Announced Care Inspection Report
1 August 2017

Ballybot Dental Surgery Limited

Type of Service: Independent Hospital (IH) - Dental Treatment
Address: 25 Patrick Street, Newry BT35 8EB
Tel No: 028 3026 3326
Inspector: Emily Campbell

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 three registered places. The practice provided private and NHS dental care and treatment.

3.0 Service details

Registered organisation/registered provider: Ballybot Dental Surgery Limited **Responsible Individual:** Ms Morna Baxter	**Registered manager:** Ms Morna Baxter
Person in charge of the service at the time of inspection: Ms Morna Baxter	**Date manager registered:** 30 May 2012
Categories of care: Independent Hospital (IH) – Dental Treatment	**Number of registered places:** 3

4.0 Inspection summary

An announced inspection took place on 1 August 2017 from 10:00 to 13:50.

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 in all four domains. These related to patient safety in respect of staff induction, the management of medical emergencies, decontamination and management of the environment. Other examples included health promotion and engagement to enhance the patients' experience.

Nine areas for improvement have been identified, one against the regulations in relation to radiology and eight against the standards. Two areas for improvement against the standards have been identified for the second time in relation to further development of the recruitment policy and the fire risk assessment. Four areas have been identified in relation to staff appraisal, training, professional registration monitoring and maintaining the staff register. A further two areas have been identified in relation to safeguarding children training and the development of a policy for prescription pad use and security. These matters have an impact on quality assurance and good governance. It is important these are kept under review to ensure improvements are sustained.

Patients who submitted questionnaire responses indicated a high level of satisfaction with the services provided in Ballybot Dental Surgery.

The findings of this report will provide the practice with the necessary information to assist them to fulfil their responsibilities, 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	1	8

Details of the Quality Improvement Plan (QIP) were discussed with Ms Morna Baxter, 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 23 August 2016

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 23 August 2016.

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 and staff 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 Ms Morna Baxter, registered person, an associate dentist, a dental nurse and a decontamination assistant. 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 the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 23 August 2016

The most recent inspection of the practice was an announced care inspection.

The completed QIP was returned and approved by the care inspector.

6.2 Review of areas for improvement from the last care inspection dated 23 August 2016

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Minimum Standards for Dental Care and Treatment (2011)		**Validation of compliance**
Recommendation 1 **Ref**: Standard 11.3 **Stated:** First time	Induction programmes should be further developed to include specific topics to be covered as applicable to the role.	**Met**
	Action taken as confirmed during the inspection: Ms Baxter confirmed that induction templates had been further developed to include specific topics to be covered as applicable to the role. Review of induction records of three staff recruited since the previous inspection evidenced this.	

Area for improvement 2 **Ref**: Standard 11.1 **Stated:** First time	The recruitment policy should be further developed to include the following: • Issuing of contracts of employment or agreement • Documents to be obtained in respect of new staff prior to commencing work in the practice, namely: proof of identification including a recent photograph; physical and mental health assessment; two written references, one of which should be from the most recent/current employer; criminal conviction declaration; full employment history including dates, reasons for leaving and an explanation of any gaps in employment; evidence of qualifications, if applicable; information regarding General Dental Council (GDC) registration, if applicable; and that AccessNI disclosure checks are at enhanced level. It was suggested that the documents to be obtained in respect of new staff could be appended to the policy.	**Not met**
	Action taken as confirmed during the inspection: This area for improvement has not been addressed and was stated for the second time.	
Area for improvement 3 **Ref**: Standard 12.4 **Stated:** Second time	It is recommended that the availability of an automated external defibrillator (AED) should be reviewed. Ms Baxter should seek advice and guidance from her medico-legal advisor in this regard. Advice as provided by the medico-legal advisor should be actioned. Confirmation should be provided to RQIA that an AED is readily available.	**Met**
	Action taken as confirmed during the inspection: Ms Baxter confirmed that the practice now have timely access to an AED from a nearby dental practice and staff have been provided with training in its use. Ms Baxter also advised that she has recently ordered an AED for the practice.	

