Announced Care Inspection Report
30 January 2017

Gentle Dentistry Omagh

Type of service: Independent Hospital (IH) – Dental Treatment
Address: 6 New Brighton Terrace, Kevlin Road, Omagh, BT78 1LL
Tel no: 028 8224 2218
Inspector: Emily Campbell

1.0 Summary

An announced inspection of Gentle Dentistry Omagh took place on 30 January 2017 from 9:50 to 13:15.

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

Is care safe?

Observations made, review of documentation and discussion with Mr Marius Monaghan, 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 nine recommendations were made. The requirement was made to review the radiation protection file and implement actions as identified. One recommendation was made in relation to retaining an overview of staff training. Three recommendations were made in relation to recruitment and selection arrangements, two of which were stated for the second time. Two recommendations were made to update the safeguarding policy and provide staff training and one recommendation was made for the second time in relation to the development of a management of a medical emergency policy. 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 Monaghan and staff demonstrated that in general 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 should be retained.

Is care compassionate?

Observations made, review of documentation and discussion with Mr Monaghan and staff demonstrated that arrangements are in place to promote patients' dignity, respect and involvement in decision making. A recommendation was made that the patient satisfaction survey process is further developed.

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, Effective and Compassionate domains will

further enhance the governance arrangements in the practice. No requirements or recommendations have been made 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	11

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mr Marius Monaghan, 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 27 January 2016.

2.0 Service details

Registered organisation/registered person: Mr Marius Monaghan	**Registered manager:** Mr Marius Monaghan
Person in charge of the practice at the time of inspection: Mr Marius Monaghan	**Date manager registered:** 16 September 2013
Categories of care: Independent Hospital (IH) – Dental Treatment	**Number of registered places:** 3

3.0 Methods/processes

Questionnaires were provided to patients and staff prior to the inspection by the practice on behalf of the RQIA. Prior to inspection we analysed the following records: staffing information, complaints declaration and returned completed patient and staff questionnaires.

During the inspection the inspector met with Mr Monaghan, a dental nurse and a receptionist. A tour of the premises was also undertaken.

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

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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 15 November 2016

The most recent inspection of the establishment was an announced premises inspection. The completed QIP was returned and approved by the estates inspector. This QIP will be validated by the estates inspector at the next premises inspection.

Review of documentation and discussion with staff evidenced that fire drills and fire safety awareness training had been undertaken and water temperatures were monitored and recorded in keeping with the legionella risk assessment, as recommended by the estates inspector.

4.2 Review of requirements and recommendations from the last care inspection dated 27 January 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 15.6 **Stated:** First time	The registered person must ensure that a robust system for checking the emergency medications and equipment is put in place.	**Met**
	Action taken as confirmed during the inspection: Review of the checking procedures evidenced that a robust system had been implemented to monitor expiry dates of the the emergency medications and equipment.	
Requirement 2 **Ref**: Regulation 15.6 **Stated:** First time	The registered person must ensure that the expired buccal Midazolam medication, for the emergency treatment of status epilepticus is replaced. This should be replaced with the format ' Buccolam' as recommended by the Health and Social Care Board.	**Met**
	Action taken as confirmed during the inspection: Observations made confirmed that Buccolam pre-filled syringes were available as recommended by the Health and Social Care Board.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 12.1	An overarching policy for the management of medical emergencies should be developed.	**Not Met**
	Action taken as confirmed during the inspection: This recommendation has not been addressed and is stated for the second time. Information was emailed to Mr Monaghan on 31 January 2017 detailing the components that should be included in the policy.	

Recommendation 2 **Ref**: Standard 12.1	Protocols for dealing with medical emergencies should be further developed to ensure they provide concise details/actions in respect of the all of the various medical emergencies for staff reference.	**Met**
	Action taken as confirmed during the inspection: Review of documentation evidenced that protocols had been further developed as recommended.	
Recommendation 3 **Ref**: Standard 12.4	It is recommended that the availability of an automated external defibrillator (AED) should be reviewed. Mr Monaghan should seek advice and guidance from his medico-legal advisor in this regard.	**Met**
	Action taken as confirmed during the inspection: Mr Monaghan and staff confirmed that the practice have access to a community AED and an AED from a nearby dental practice. Mr Monaghan provided assurances that the AED could be accessed in a timely manner in the event of a cardiac event in the practice.	

