# Announced Care Inspection Report
# 10 February 2017

# Clogher Valley Dental Care (Clogher)

**Type of service: Independent Hospital (IH) – Dental Treatment**
**Address: 25 Main Street, Clogher, BT76 0AA**
**Tel no: 028 8554 8100**
**Inspectors: Emily Campbell and Stephen O'Connor**

## 1.0 Summary

An announced inspection of Clogher Valley Dental Care, Clogher, took place on 10 February 2017 from 14:00 to 16:25.

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

Mr Richard Graham, registered person, operates two dental practices; Clogher Valley Dental Care, Clogher, and Clogher Valley Dental Care, Fivemiletown.

**Is care safe?**

Observations made, review of documentation and discussion with Mr Richard Graham, registered person, and staff demonstrated that further development is needed to ensure that care provided to patients is safe and avoids and prevents harm. Areas reviewed included staffing, recruitment and selection, safeguarding, management of medical emergencies, infection prevention control and decontamination, radiology and the general environment. One requirement and 10 recommendations were made to progress improvement. The requirement was made in relation to validation of decontamination equipment. Five recommendations were made in relation to the staff register, staff appraisal, training records, recruitment records and storage of AccessNI information. Three recommendations were made in relation to the safeguarding policy, medical emergency medications and radiology, and two recommendations were made in relation to infection prevention and control and decontamination.

**Is care effective?**

Observations made, review of documentation and discussion with Mr Graham and staff demonstrated that systems and processes were in place to ensure that care provided in the establishment was effective. Areas reviewed included clinical records, health promotion, audits and communication. A recommendation was made that minutes of staff meetings are retained.

**Is care compassionate?**

Observations made, review of documentation and discussion with Mr Graham and staff demonstrated that arrangements are in place to promote patients' dignity, respect and involvement in decision making. No requirements or recommendations have been made.

**Is the service well led?**

Information gathered during the inspection evidenced that, in general, there was effective leadership and governance arrangements in place which creates a culture focused on the needs of patients in order to deliver safe, effective and compassionate care. Areas reviewed included organisational and staff working arrangements, the arrangements for policy and risk assessment reviews, the arrangements for dealing with complaints, incidents and alerts, insurance arrangements and the registered provider's understanding of their role and responsibility in accordance with legislation. Implementation of the requirement and recommendations made under the Is Care Safe domain will further enhance the governance arrangements in the practice. One recommendation was made to further develop the complaints polices under the well led domain.

This inspection was underpinned by The Independent Health Care Regulations (Northern Ireland) 2005, The Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011 and the Department of Health, Social Services and Public Safety (DHSSPS) Minimum Standards for Dental Care and Treatment (2011).

While we assess the quality of services provided against regulations and associated DHSSPS care standards, we do not assess the quality of dentistry provided by individual dentists.

## 1.1 Inspection outcome

| | Requirements | Recommendations |
|---|---|---|
| **Total number of requirements and recommendations made at this inspection** | 1 | 12 |

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mr Richard Graham, 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.

## 1.2 Actions/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 21 August 2015.

## 2.0 Service details

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| **Registered organisation/registered person:**<br>Mr Richard Graham | **Registered manager:**<br>Mr Richard Graham |
| **Person in charge of the practice at the time of inspection:**<br>Mr Richard Graham | **Date manager registered:**<br>04 November 2013 |
| **Categories of care:**<br>Independent Hospital (IH) – Dental Treatment | **Number of registered places:**<br>2 |

## 3.0 Methods/processes

Questionnaires were provided to patients and staff prior to the inspection by the practice on behalf of the RQIA. Prior to inspection we analysed the following records: staffing information, complaints declaration and returned completed patient and staff questionnaires. During the inspection the inspectors met with Mr Graham, registered person, and two dental nurses. A tour of the premises was also undertaken.

Records were examined during the inspection in relation to the following areas:

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

## 4.0 The inspection

### 4.1 Review of requirements and recommendations from the most recent inspection dated 21 October 2016

The most recent inspection of the establishment was an announced premises inspection which was convened to ascertain that the Dental Unit Water Lines in the dental practice were sterilised and maintained in accordance with Department of Health, Social Services and Public Safety (DHSSPS) Sustainable Development Engineering Branch (SDEB) recommendations. The estates inspector confirmed that there are no outstanding issues relating to this matter.