Area for improvement 4 **Ref**: Standard 12.3 **Stated:** First time	Arrangements should be established to ensure that management of medical emergencies training is provided on an annual basis.	**Met**
	Action taken as confirmed during the inspection: Review of documentation evidenced that management of medical emergencies training was provided in November 2016. Ms Baxter confirmed that the training has been scheduled to be delivered again in September 2017 and annually thereafter.	
Area for improvement 5 **Ref**: Standard 13 **Stated:** First time	Compliance with Health Technical Memorandum (HTM) 01-05 should be audited on a six monthly basis, using the Infection Prevention Society (IPS) audit tool and an action plan devised to address any shortfalls in compliance.	**Met**
	Action taken as confirmed during the inspection: Review of IPS HTM 01-05 audits evidenced they have been carried out six monthly.	
Area for improvement 6 **Ref**: Standard 14.2 **Stated:** First time	The exterior covering of the drop down support bar in the disabled toilet should be made right.	**Met**
	Action taken as confirmed during the inspection: Observations made evidenced that a new down support bar has been installed in the disabled toilet	
Area for improvement 7 **Ref**: Standard 14.2 **Stated:** First time	Arrangements should be established to ensure the heating boiler is serviced on a regular basis.	**Met**
	Action taken as confirmed during the inspection: Review of documentation confirmed that the heating boiler had been serviced on 22 October 2016 and Ms Baxter confirmed that arrangements have been established for it to be serviced annually.	

Area for improvement 8 **Ref**: Standard 12.5 **Stated:** First time	Fire safety awareness training should be provided on an annual basis.	**Met**
	Action taken as confirmed during the inspection: Ms Baxter and staff advised that fire safety awareness training had been provided and Ms Baxter confirmed this would be provided annually. Training records were not available in this regard for all staff. This matter is discussed further in section 6.4 of the report.	
Area for improvement 9 **Ref**: Standard 14.2 **Stated:** First time	The fire risk assessment should be further developed. Advice can be sought from the Northern Ireland Fire and Rescue Service and the Health and Safety Executive Northern Ireland.	**Not met**
	Action taken as confirmed during the inspection: Ms Baxter advised that she contacted an external contractor to carry out a fire risk assessment in October 2016; however, they did not complete the risk assessment until 27 July 2017 and she is awaiting the report. Documentary evidence was available in this regard. This area for improvement has not been addressed and is stated for a 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

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

Induction programme templates were in place relevant to specific roles and responsibilities. A sample of three evidenced that induction programmes had been completed when new staff joined the practice.

Ms Baxter advised during the previous inspection that appraisals had been undertaken informally and that a formal process for appraisal had been established. However, these have not yet taken place. An area for improvement against the standards has been identified in this regard. Appraisal templates were available for inspection.

Staff confirmed that they keep up to date with the General Dental Council (GDC) continuing professional development (CPD) and other mandatory training. Although some training records were available, there was no overview in place to ensure that all staff receive appropriate training to fulfil the duties of their role. An area for improvement against the standards has been identified in this regard. Training records should also be retained of any training provided.

A review of records evidenced that the General Dental Council (GDC) registration status was monitored in respect of associate dentists. Some dental nursing staff have provided evidence of their GDC registration renewal; however, there was no system in place to monitor that all clinical staff have up to date registration with the GDC. An area for improvement against the standards was identified in this regard.

A system was in place to review the professional indemnity of all clinical staff.

Recruitment and selection

A review of the submitted staffing information and discussion with Ms Baxter confirmed that three staff have been recruited since the previous inspection. A review of the personnel files for these staff demonstrated that all the relevant information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 has been sought and retained.

As discussed previously, an area for improvement has been identified for the second time in relation to further development of the recruitment policy.

A staff register was in place; however, on review, it was identified that staff names were removed from the register when they left the practice. Ms Baxter was advised that the staff register is a live document which should be kept updated, entries should not be deleted and the date of leaving entered. An area for improvement against the standards has been identified in this regard.

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.

