify the surgeries referenced in the RPA report.

	Regulations	Standards
Areas for improvement	**1**	**0**

6.7 Additional areas

The most recent fire risk assessment was dated January 2018. There was no evidence to confirm that the recommendations made by the fire risk assessor had been actioned. An area for improvement against the standards has been made in this regard.

	Regulations	Standards
Areas for improvement	**0**	**1**

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Ms Bell and Ms McVey as part of the inspection process and were also discussed at the failure to comply notice meeting held in RQIA on 30 May 2018. The timescales commence from the date of inspection.

The registered provider/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 provider 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 (DOH) Minimum Standards for Dental Care and Treatment (2011).

7.2 Actions to be taken by the service

Quality Improvement Plan	
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 26 **Stated:** Second time **To be completed by:** 16 June 2018	The registered person shall ensure that six monthly unannounced visits by the responsible individual or their nominated representative, as outlined in Regulation 26 of The Independent Health Care Regulations (Northern Ireland) 2005, as amended, are carried out. Written reports of the unannounced visits should be available for inspection. Ref: 6.2
	Response by registered person detailing the actions taken: Mrs Pamela McKay is the nominated representative for the 6 monthly unannounced visits and this is being undertaken at present on a monthly basis from June 2018 for a period of 3 months.
Area for improvement 2 **Ref:** Regulation 26 **Stated:** First time **To be completed by:** 30 August 2018	The registered person shall ensure that the reports completed in accordance with Regulation 26 of The independent Health Care Regulations (Northern Ireland) 2005 are forwarded to RQIA on a monthly basis for a period of three months (from June 2018). These should include a clear focus on the actions as outlined in the quality improvement plan within this report. Ref: 6.2
	Response by registered person detailing the actions taken: The reports for the practice are being carried out on a monthly basis. Area for improvement within the report have been addressed and are being implemented in the next monthly report submitted to the RQIA.
Area for improvement 3 **Ref:** Regulation 11 **Stated:** Second time **To be completed by:** 16 June 2018	The registered person shall ensure that RQIA is formally notified of the acting management arrangements until such time as a registered manager is appointed. The application for a registered manager should be submitted to RQIA at the earliest opportunity. Ref: 6.2
	Response by registered person detailing the actions taken: Miss Megan Bell is now the acting manager for the practice.

Area for improvement 4 **Ref:** Regulation 19 (1) (c) **Stated:** Second time **To be completed by:** 16 June 2018	The registered person shall ensure that a system is established to review the General Dental Council (GDC) registration status of clinical staff. Records should be retained. Ref: 6.2
	Response by registered person detailing the actions taken: On inspection all staff have their GDC registeration on file until the end of July. This includes Dentists registerations which are present and correct.New certificates will be sent in due courseto the members of staff who have continued to stay on register. These copies are to be given to the registered manager. Each manager to have a computer/calender reminder to inspect on specific date that each member is able to work in the practice.ACTION STILL IN PROGRESS IN REGARDS TO COMPUTER / CALENDER REMINDER
Area for improvement 5 **Ref:** Regulation 19 (3) **Stated:** Second time **To be completed by:** 16 June 2018	The registered person shall ensure that a system is established to review the professional indemnity of staff who required individual professional indemnity. Records should be retained. Ref: 6.2
	Response by registered person detailing the actions taken: Mrs Mckay was able to find indemnity certificates in personnel folders for all staff members. Document to be organised by the manager with all staff members who require indemnity, start date of policy, expiry date and to be checked regularly to ensure that all members are compliant. ACTION MET
Area for improvement 6 **Ref:** Regulation 18 (2) **Stated:** Second time **To be completed by:** 16 June 2018	The registered person shall ensure that a system is established to ensure that all staff receive appropriate training to fulfil the duties of their role. Training records should also be retained including any training provided in house. Ref: 6.2, 6.4 and 6.5
	Response by registered person detailing the actions taken: Staff records for safeguarding and medical emergency training certificatesare in file. Fire training has been carried out on 12th January 2018 . These certificates have been added to Smart dental care website specific for this practice. Company is aware when decontamination, hand hygiene courses need updating.for specific nurse role . The practice is continuously training staff for specific roles using online providers. ACTION IN ONGOING AND IN PROGRESS