### 4.2 Review of requirements and recommendations from the last care inspection dated 21 August 2015

| Last care inspection recommendations | | Validation of compliance |
|---|---|---|
| **Recommendation 1**<br><br>**Ref**: Standard 13<br><br>**Stated:** First time | It is recommended that advice and guidance should be sought from the Department of Health, Social Services and Public Safety (DHSSPS) Sustainable Development Engineering Branch (SDEB) regarding the use of a disinfection procedure for the management of dental unit water lines (DUWLs).<br>Any recommendations made by SDEB should be implemented. | **Met** |
| | **Action taken as confirmed during the inspection**: Following the previous care inspection and Mr Graham's response to this recommendation, an estates inspection was requested to follow up on this matter. Following advice from the estates inspector and the Health and Safety Executive it was agreed that DUWLs would be disinfected. Mr Graham and staff confirmed that DUWLs are actively being disinfected. | |

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| **Recommendation 2**<br><br>**Ref**: Standard 12.4<br><br>**Stated:** First time | It is recommended that oropharyngeal airways sizes 0 – 4 should be replaced and included in the monthly checking procedure. | **Met** |
| | **Action taken as confirmed during the inspection**: Review of the medical emergency equipment confirmed that this recommendation has been addressed. | |
| **Recommendation 3**<br><br>**Ref**: Standard 11.1<br><br>**Stated:** First time | It is recommended that a staff register is developed containing staff details including, name, date of birth, position; dates of employment; and details of professional qualification and professional registration with the GDC, where applicable. This should include associate dentists or other self-employed persons working in the practice. | **Partially Met** |
| | **Action taken as confirmed during the inspection**: A staff register had been developed incorporating staff details for both the Clogher and Fivemiletown practices. The dates of commencement of employment identified the month and year only and there was nowhere to insert the dates of leaving.<br><br>A recommendation was made that the staff register is further developed to include the exact dates of commencement of employment and to facilitate entry of the date of leaving employment. | |

## 4.3 Is care safe?

**Staffing**

Two dental surgeries are in operation in this practice. Discussion with staff indicated 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.

Mr Graham advised that staff appraisal is undertaken, however, this is not formalised. A recommendation was made in this regard. Appraisal should be carried out with each staff member on an annual basis and records retained. Staff confirmed that they felt supported and involved in discussions about their personal development.

There was no overview in place to ensure that all staff receive appropriate training to fulfil the duties of their role and a recommendation was made in this regard. Training records should also be retained of any training provided in house. Mr Graham was advised that the training overview will also link with the appraisal process to identify specific training needs as part of the staff member's personal development. Staff confirmed that they are provided with training opportunities and keep up to date with mandatory training and their General Dental Council (GDC) continuing professional development (CPD).

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

**Recruitment and selection**

Staff recruitment for the Clogher and Fivemiletown practices is managed from the Clogher practice and staff are recruited to provide cover across both practices. Staff personnel files are retained at this practice. A review of the submitted staffing information and discussion with Mr Graham confirmed that two staff have been recruited since the previous inspection.

Review of the personnel files for these staff demonstrated that all the relevant information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 has been sought and retained with the exception of the following:

- proof of identity, including a recent photograph
- criminal conviction declaration

A recommendation was made in this regard. A copy of a criminal conviction declaration was emailed to Mr Graham on 15 February 2017.

Enhanced AccessNI checks were received prior to new staff commencing employment in keeping with good practice. However, copies of the original disclosure checks were retained in the staff personnel files. The storage of disclosure information is not in keeping with AccessNI's code of practice. A recommendation was made 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 check.

As discussed previously, a staff register had been developed. The dates of commencement of employment identified the month and year only and there was nowhere to insert the dates of leaving. A recommendation was made that the staff register is further developed to include the exact dates of commencement of employment and to facilitate entry of the date of leaving employment.

There was a recruitment policy and procedure available.

**Safeguarding**

Staff spoken with were aware of the types and indicators of abuse and the actions to be taken in the event of a safeguarding issue being identified, including who the nominated safeguarding lead was.

Review of induction templates confirmed that safeguarding is included in the induction programme. As discussed previously training records were not retained, however, Mr Graham and staff confirmed that refresher training was provided in 2016.