Ms Baxter confirmed that all clinical staff have received safeguarding adults at risk of harm training provided by NIMDTA on 5 April 2017 and that all clinical and non-clinical staff completed online training in April 2017. It was agreed that Ms Baxter would check if her training, as the safeguarding lead, was provided at Level 2 in keeping with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016).

Ms Baxter advised that staff have not completed safeguarding children training in the last two years as outline in the Minimum Standards for Dental Care and Treatment 2011. An area for improvement against the standards was identified in this regard. As discussed previously, records of training should be retained.

Policies and procedures were in place for the safeguarding and protection of adults and children at risk of harm. An area for improvement was identified that the safeguarding adults policy is further developed to reflect the regional guidance issued in July 2015.

The policies included the types and indicators of abuse and distinct referral pathways in the event of a safeguarding issue arising with an adult or child. The relevant contact details for onward referral to the local Health and Social Care Trust should a safeguarding issue arise were included.

Ms Baxter confirmed that copies of the regional policy entitled 'Co-operating to safeguard children and young people in Northern Ireland' (March 2016) and the regional guidance document entitled 'Adult Safeguarding Prevention and Protection in Partnership' (July 2015) were both available on the computer for staff reference.

A copy of the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy was forwarded to the practice by email following the inspection.

Management of medical emergencies

A review of medical emergency arrangements evidenced that emergency medicines were provided in keeping with the British National Formulary (BNF). Emergency equipment as recommended by the Resuscitation Council (UK) guidelines was retained, with the exception of an AED. As discussed previously, the practice have access to an AED from a nearby dental practice and an AED has been ordered for the practice. 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 documentation evidenced that management of medical emergencies is included in the induction programme and training was provided in November 2016. Ms Baxter confirmed that the training has been scheduled to be delivered again in September 2017 and annually thereafter.

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 was available; this was not reviewed during the inspection. Protocols were in place for staff reference outlining the local procedure for dealing with the various medical emergencies.

Infection prevention control and decontamination procedures

In general 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. Some cabinetry in surgery 1 was observed to be warped and Ms Baxter confirmed that this surgery will be refurbished in the near future. Staff were observed to be adhering to best practice in terms of the uniform and hand hygiene policies.

Discussion with staff demonstrated that they had an understanding of infection prevention and control policies and procedures and were aware of their roles and responsibilities. Staff

confirmed that they have received training in infection prevention and control and decontamination in keeping with best practice.

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

A decontamination room separate from patient treatment areas and dedicated to the decontamination process was available. Appropriate equipment, including a washer disinfector and two steam sterilisers, has been provided to meet the practice requirements. A review of documentation evidenced that equipment used in the decontamination process has been appropriately validated. The practice also have an ultrasonic cleaner which is not in use. Ms Baxter confirmed that the ultrasonic cleaner would not be brought back into use, if at all, until it has been 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 June 2017.

A range of policies and procedures were in place in relation to decontamination and infection prevention and control. These were not reviewed during the inspection.

Radiography

The practice has three surgeries, each of which has an intra-oral x-ray machine. In addition there is an orthopan tomogram machine (OPG), which is located in a separate room.

A dedicated radiation protection file containing the relevant local rules, employer's procedures and other additional information was retained. The following issues were identified on review of the radiation protection file:

- Some clinical staff have not been entitled and authorised by the radiation protection supervisor (RPS) for their relevant duties.
- Some clinical staff have not signed to confirm they have read and understood the local rules.
- X-ray quality grading audits were not undertaken six monthly.

An area for improvement under the regulation was identified in this regard.

It was evidenced that measures taken to optimise dose exposure included the use of rectangular collimation and digital x-ray processing. This will be further enhanced by undertaking x-ray quality grading audits. X-ray justification and clinical evaluation recording audits are carried out annually.

A copy of the local rules was on display near each x-ray machine and staff spoken with demonstrated sound knowledge of the local rules and associated practice.

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

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

Environment

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

Cleaning schedules were in place for all areas and a colour coded cleaning system was in place.