Recommendation 4 **Ref**: Standard 11 **Stated:** First time	A policy for recruitment should be developed which is comprehensive and reflective of best practice guidance.	**Partially Met**
	Action taken as confirmed during the inspection: Review of documentation confirmed that a policy for recruitment had been developed. However the policy requires further development to ensure it is comprehensive and reflective of best practice guidance. A recommendation was made during this inspection that the policy is further developed to include the following: • enhanced AccessNI checks must be undertaken and received prior to staff commencing work in the practice (including self-employed staff) • one of the two written references should be from the current/most recent employer • physical and mental health assessment • full employment history, including dates, reasons for leaving and explanation of any gaps in employment The policy states that staff may be asked to attend for a trial period of one week prior to the offer of employment. It was stressed that full employment checks as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005, including enhanced AccessNI checks, must be undertaken and obtained prior to the trial period. This should be reflected in the policy.	
Recommendation 5 **Ref**: Standard 11 **Stated:** First time	Dedicated staff personnel files should be developed.	**Met**
	Action taken as confirmed during the inspection: Observations made evidenced that dedicated staff personnel files had been developed.	

Recommendation 6 **Ref**: Standard 11 **Stated:** First time	Information pertaining to the recruitment process should be retained in staff personnel files in respect of any new staff including self-employed staff, commencing work in the practice. This should include the following: • positive proof of identity, including a recent photograph • evidence that an enhanced AccessNI check was received prior to commencement of employment • two written references, one of which should be from the current/most recent employer • details of full employment history, including an explanation of any gaps in employment • documentary evidence of qualifications, where applicable • evidence of current GDC registration, where applicable • criminal conviction declaration on application • confirmation that the person is physically and mentally fit to fulfil their duties; and • evidence of professional indemnity insurance, where applicable	**Partially Met**
	Action taken as confirmed during the inspection: Review of submitted staffing information and discussion with Mr Monaghan confirmed that no new staff have been recruited since the previous inspection. As staff personnel files were not available during the previous inspection, the personnel file of the staff member recruited during the year previous to the last inspection was reviewed. The following information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 was not available: • two written references • criminal conviction declaration • confirmation that the person was physically and mentally fit to fulfil the duties of their role Mr Monaghan advised that he had obtained a verbal reference in respect of the staff member, however, there was no record retained in this regard. This recommendation has been partially	

	addressed and is stated for the second time specifying the omitted information as identified above.	
Recommendation 7 **Ref**: Standard 11 **Stated:** First time	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 assessment of the check.	**Not Met**
	Action taken as confirmed during the inspection: Information pertaining to the enhanced AccessNI check in respect of the personnel file reviewed evidenced that the record retained only made reference to 'police information', and a number, which Mr Monaghan advised was the unique identification number. The dates the check was applied for and received and the outcome of the assessment of the check were not recorded. It was confirmed by the inspector during the previous inspection that the enhanced AccessNI check had been received prior to the staff member commencing employment This recommendation was stated for the second time.	

4.3 Is care safe?

Staffing

The practice has three dental surgeries, however, only two surgeries are currently in operation. 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 one evidenced that an induction programme had been completed when the staff joined the practice.

Procedures were in place for appraising staff performance and staff confirmed that appraisals had taken place. Staff confirmed that they felt supported and involved in discussions about their personal development. A review of a sample of three evidenced that appraisals had been completed within the last year. It was noted that appraisals were signed only by Mr Monaghan and it was suggested that these should also be signed by staff.

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 Monaghan 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.

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

Recruitment and selection

A review of the submitted staffing information and discussion with Mr Monaghan confirmed that no new staff have been recruited since the previous inspection.

As discussed in section 4.2, the personnel file of the staff member recruited during the year previous to the last inspection was reviewed. The following recruitment information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 was not available:

- two written references
- criminal conviction declaration
- confirmation that the person was physically and mentally fit to fulfil the duties of their role

A recommendation was made for the second time in this regard.

As discussed previously, information pertaining to the enhanced AccessNI check in respect of the personnel file reviewed was not in keeping with AccessNI's code of practice and a recommendation was made for the second time in this regard.

A recruitment policy was available. As stated in section 4.2 a recommendation was made that this is further developed to include the following, to ensure it is comprehensive and reflective of best practice guidance:

- enhanced AccessNI checks must be undertaken and received prior to staff commencing work in the practice (including self-employed staff)
- one of the two written references should be from the current/most recent employer
- physical and mental health assessment
- full employment history, including dates, reasons for leaving and explanation of any gaps in employment

The policy states that staff may be asked to attend for a trial period of one week prior to the offer of employment. Full employment checks as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005, including enhanced AccessNI checks, must be undertaken and obtained prior to the trial period. This should be reflected in the policy.

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 programmes confirmed that safeguarding is covered at induction. However, Mr Monaghan confirmed that refresher safeguarding training had not been provided in approximately three years.