A safeguarding children and vulnerable adults policy was available. A recommendation was made that this is further developed to provide a safeguarding children and adults at risk of harm policy and should reflect the new regional guidance Adult Safeguarding Prevention and Protection in Partnership (July 2015) and Co-operating to safeguard children and young people in Northern Ireland (March 2016). Copies of the new regional guidance documents were emailed to Mr Graham on 15 February 2017. On completion of the policy development

staff training should be provided to ensure that staff are aware of the new regional guidance documents and practice policy.

**Management of medical emergencies**

A review of medical emergency arrangements evidenced that emergency medicines were provided in keeping with the British National Formulary (BNF). However, the format of buccal Midazolam retained was not Buccolam, in keeping with the Health and Social care Board (HSCB) guidance. A recommendation was made in this regard. Emergency equipment as recommended by the Resuscitation Council (UK) guidelines was retained with the exception of an automated external defibrillator (AED). Staff advised that they have access to a community AED and Mr Graham confirmed that the AED could be accessed in a timely manner. 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.

Training records in respect of the management of medical emergencies were available. It was confirmed that the management of medical emergencies is included in the induction programme and training is updated on an annual basis in keeping with best practice guidance.

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

It was confirmed that a policy for the management of medical emergencies and protocols outlining the local procedure for dealing with the various medical emergencies were available for staff reference.

**Infection prevention control and decontamination procedures**

Clinical and decontamination areas were tidy and uncluttered and work surfaces were intact and easy to clean. Fixtures, fittings, dental chairs and equipment were free from damage, dust and visible dirt. A non wipeable fabric covered chair was observed in one surgery and a recommendation was made that this should be removed. 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. As discussed previously, training records were not available and a recommendation was made in this regard.

There was a nominated lead who had responsibility for infection control and decontamination in the practice.

A decontamination room separate from patient treatment areas and dedicated to the decontamination process was available. Appropriate equipment, including a washer disinfector and two steam sterilisers, has been provided to meet the practice requirements. A review of documentation evidenced that the sterilisers had been validated in August 2016, however, the washer disinfector had not been validated since August 2015. Mr Graham and staff advised that the washer disinfector has been scheduled to be validated on 17 February 2017. A requirement was made that the washer disinfector should be validated and arrangements established for revalidation to be carried out on an annual basis. A copy of the validation certificate should be submitted to RQIA. Staff advised that dental handpieces are

manually cleaned as they are not compatible with a washer disinfector. Mr Graham should ensure that as new dental handpieces are purchased, they should be processed through the washer disinfector, if compatible with this process.

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.

The Infection Prevention Society (IPS) audit of HTM 01-05 was not available and it was unclear when compliance was last audited. A recommendation was made that compliance with HTM 01-05 should be audited on a six monthly basis. A copy of the IPS audit tool was emailed to Mr Graham on 15 February 2017.

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

**Radiography**

The practice has two surgeries, each of which has an intra-oral x-ray machine.

A dedicated radiation protection file containing the relevant local rules, employer's procedures and other additional information was retained. X-rays are chemically processed and audits of x-ray quality grading and justification and clinical evaluation recording have been carried out. 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 in December 2014 demonstrated that the recommendations made have been addressed. The following issues were identified on review of the radiation protection file:

- not all clinical staff had signed to confirm they had read and understood the local rules
- not all clinical staff had been authorised by the radiation protection supervisor (RPS) for their relevant duties
- training records were not retained

A recommendation was made in this regard.

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

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

**Environment**

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

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

Arrangements are in place for maintaining the environment. This included review of health and safety and control of substances hazardous to health (COSHH) risk assessments, and review of the fire and legionella risk assessments. Fire extinguishers were serviced in October 2016. Staff demonstrated that they were aware of the action to take in the event of a fire.

Pressure vessels had been inspected in keeping with the written scheme of examination of pressure vessels

**Patient and staff views**

Eight patients submitted questionnaire responses to RQIA. All indicated that they felt safe and protected from harm. No comments were included in submitted questionnaire responses.

One staff member submitted a questionnaire response and indicated that they felt that patients are safe and protected from harm. Staff spoken with during the inspection concurred with this. No comments were included in the submitted questionnaire response.

**Areas for improvement**

Staff appraisal should be formalised and records retained.