Area for improvement 7 **Ref:** Regulation 19 (2) Schedule 2 **Stated:** Second time **To be completed by:** 16 May 2018	The registered person shall ensure that a criminal conviction declaration and a physical and mental health assessment are obtained prior to any new staff commencing employment. Records should be retained in staff personnel files. Ref: 6.2
	Response by registered person detailing the actions taken: Criminal conviction declaration , physical and mental health declaration is available readily in staff members personnel folders .ACTION MET
Area for improvement 8 **Ref:** Regulation 18 (2) **Stated:** Second time **To be completed by:** 16 July 2018	The registered person shall ensure that induction programmes, specific to the role are further developed to provide meaningful induction and mentorship arrangements. Ref: 6.2
	Response by registered person detailing the actions taken: Staff induction programmes specific to the role have been carried out for most recent members of staff . There are still a few areas to be addressed within the practice for trainee dental nurse who is working in the practice. ACTION PARTIALLY MET AND IN FURTHER PROGRESS .
Area for improvement 9 **Ref:** Regulation 15 (1) (2) **Stated:** First time **To be completed by:** 16 June 2018	The registered person shall ensure that the radiation protection advisor (RPA) reviews the report of the critical examination check carried out by the installer for the newly installed x-ray unit prior to use. Any recommendations made by the RPA should be actioned and a record retained to evidence this. The dental surgeries should be clearly labelled/numbered to ensure that staff can identify the surgeries referenced in the RPA report. Ref: 6.6
	Response by registered person detailing the actions taken: The dental surgeries are now clearly labelled and numbered to ensure that staff can identify the surgeries. ACTION MET
Area for improvement 10 **Ref:** Regulation 25 (2) (d) **Stated:** First time **To be completed by:** 16 May 2018	The registered person shall ensure that all cleaning chemicals are stored safely in keeping with the Control of Substances Hazardous to Health Regulations (COSHH) 2002. Ref: 6.4
	Response by registered person detailing the actions taken: All COSHH products are now stored away in locked cabinet. ACTION MET

Area for improvement 11 **Ref:** Regulation 15(5) **Stated:** First time **To be completed by:** 16 May 2018	The registered person shall ensure that dental handpieces are decontaminated in keeping with manufacturer's instructions and Professional Estates Letter (PEL) (13) 13. Compatible handpieces should be processed in the washer disinfector. Ref: 6.2 and 6.5
	Response by registered person detailing the actions taken: There is a sufficient supply of handpieces available within the practice. Staff were clear on the handpieces which were compatable with the washer disinfector. Some handpieces did not show this and need to be checked with the manufacturer. Portal for washer is available. ACTION PARTIALLY MET AND UNDER PROGRESS .
Area for improvement 12 **Ref:** Regulation 15(5) **Stated:** First time **To be completed by:** 16 May 2018	The registered person shall ensure that periodic testing as outlined in HTM 01-05 are undertaken and recorded for all equipment used in the decontamination process. Records are to be retained in the log books provided for each piece of equipment. Ref: 6.2 and 6.5
	Response by registered person detailing the actions taken: Review of the equipment book showed evidence that periodic tests had been carried out daily within last week and logged. Evidence did not show that test were done week begining 9th July, week begining 16th July. Staff informed and issue is being addressed .Evidence to now be sent on a daily basis to compliance manager to confirm that recordings are daily occurrence. ACTION PARTIALLY MET AND IN FULL PROGRESS
Action required to ensure compliance with the Minimum Standards for Dental Care and Treatment (2011)	
Area for improvement 1 **Ref**: Standard 12.5 **Stated:** Second time **To be completed by:** 16 July 2018	The registered person shall ensure that fire safety awareness training is provided and fire drills are carried out on an annual basis. Records should be retained. Ref: 6.2
	Response by registered person detailing the actions taken: Fire safety awareness training was provided for all staff and records available . Fire drills have been carried out and logged .ACTION MET

Area for improvement 2 **Ref**: Standard 11.1 **Stated:** Second time **To be completed by:** 16 June 2018	The registered person shall ensure that enhanced AccessNI disclosure certificates are disposed of in keeping with AccessNI's code of practice, and a record retained of the dates the check was applied for and received, the unique identification number and the outcome of the assessment of the check. Ref: 6.2
	Response by registered person detailing the actions taken: ACCESSNI Disclosure certificates are now disposed off in keeping with the ACCESSNI'S Code of practice. A record has been retained of the dates the check was applied for and received, Unique identifiaction number and the outcome. This has now been met within the practice. ACTION MET
Area for improvement 3 **Ref**: Standard 11 **Stated:** Second time **To be completed by:** 16 July 2018	The registered person shall ensure that written induction programmes are provided for any new staff recruited. Copies should be retained in staff personnel files. Ref: 6.2
	Response by registered person detailing the actions taken: ACTION MET
Area for improvement 4 **Ref**: Standard 11 **Stated:** Second time **To be completed by:** 16 July 2018	The registered person shall ensure that the staff register is kept updated and available for inspection. Ref: 6.2
	Response by registered person detailing the actions taken: Staff register for the practice has been updated and includes all current staff members. ACTION MET
Area for improvement 5 **Ref**: Standard 13.2 **Stated:** First time **To be completed by:** 01 August 2018	The registered person shall ensure that the upholstery on the dental stools in the identified surgeries is repaired/ re-upholstered. Ref: 6.2 and 6.4
	Response by registered person detailing the actions taken: The upholstery on the dental stools in the identified surgeries have now been reupholstered. ACTION MET

Area for improvement 6 **Ref**: Standard 1 **Stated:** Second time **To be completed by:** 16 July 2018	The statement of purpose (SOP) should be further developed to include the following as outlined in Regulation 7, Schedule 1 of The Independent Health Care Regulations (Northern Ireland) 2005: • name and address of the registered provider and registered manager • relevant experience of the registered provider and registered manager • the number, relevant qualifications and experience of the staff working in the practice • the arrangements in the event of a patient being dissatisfied with the outcome of a complaints investigation The revised copy of the SOP should be submitted to RQIA upon return of the QIP. Ref: 6.2
	Response by registered person detailing the actions taken: New statement of purpose is available in the practice which includes the name of the registered manager, the number of staff, qualifications and experience. Information of the facilities available for patients . Arrangements in the event of a patient being dissatisfied with the outcome of omplaint investigation. ACTION MET
Area for improvement 7 **Ref**: Standard 1 **Stated:** Second time **To be completed by:** 16 July 2018	The patient guide should be further developed to fully reflect the key areas and themes specified in Regulation 8 of The Independent Health Care Regulations (Northern Ireland) 2005. The revised copy should be submitted to RQIA upon return of the QIP. Ref: 6.2
	Response by registered person detailing the actions taken: The patient guide has been updated ACTION MET
Area for improvement 8 **Ref**: Standard 8 **Stated:** Second time **To be completed by:** 16 July 2018	The following policies and procedures should be further developed in accordance with legislative and best practice guidance: • safeguarding children and adults at risk of harm • whistleblowing Policies should be indexed in topical areas to ensure that staff have easy access to all relevant policies within a specific topic area or be cross referenced to associated relevant policies. Ref: 6.2

	Response by registered person detailing the actions taken: Safeguarding policy has been updated. Whistleblowing policy has been updated and in policy folder. ACTION MET
Area for improvement 9 **Ref**: Standard 14.2 **Stated:** First time **To be completed by:** 16 July 2018	The registered person shall ensure that the fire risk assessment recently undertaken is reviewed and any recommendations made therein are addressed within the timeframes specified. Records should be retained for inspection. Ref: 6.7
	Response by registered person detailing the actions taken: All Recommendations made for fire door is in progress and work being carried out within next few weeks . Date still to be confirmed. ACTION PARTIALLY MET

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