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 Monaghan on 31 January 2017 along with the Adult Protection Gateway referral numbers. Mr Monaghan was advised that the safeguarding policy should include the following:

- name of the safeguarding lead
- definitions of abuse
- types, and indicators of abuse
- onward referral arrangements including contact information
- documentation arrangements
- training arrangements

On completion of the policy staff training should be provided, and refresher training provided every two years as outlined in the Minimum Standards for Dental Care and Treatment 2011. A recommendation was made in this regard.

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. Mr Monaghan confirmed that the practice has access to an AED from another source 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.

Review of medical emergency 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 annual update training for this year is slightly behind schedule; Mr Monaghan advised this was due to unavailability of the training provider and training will be provided during March 2017. Mr Monaghan confirmed this training will include the use of an AED.

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.

As discussed in section 4.2, a recommendation was made for the second time that an overarching policy for the management of medical emergencies should be developed. Mr Monaghan was advised that the following information should be included in the policy:

- training
- a list of equipment and emergency medication provided
- checking procedures
- how to summons help
- documentation of any incidents
- staff debriefing post incident

Protocols were available for staff reference outlining the local procedure for dealing with the various medical emergencies.

Infection prevention control and decontamination procedures

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

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 for inspection 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 two washer disinfectors 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. Logbooks were in place for the washer disinfectors and these evidenced that periodic tests are undertaken and recorded in keeping with Health Technical Memorandum (HTM) 01-05 Decontamination in primary care dental practices. Appropriate periodic tests are also undertaken and recorded in respect of the sterilisers, however, logbooks have not been established for these. A recommendation was made in this regard.

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 on 17 January 2017. Mr Monaghan confirmed this is completed on an annual basis. A recommendation was made that the IPS HTM 01-05 audit is completed on a six monthly basis as directed by the Department of Health. It was noted that the most recent audit was completed using the old version of the audit tool. A copy of the revised 2013 edition IPS audit tool was emailed to Mr Monaghan on 31 January 2017.

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

Radiography

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

A dedicated radiation protection file containing the relevant local rules, employer's procedures and other additional information was retained. Mr Monaghan is the radiation protection supervisor (RPS) for the practice.

Rectangular collimation was observed to be in situ and x-rays are processed chemically.

A copy of the local rules was on display near each x-ray machine, however, these were copies of the previous local rules, not the updated versions.

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 and review of the radiation protection file evidenced that not all of the recommendations made by the RPA have been addressed. A requirement was made that the radiation protection file should be reviewed. The review should include the following:

- the recommendations made by the RPA should be addressed. Records should be retained confirming each recommendation has been actioned
- updated local rules should be displayed near each x-ray machine
- staff should sign to confirm they have read the local rules and radiation protection folder
- entitlement and authorisation of clinical staff by the RPS should be updated
- x-ray quality grading audits should be undertaken and recorded six monthly
- x-ray justification and clinical evaluation recording audits should be undertaken and recorded on an annual basis
- staff training records should be retained
- x-ray equipment should be 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 all areas and a colour coded cleaning system was in place.

A premises inspection was carried out in this practice by an estates inspector on 15 November 2016. The arrangements in place for maintaining the environment where therefore not reviewed in detail during this inspection. Documents were reviewed evidencing servicing of the alarm system, firefighting equipment and the heating boiler. An electrical wiring installation report was also available.

Review of documentation and discussion with staff evidenced that fire drills and fire safety awareness training had been undertaken. Staff demonstrated good awareness of the actions to be taken in the event of a fire.

Water temperatures were monitored and recorded in keeping with the legionella risk assessment.

Mr Monaghan confirmed that pressure vessels had been inspected in keeping with the written scheme of examination of pressure vessels.

Patient and staff views

Seven patients submitted questionnaire responses to RQIA. All indicated that they felt safe and protected from harm. The following comment was provided:

- 'Excellent reception staff and dental care.'

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

Areas for improvement

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

Recruitment information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 should be obtained and retained in respect of any new staff recruited.

Enhanced AccessNI disclosure certificates should be disposed of and pertinent information retained in keeping with AccessNI's code of practice.

The recruitment policy and procedure should be further developed.

The safeguarding children and vulnerable adults policy should be further developed to provide a safeguarding children and adults at risk of harm policy.

Safeguarding training should be provided.

An overarching policy for the management of medical emergencies should be developed.

Logbooks should be established for each steriliser.

Compliance with HTM 01-05 should be audited on a six monthly basis using the 2013 edition of the IPS audit tool.

The radiation protection file should be reviewed and actions implemented as identified.