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

Staff recruitment practice should be further developed to ensure that all the relevant information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 has been sought and retained.

Enhanced AccessNI disclosure certificates should be 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 check.

The staff register should be further developed to include the exact dates of commencement of employment and to facilitate entry of the date of leaving employment.

The safeguarding children and vulnerable adults policy should be further developed to provide a safeguarding children and adults at risk of harm policy to reflect the new regional guidance. On completion of the policy development staff training should be provided to ensure staff are aware of the new regional guidance documents and practice policy.

Buccal Midazolam should be replaced with Buccolam pre-filled syringes.

Fabric covered chairs should not be provided in clinical areas.

The washer disinfector should be validated and arrangements established for revalidation to be carried out on an annual basis. A copy of the validation certificate should be submitted to RQIA.

Compliance with HTM 01-05 should be audited on a six monthly basis using the IPS audit tool.

The radiation protection file should be reviewed and issues identified addressed.

| Number of requirements | 1 | Number of recommendations | 10 |
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## 4.4 Is care effective?

### Clinical records

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

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

Both manual and computerised records are maintained. Patient records are retained in manual format. 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.

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

### Health promotion

There was information and products available in in the practice promoting good oral health and hygiene and the practice takes part in national campaigns such as no smoking and cancer awareness. Two staff are qualified as oral health educators and the practice have provided oral health promotion sessions to local primary and play schools. Mr Graham and staff confirmed that oral health is actively promoted on an individual level with patients during their consultations.

### Audits

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

- x-ray quality grading
- x-ray justification and clinical evaluation recording
- patient satisfaction surveys
- review of complaints/accidents/incidents
- peer review

As discussed, a recommendation was made to audit compliance with HTM 01-05. It was suggested that the auditing process could be further developed through the introduction of audits of clinical record keeping, clinical waste management and hand hygiene. Mr Graham advised that he informally audits clinical records.

**Communication**

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

Staff meetings are held on three to four monthly basis, or more often if required, to discuss clinical and practice management issues. Minutes of staff meetings are not retained and a recommendation was made in this regard. Mr Graham and staff confirmed that meetings also facilitated informal and formal in house training sessions.

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

**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. No comments were included in submitted questionnaire responses.

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

**Areas for improvement**

Minutes of staff meetings should be retained.

| Number of requirements | 0 | Number of recommendations | 1 |
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## 4.5 Is care compassionate?

**Dignity, respect and involvement in decision making**

Staff demonstrated a good understanding of the core values of privacy, dignity, respect and patient choice. Mr Graham and 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. Mr Graham and staff demonstrated how consent would be obtained.

The practice is accessible to patients with a disability with a surgery on the ground floor. An interpreter service is available for patients who require this assistance. Staff advised that they endeavour to accommodate any specific individual needs a patient may have.

The practice undertakes patient satisfaction surveys on an annual basis. Review of the most recent patient satisfaction report demonstrated that the practice pro-actively seeks the views of patients about the quality of treatment and other services provided. Patient feedback whether constructive or critical, is used by the practice to improve, as appropriate. On discussion with Mr Graham, it was confirmed that the patient satisfaction survey incorporates patient's views from both the Clogher and Fivemiletown practices. Mr Graham was advised that separate surveys should be carried out for each practice and the summary reports should identify the number of patients who took part in the survey.

A policy and procedure was in place in relation to confidentiality which included the arrangements for respecting patient's privacy, dignity and providing compassionate care and treatment.

**Patient and staff views**

Seven of the eight patients who submitted questionnaire responses indicated that they are treated with dignity and respect and are involved in decision making affecting their care. One patient did not complete this section of the questionnaire. The following comment was provided in a submitted questionnaire:

- "Very pleasant team, always willing to help."

The submitted staff questionnaire response indicated that they felt that patients are treated with dignity and respect and are involved in decision making affecting their care. Staff spoken with during the inspection concurred with this. No comments were included in the submitted questionnaire response.

**Areas for improvement**

No areas for improvement were identified during the inspection.

| Number of requirements | 0 | Number of recommendations | 0 |
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## 4.6 Is the service well led?