Arrangements are in place for maintaining the environment. This included risk assessment review, portable appliance testing, fire safety equipment servicing, boiler servicing and air conditioning servicing.

A legionella risk assessment was in place and water temperature is monitored and recorded as recommended.

Staff demonstrated that they were aware of the action to take in the event of a fire and fire drills were carried out on a regular basis. As discussed previously, Ms Baxter and staff confirmed that fire safety awareness training has been provided, however, training records were not retained and this matter has been identified as an area for improvement.

As discussed previously, an area for improvement has been identified for the second time in relation to further development of the fire risk assessment.

The compressor and sterilisers have been inspected under the written scheme of examination of pressure vessels on 26 August 2016.

Ms Baxter confirmed that robust arrangements are in place for the management of prescription pads/forms, to reduce the risk of prescription theft and misuse. However a written policy and procedure has not been established in this regard as directed by the Health and Social Care Board (HSCB). An area for improvement against the standards has been identified in this regard. Copies of correspondence issued to dental practices by the HSCB in March 2017 were emailed to the practice on the afternoon of the inspection.

Patient and staff views

Twenty patients submitted questionnaire responses to RQIA. All indicated that they felt safe and protected from harm and that they were very satisfied with this aspect of care. Comments provided included the following:

- "Completely safe."
- "Very protected."
- "Very safe."
- "Yes and I always have."

Eight staff submitted questionnaire responses. All indicated that they felt that patients are safe and protected from harm. Seven staff indicated they were very satisfied with this aspect of care and one indicated they were satisfied. Staff spoken with during the inspection concurred with this. No comments were included in submitted questionnaire responses.

Areas of good practice

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

Areas for improvement

Staff appraisal should be provided on an annual basis and records retained.

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

A system should be established to review the General Dental Council (GDC) registration status of all clinical staff.

The recruitment policy should be further developed.

The staff register should be kept updated, details of staff who leave the service should not be deleted and the dates of leaving entered.

Safeguarding children training should be provided for all staff and should be updated every two years. Training records should be retained.

All clinical staff should be entitled and authorised by the RPS, clinical staff should sign to confirm they have read the local rules and x-ray quality grading audits should be undertaken six monthly.

The fire risk assessment should be further developed.

A written policy and procedure to reduce the risk of prescription theft or misuse should be developed.

	Regulations	Standards
Total number of areas for improvement	1	8

6.5 Is care effective?

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

Clinical records

Ms Baxter and staff spoken with confirmed that clinical records are updated contemporaneously during each patient's treatment session in accordance with best practice.

Routine dental examinations include a review of medical history, a check for gum disease and oral cancers and that treatment plans are developed in consultation with patients. It was confirmed that patients are informed about the cost of treatments, choices and options. Written treatment plans including estimated costs are provided to patients as appropriate.

Both manual and computerised records are maintained; patient care records are retained electronically. 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, data protection and confidentiality and consent. These were not reviewed during the inspection.

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

Health promotion

The practice has a strategy for the promotion of oral health and hygiene. Ms Baxter and staff confirmed that oral health, including smoking cessation advice, is actively promoted on an individual level with patients during their consultations, and a hygienist service is available. Models are available for demonstration purposes to promote good oral hygiene.

Audits

There were arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to patients at appropriate intervals which included:

- x-ray justification and clinical evaluation recording
- IPS HTM 01-05 compliance
- Patient satisfaction
- review of complaints/accidents/incidents

As discussed previously x-ray quality grading audits should be carried out six monthly. It was suggested that the auditing programme could be further developed to include audits on areas such as record keeping and clinical waste.

Communication

Ms Baxter and staff confirmed that arrangements are in place for onward referral in respect of specialist treatments.

Staff meetings are held every three to four months and Ms Baxter established a system whereby regular memo updates are provided to staff which they sign to confirm receipt of.

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

Patient and staff views

All patients who submitted questionnaire responses indicated that they get the right care, at the right time and with the best outcome for them and that they were very satisfied with this aspect of care. Comments provided included the following:

- "The best care."
- "Best care."
- "Yes."

All submitted staff questionnaire responses indicated that they felt that patients get the right care, at the right time and with the best outcome for them and that they were very satisfied with this aspect of care. Staff spoken with during the inspection concurred with this. No comments were included in submitted questionnaire responses.

Areas of good practice

There were examples of good practice found in relation to the management of clinical records, health promotion strategies and ensuring effective communication between patients and staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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 observed to converse with patients and conduct telephone enquiries in a professional and confidential manner.

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

It was confirmed that treatment options, including the risks and benefits, were discussed with each patient. This ensured patients understood what treatment is available to them and can make an informed choice. Ms Baxter advised that she is currently developing a treatment co-ordinator role whereby the treatment co-ordinator will discuss treatment options and plans with the patient following discussion with a dentist, to ensure that the patient has a clear understanding of what is involved in the various treatment options offered.
Staff demonstrated how consent would be obtained.

The practice undertakes patient satisfaction surveys on an annual basis. However, review of the most recent patient satisfaction survey identified that only four patients provided questionnaire responses. The current process for obtaining patients' views was discussed and

it was suggested that the time period is extended over a number of days as opposed to one day to proactively distribute patient satisfaction questionnaires.

Patient and staff views

All patients who submitted questionnaire responses indicated that they are treated with dignity and respect and are involved in decision making affecting their care. Nineteen patients indicated that they were very satisfied with this aspect of care and one indicated that they were satisfied. Comments provided included the following:

- "100% dignity and respect."
- "Free to make choices."
- "Staff are always very nice and respectful."

All submitted staff questionnaire responses indicated that they felt that patients are treated with dignity and respect and are involved in decision making affecting their care. All staff indicated that they were very satisfied with this aspect of care. Staff spoken with during the inspection concurred with this. The following comment was provided:

- "Every effort is made by every staff member to make patients feel relaxed, comfortable and overall important to the practice. Their comfort is a priority and the utmost effort is made to accommodate patients."

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 who to speak to if they had a concern. Staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

There was a 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, dated and systematically reviewed on an annual basis. Staff spoken with were aware of the policies and how to access them.

Arrangements were in place to review risk assessments.

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.

Ms Baxter confirmed that arrangements were in place to monitor, audit and review the effectiveness and quality of care delivered to patients at appropriate intervals. If required an action plan is developed and embedded into practice to address any shortfalls identified during the audit process. However, a number of issues were identified within the "Is care safe?" domain which have an impact on quality assurance and good governance. Nine areas for improvement have been made, two of which are stated for the second time, in order to progress improvement in identified areas. It is important these are kept under review to ensure improvements are sustained.

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

Ms Baxter demonstrated a clear understanding of her role and responsibility in accordance with legislation. It was confirmed that statement of purpose and patient guide are kept under review, revised and updated when necessary and available on request.

The RQIA certificate of registration was not on display at the commencement of the inspection, as it had been removed for redecoration, however, this was addressed during the inspection. Ms Baxter is aware that the certificate should remain on display.

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

Patient and staff views

All patients who submitted questionnaire responses indicated that they felt that the service is well led and that they were very satisfied with this aspect of the service. Comments provided included the following:

- "Excellent service."
- "Very happy, really satisfied."

- "Everyone always informs me of any treatment I need and nurses, dentists receptionist are always very accommodating."

All submitted staff questionnaire responses indicated that they felt that the service is well led and that they were very satisfied with this aspect of the service. Staff spoken with during the inspection concurred with this. The following comment was provided:

- "The practice is very well led. Dr Baxter is very approachable and with the support of all her staff, the surgery is run very well."

Areas of good practice

There were examples of good practice found in relation to management of complaints and incidents and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Morna Baxter, 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 to Independent.Healthcare@rqia.org.uk for assessment by the inspector.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

Quality Improvement Plan

Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 15 (1) (b) **Stated:** First time **To be completed by:** 1 September 2017	The registered person shall ensure that: • all clinical staff are entitled and authorised by the radiation protection supervisor (RPS) for their relevant duties. • clinical staff sign to confirm they have read and understood the local rules. • x-ray quality grading audits are undertaken six monthly. Ref: 6.4
	Response by registered person detailing the actions taken: Radiology file updated and Audits planned to include new staff members.
Action required to ensure compliance with The Minimum Standards for Dental Care and Treatment (2011)	
Area for improvement 1 **Ref**: Standard 11 **Stated:** First time **To be completed by:** 1 November 2017	The registered person shall ensure that staff appraisal is provided on an annual basis and records retained. Ref: 6.4
	Response by registered person detailing the actions taken: Staff appraisals planned for October 2017 and records of these will be retained.
Area for improvement 2 **Ref**: Standard 11.4 **Stated:** First time **To be completed by:** 1 November 2017	The registered person shall establish a system to ensure that all staff receive appropriate training to fulfil the duties of their role. Training records should also be retained of any training provided. Ref: 6.4
	Response by registered person detailing the actions taken: A register of all training provided will be kept and training will be tailored to the duties of the individuals position.
Area for improvement 3 **Ref**: Standard 11 **Stated:** First time **To be completed by:** 1 September 2017	The registered person shall establish a system to review the General Dental Council (GDC) registration status of all clinical staff. Ref: 6.4
	Response by registered person detailing the actions taken: Our staff register has been updated accordingly and each renewal date is now in Dr Baxter's diary with reminders in place for to check the renewals throughout the year.

Area for improvement 4 **Ref**: Standard 11.1 **Stated:** Second time **To be completed by:** 1 October 2017	The recruitment policy should be further developed to include the following: • Issuing of contracts of employment or agreement • Documents to be obtained in respect of new staff prior to commencing work in the practice, namely: proof of identification including a recent photograph; physical and mental health assessment; two written references, one of which should be from the most recent/current employer; criminal conviction declaration; full employment history including dates, reasons for leaving and an explanation of any gaps in employment; evidence of qualifications, if applicable; information regarding General Dental Council (GDC) registration, if applicable; and that AccessNI disclosure checks are at enhanced level. It was suggested that the documents to be obtained in respect of new staff could be appended to the policy. Ref: 6.2, 6.4
	Response by registered person detailing the actions taken: The recruitment policy and procedure had been developed to include all of the above, including the document list required appended to the policy as advised.
Area for improvement 5 **Ref**: Standard 11 **Stated:** First time **To be completed by:** 1 September 2017	The registered person shall ensure the staff register is kept updated, details of staff who leave the service should not be deleted and the dates of leaving entered. Ref: 6.4
	Response by registered person detailing the actions taken: Our staff register has been updated accordingly and each renewal date is now in Dr Baxter's diary with reminders in place for to check the renewals throughout the year.
Area for improvement 6 **Ref**: Standard 15.3 **Stated:** First time **To be completed by:** 1 November 2017	The registered person shall ensure that safeguarding children training is provided and is updated every two years as outline in the Minimum Standards for Dental Care and Treatment 2011. Training records should be retained. Ref: 6.4
	Response by registered person detailing the actions taken: Dr Baxter is to arrange Level 2 training as recommended.

Area for improvement 7 **Ref**: Standard 14.2 **Stated:** Second time **To be completed by:** 15 September 2017	The fire risk assessment should be further developed. Advice can be sought from the Northern Ireland Fire and Rescue Service and the Health and Safety Executive Northern Ireland. Ref: 6.2, 6.4
	Response by registered person detailing the actions taken: Thei fire risk assessment has been carried out Friday 1st September 2017.
Area for improvement 8 **Ref**: Standard 14.7 **Stated:** First time **To be completed by:** 1 November 2017	The registered person shall develop a written policy and procedure to reduce the risk of prescription theft or misuse. Ref: 6.4
	Response by registered person detailing the actions taken: Our prescription policy and procedure has been updated to comply with current best practice with particular reference to reduction of the risk of prescription theft or misuse.

Please ensure this document is completed in full and returned to Independent.Healthcare@rqia.org.uk from the authorised email address*

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