Number of requirements	1	**Number of recommendations**	9

4.4 Is care effective?

Clinical records

Mr Monaghan 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.

Patients' records are maintained electronically, however, some associated manual records are also retained. 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.

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. Various information was available promoting oral health and hygiene including demonstration models and the practice takes part in national campaigns such as no smoking and cancer awareness. Mr Monaghan and staff confirmed that oral health is actively promoted on an individual level with patients during their consultations.

Audits

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

- IPS HTM 01-05 compliance
- review of complaints/accidents/incidents
- patient satisfaction surveys
- peer review
- patient medications

As discussed a requirement was made which includes the implementation of x-ray quality grading and justification and clinical evaluation recording audits. This will further enhance the quality assurance process. Consideration could also be given to developing the audit programme in areas such as clinical record recording and waste management.

Communication

Mr Monaghan confirmed that arrangements are in place for onward referral in respect of specialist treatments.

Staff confirmed that staff meetings are held periodically and that meetings also facilitated informal/formal in house training sessions. Mr Monaghan advised that in general these are on an informal basis and minutes of meetings are not recorded. The last staff meeting was held on 17 January 2017 and an agenda had been devised, however, there were no records of who attended or minutes retained. The last staff meeting recorded previous to this was in January 2016, minutes of the meeting had been retained and staff had signed to confirm they had read these.

A recommendation was made that minutes of staff meetings should be retained. Minutes should include details of who chaired the meeting, the staff who attended and the matters discussed.

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. The following comment was provided:

- 'Always treated promptly with excellent results.'

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. Staff spoken with during the inspection concurred with this. No comments were included in submitted questionnaire responses.

Areas for improvement

Minutes of staff meetings should be retained.

Number of requirements	0	Number of recommendations	1

4.5 Is care compassionate?

Dignity, respect and involvement in decision making

Staff spoken with demonstrated a good understanding of the core values of privacy, dignity, respect and patient choice. Staff confirmed that if they needed to speak privately with a patient that arrangements are provided to ensure the patient's privacy is respected. Staff were observed to converse with patients and conduct telephone enquiries in a professional and confidential manner.

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

It was confirmed that treatment options, including the risks and benefits, were discussed with each patient. This ensured patients understood what treatment is available to them and can make an informed choice. Staff demonstrated how consent would be obtained.

The practice undertakes patient satisfaction surveys on an annual basis. Review of the most recent patient satisfaction summary report, compiled in March 2016, demonstrated that the practice pro-actively seeks the views of patients about the quality of treatment and other services provided. A recommendation was made that the patient satisfaction survey process is further developed to include in the summary report the number of patients who participated, the outcome of results in relation to each specific question, and the actions taken, if any, to implement improvements.

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

Patient and staff views

All patients who submitted questionnaire responses indicated that they are treated with dignity and respect and are involved in decision making affecting their care. The following comment was provided:

- 'Kindness personified.'

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. Staff spoken with during the inspection concurred with this. No comments were included in submitted questionnaire responses.

Areas for improvement

The patient satisfaction survey process should be further developed.

Number of requirements	0	Number of recommendations	1

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.

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. 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 evidence provided in the returned questionnaire indicated that complaints have been managed in accordance with best practice.

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 Monaghan 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 requirement and recommendations made under the Is Care Safe, Effective and Compassionate domains will further enhance the governance arrangements in the practice.

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

Mr Monaghan demonstrated a clear understanding of his role and responsibility in accordance with legislation. The QIP from the previous inspection was not submitted to RQIA within the specified timeframe. This was discussed with Mr Monaghan with a view to the provision of information requested by RQIA in a timely manner. It was confirmed that the Statement of Purpose and Patient's Guide are kept under review, revised and updated when necessary and available on request.

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

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

Patient and staff views

All patients who submitted questionnaire responses indicated that they felt that the service is well managed. One patient provided the following comment which was discussed with Mr Monaghan:

- 'However long waiting times and phones not answered.'

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

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mr Marius Monaghan, 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 independent.healthcare@rqia.org.uk for assessment by the inspector.