**Management and governance arrangements**

There was a clear organisational structure within the practice and staff were able to describe their roles and responsibilities and were aware of who to speak to if they had a concern. Staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

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 a three yearly basis or more frequently if required. 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. Two complaints policies are in place; one for NHS dental care and treatment and one for private dental care and treatment. The NHS complaints policy referred patients to the Ombudsman, the GDC, the HSCB and RQIA in the event of dissatisfaction and the private complaints policy referred patients to the Dental Complaints Service, the GDC and RQIA. A recommendation was made that both policies are further developed to reflect that in the event of dissatisfaction following the establishment's investigation, patients should only be referred to the Ombudsman and the Dental Complaints Service for NHS and private care respectively. The details of the GDC and the HSCB should be included as agencies that may be utilised within the complaints investigation at local resolution and the details of RQIA should be included as a regulatory body that takes an overview of complaints management.

Staff demonstrated a good awareness of complaints management. A complaints questionnaire was forwarded by RQIA to the practice for completion. The returned questionnaire indicated that no complaints have been received for the period 1 April 2015 to 31 March 2016.

A system was in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies as appropriate. A system was also in place to ensure that urgent communications, safety alerts and notices are reviewed and where appropriate, made available to key staff in a timely manner.

Mr Graham 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. Implementation of the requirements and recommendations made under the Is Care Safe domain will further enhance the governance arrangements in the practice.

A whistleblowing/raising concerns policy was available.

Mr Graham demonstrated a clear understanding of his role and responsibility in accordance with legislation. It was confirmed that the 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 up to date and displayed appropriately.

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

**Patient and staff views**

Seven of the eight patients who submitted questionnaire responses indicated that they felt that the service is well managed. One patient did not complete this section of the questionnaire. The following comment was provided in a submitted questionnaire:

- "Am very happy and confident with Richard at C V Dental Care. He is very gentle and an excellent dentist who will facilitate you if at all possible. Staff are also very pleasant and obliging. Excellent practice."

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

**Areas for improvement**

The complaints policies should be further developed.

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

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mr Richard Graham, registered person, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the dental practice. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

## 5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Independent Health Care Regulations (Northern Ireland) 2005.

## 5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Minimum Standards for Dental Care and Treatment (2011). They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

## 5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to RQIA's office for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

## Quality Improvement Plan

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| **Statutory requirements** | |
| **Requirement 1**<br><br>**Ref**: Regulation 15 (2)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>7 April 2017 | The registered provider must ensure that the washer disinfector is validated and arrangements established for revalidation to be carried out on an annual basis.<br><br>A copy of the validation certificate should be submitted to RQIA upon return of this Quality Improvement Plan (QIP).<br><br>**Response by registered provider detailing the actions taken:**<br>COPY ENCLOSED |
| **Recommendations** | |
| **Recommendation 1**<br><br>**Ref**: Standard 11<br><br>**Stated:** First time<br><br>**To be completed by:**<br>10 May 2017 | Staff appraisal should be formalised and carried out with each staff member on an annual basis. Records should be retained.<br><br>**Response by registered provider detailing the actions taken:**<br>THIS HAS BEEN POINTED OUT TO THE NEW OWNERS |
| **Recommendation 2**<br><br>**Ref**: Standard 11.4<br><br>**Stated:** First time<br><br>**To be completed by:**<br>10 April 2017 | A system should be established to ensure that all staff receive appropriate training to fulfil the duties of their role.<br><br>Training records should also be retained of any training provided in house.<br><br>**Response by registered provider detailing the actions taken:**<br>THIS HAS BEEN POINTED OUT TO THE NEW OWNERS |

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| **Recommendation 3**<br><br>**Ref**: Standard 11.2<br><br>**Stated:** First time<br><br>**To be completed by:**<br>13 February 2017 | Staff recruitment practice should be further developed to ensure that all the relevant information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 has been sought and retained to include the following:<br><br>• proof of identity, including a recent photograph<br>• criminal conviction declaration |
| | **Response by registered provider detailing the actions taken:**<br><br>THIS HAS BEEN POINTED OUT TO THE NEW OWNER) |
| **Recommendation 4**<br><br>**Ref**: Standard 11.2<br><br>**Stated:** First time<br><br>**To be completed by:**<br>13 February 2017 | Enhanced AccessNI disclosure certificates should be disposed of in keeping with AccessNI's code of practice and a record retained of:<br><br>• the name of the individual<br>• the date the check was applied for<br>• the date the check was received<br>• the unique identification number<br>• the outcome of the check. |
| | **Response by registered provider detailing the actions taken:**<br><br>THIS HAS BEEN DONE |
| **Recommendation 5**<br><br>**Ref**: Standard 11<br><br>**Stated:** First time<br><br>**To be completed by:**<br>10 April 2017 | The staff register should be further developed to include the exact dates of commencement of employment and to facilitate entry of the date of leaving employment. |
| | **Response by registered provider detailing the actions taken:**<br><br>THIS HAS BEEN POINTED OUT TO THE NEW OWNER) |

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| **Recommendation 6**<br><br>**Ref**: Standard 15.3<br><br>**Stated:** First time<br><br>**To be completed by:**<br>10 May 2017 | The safeguarding children and vulnerable adults policy should be further developed to provide a safeguarding children and adults at risk of harm policy.<br><br>The policy should reflect the new regional guidance Adult Safeguarding Prevention and Protection in Partnership (July 2015) and Co-operating to safeguard children and young people in Northern Ireland (March 2016).<br><br>On completion of the policy development staff training should be provided to ensure that staff are aware of the new regional guidance documents and practice policy. |
| | **Response by registered provider detailing the actions taken:**<br><br>THE BDA ARE DEVELOPING NEW POLICIES FOR USE BY MEMBERS. |
| **Recommendation 7**<br><br>**Ref**: Standard 12.4<br><br>**Stated:** First time<br><br>**To be completed by:**<br>10 April 2017 | Buccal Midazolam should be replaced with Buccolam pre-filled syringes in keeping with the Health and Social Care Board (HSCB) guidance. |
| | **Response by registered provider detailing the actions taken:**<br><br>THE BUCCAL MIDAZOLAM IS BEING REPLACED WHEN IT REACHES THE EXPIRY DATE |
| **Recommendation 8**<br><br>**Ref**: Standard 13..2<br><br>**Stated:** First time<br><br>**To be completed by:**<br>17 February 2017 | Fabric covered chairs should not be provided in clinical areas. |
| | **Response by registered provider detailing the actions taken:**<br><br>FABRIC CHAIRS ARE NOT PROVIDED IN THE CLINICAL AREA. |

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| **Recommendation 9**<br><br>**Ref**: Standard 13..2<br><br>**Stated:** First time<br><br>**To be completed by:**<br>10 April 2017 | Compliance with Health Technical Memorandum (HTM) 01-05 should be audited on a six monthly basis using the Infection Prevention Society (IPS) audit tool.<br><br>**Response by registered provider detailing the actions taken:**<br><br>THIS IS BEING DONE BY THE NEW OWNERS |
| **Recommendation 10**<br><br>**Ref**: Standard 8.3<br><br>**Stated:** First time<br><br>**To be completed by:**<br>10 March 2017 | The radiation protection file should be reviewed and the following issues addressed:<br><br>• all clinical staff should sign to confirm they had read and understood the local rules<br>• all clinical staff should be authorised by the radiation protection supervisor (RPS) for their relevant duties<br>• training records should be retained<br><br>**Response by registered provider detailing the actions taken:**<br><br>THIS IS BEING DONE BY THE NEW OWNERS |
| **Recommendation 11**<br><br>**Ref**: Standard 11.6<br><br>**Stated:** First time<br><br>**To be completed by:**<br>10 March 2017 | Minutes of staff meetings should be retained.<br><br>**Response by registered provider detailing the actions taken:**<br><br>THIS IS BEING DONE BY THE NEW OWNERS |

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| **Recommendation 12**<br><br>**Ref**: Standard 9.1<br><br>**Stated:** First time<br><br>**To be completed by:**<br>10 May 2017 | The complaints policies should be further developed to reflect that in the event of dissatisfaction following the establishment's investigation, patients should only be referred to the Ombudsman and the Dental Complaints Service for NHS and private care respectively. The details of the GDC and the HSCB should be included as agencies that may be utilised within the complaints investigation at local resolution and the details of RQIA should be included as a regulatory body that takes an overview of complaints management. |
| | **Response by registered provider detailing the actions taken:**<br><br>THIS IS BEING DONE BY THE NEW OWNERS |

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