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

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 15 (1) (b) **Stated:** First time **To be completed by:** 30 March 2017	The registered provider must ensure that the radiation protection file is reviewed. The review should include the following: • the recommendations made by the radiation protection advisor (RPA) should be addressed. Records should be retained confirming each recommendation has been actioned • updated local rules should be displayed near each x-ray machine • staff should sign to confirm they have read the local rules and the radiation protection folder • entitlement and authorisation of clinical staff by the radiation protection supervisor (RPS) should be updated • x-ray quality grading audits should be undertaken and recorded six monthly • x-ray justification and clinical evaluation recording audits should be undertaken and recorded on an annual basis • staff training records should be retained • x-ray equipment should be serviced and maintained in accordance with manufacturer's instructions
	Response by registered provider detailing the actions taken: The entire radiation protection file has been reviewed and all the above points have been considered and actioned where appropriate.
Recommendations	
Recommendation 1 **Ref**: Standard 11.4 **Stated:** First time **To be completed by:** 30 April 2017	A system should be established 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 in house.
	Response by registered provider detailing the actions taken: Each member of staff now has their own training log.
Recommendation 2 **Ref**: Standard 11 **Stated:** Second time **To be completed by:** 31 January 2017	Information pertaining to the recruitment process should be retained in staff personnel files in respect of any new staff including self-employed staff, commencing work in the practice. This should include the following: • two written references • criminal conviction declaration • confirmation that the person was physically and mentally fit to fulfil the duties of their role
	Response by registered provider detailing the actions taken: We have developed a tick box sheet for use with any new staff covering all relavant information including the items listed above,to ensure some info is not missed.

Recommendation 3 **Ref**: Standard 11 **Stated:** Second time **To be completed by:** 31 January 2017	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 assessment of the check.
	Response by registered provider detailing the actions taken: This is already in place.
Recommendation 4 **Ref**: Standard 11 **Stated:** First time **To be completed by:** 30 April 2017	The recruitment policy should be further developed to include the following: • enhanced AccessNI checks must be undertaken and received prior to staff commencing work in the practice (including self-employed staff) • one of the two written references should be from the current/most recent employer • physical and mental health assessment • full employment history, including dates, reasons for leaving and explanation of any gaps in employment The policy states that staff may be asked to attend for a trial period of one week prior to the offer of employment. Full employment checks as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005, including enhanced AccessNI checks, must be undertaken and obtained prior to the trial period. This should be reflected in the policy.
	Response by registered provider detailing the actions taken: The recruitment policy has already been modified to reflect the above.
Recommendation 5 **Ref**: Standard 15.3 **Stated:** First time **To be completed by:** 30 March 2017	The safeguarding children and vulnerable adults policy should be further developed to provide a safeguarding children and adults at risk of harm policy. 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, and should include the following: • name of the safeguarding lead • definitions of abuse • types, and indicators of abuse • onward referral arrangements including contact information • documentation arrangements • training arrangements
	Response by registered provider detailing the actions taken: I have downloaded the up to date information on safeguarding children and adults at risk of harm,reviewed it and had an in house training session with my staff.

Recommendation 6 **Ref**: Standard 15.3 **Stated:** First time **To be completed by:** 30 April 2017	Safeguarding training should be provided on completion of the further development of the safeguarding policy. Arrangements should be established to provide refresher training every two years as outlined in the Minimum Standards for Dental Care and Treatment 2011.
	Response by registered provider detailing the actions taken: We will revisit the policy in 2 years.In house training provided march 2017.
Recommendation 7 **Ref**: Standard 12.1 **Stated:** Second time **To be completed by:** 30 April 2017	An overarching policy for the management of medical emergencies should be developed.
	Response by registered provider detailing the actions taken: There was a policy in place since the last inspection.This has been overhauled to produce a more complete policy from mid February 2017
Recommendation 8 **Ref**: Standard 13.4 **Stated:** First time **To be completed by:** 13 February 2017	Logbooks should be established for each steriliser.
	Response by registered provider detailing the actions taken: Done
Recommendation 9 **Ref**: Standard 13.2 **Stated:** First time **To be completed by:** 13 July 2017	Compliance with Health Technical Memorandum (HTM) 01-05 should be audited on a six monthly basis using the 2013 edition of the Infection Prevention Society (IPS) audit tool.
	Response by registered provider detailing the actions taken: 2013 version downloaded for use in July 2017
Recommendation 10 **Ref**: Standard 11.6 **Stated:** First time **To be completed by:** 27 February 2017	Minutes of staff meetings should be retained. Minutes should include details of who chaired the meeting, the staff who attended and the matters discussed.
	Response by registered provider detailing the actions taken: Being done.All staff now have their own training log.

Recommendation 11 **Ref**: Standard 9 **Stated:** First time **To be completed by:** 30 March 2017	The patient satisfaction survey process should be further developed to include in the summary report the number of patients who participated, the outcome of results in relation to each specific question, and the actions taken, if any, to implement improvements.
	Response by registered provider detailing the actions taken: Will review patient satisfaction survey later in the year when next survey due.

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

The Regulation and Quality Improvement Authority

9th Floor

Riverside Tower
5 Lanyon Place
BELFAST

BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews