Announced Care Inspection Report
27 February 2018

Harper Dental Care

Type of service: Independent Hospital (IH) – Dental Treatment
Address: 22 North Street, Carrickfergus, BT38 7AQ
Tel no: 028 9335 1418
Inspector: Carmel McKeegan

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service 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 two registered places.

3.0 Service details

Organisation/Registered Provider: Harper Dental Care	**Registered Manager:** Mr Neil Harper
Person in charge at the time of inspection: Mr Neil Harper	**Date manager registered:** 08 February 2013
Categories of care: Independent Hospital (IH) – Dental Treatment	**Number of registered places:** Two

4.0 Inspection summary

An announced inspection took place on 27 February 2018 from 10.00 to 12.50.

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 training and development, recruitment, infection prevention and control and radiology. Other examples included health promotion, engagement to enhance the patients' experience and governance arrangements.

One area for improvement made against the standards during the previous inspection in relation to updating the complaints procedure had not been addressed, subsequently an area for improvement against the regulations has been made.

The following five areas for improvement against the standards were identified. To further develop the adult safeguarding policy, to ensure the arrangement for accessing the automated external defibrillator (AED) is clearly outlined in the medical emergency policy and procedure, to ensure that the legionella risk assessment is located and that any recommendations contained therein are implemented, to develop a written security policy to reduce the risk of prescription theft and misuse, and to undertake a patient satisfaction survey on an annual basis.

All of the patients who submitted questionnaire responses to RQIA indicated that they were either very satisfied or satisfied with all aspects of care in this service.

The following comments were provided in submitted questionnaire responses:

- “Lovely staff make me feel special.”
- “Always can get treatment.”

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	5

Details of the Quality Improvement Plan (QIP) were discussed with Mr Neil Harper, 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 22 February 2017

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 22 February 2017.

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 complaints declaration

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

RQIA invited staff to complete electronic questionnaires. No completed staff questionnaires were submitted to RQIA.

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

During the inspection the inspector met with Mr Harper, registered person, the practice manager and a dental nurse. The practice manager facilitated the inspection. A tour of the premises was also undertaken.

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

- staffing
- recruitment and selection
- 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 practice manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 22 February 2017

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 22 February 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005		**Validation of compliance**
Requirement 1 **Ref**: Regulation 15 (2) **Stated:** First time	The registered provider must ensure that the equipment used in the decontamination process is validated at the earliest opportunity and arrangements established to ensure this equipment is revalidated on an annual basis. A copy of the validation certificates should be submitted to RQIA with the returned (Quality Improvement Plan) QIP.	**Met**
	Action taken as confirmed during the inspection: The equipment used in the decontamination process had been validated on 20 June 2017. The practice manager confirmed that arrangements had been established to ensure the equipment is validated every twelve months.	
Action required to ensure compliance with The Minimum Standards for Dental Care and Treatment (2011)		**Validation of compliance**
Recommendation 1 **Ref**: Standard 13 **Stated:** Second time	An action plan should be developed to progress compliance with HTM 01-05 and that the audit tool is completed six monthly.	**Met**
	Action taken as confirmed during the inspection: 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 December 2017.	

Recommendation 2 **Ref**: Standard 11 **Stated:** First time	A system should be implemented for appraising staff performance at least on an annual basis.	**Met**
	Action taken as confirmed during the inspection: Staff confirmed that they had an annual appraisal completed and a record of appraisal for each staff member was recorded in a note book. Appraisal records did not evidence that a structured appraisal process had been applied. However, staff spoken with stated they were satisfied with the appraisal process. The purpose and value of the appraisal process was discussed with the practice manager and a suggestion was made to review the appraisal process in the future.	
Recommendation 3 **Ref**: Standard 15.3 **Stated:** First time	The safeguarding children and adults policy should be reviewed and updated to reflect the new regional guidance.	**Partially Met**
	Action taken as confirmed during the inspection: The above policies had been reviewed and updated. However, the adult safeguarding policy needs to be further developed to ensure it fully reflects the regional guidance. Advice and guidance was provided and an area of improvement against the standards has been made.	

Recommendation 4 **Ref**: Standard 15.3 **Stated:** First time	Mr Harper and staff should complete refresher training in safeguarding children and adults, every two years, as outlined in the Minimum Standards for Dental Care and Treatment 2011.	**Met**
	Action taken as confirmed during the inspection: Mr Harper had completed level 2 training in safeguarding children and confirmed he intends to complete level 2 adult safeguarding. Other staff members had completed refresher training in safeguarding children and adults and confirmed that training in these areas will be renewed every two years as outlined in the Minimum Standards for Dental Care and Treatment 2011.	
Recommendation 5 **Ref**: Standard 14.4 **Stated:** First time	Mr Harper should review the x-ray machine manufacturer's instructions and establish arrangements to ensure that the x-ray equipment is serviced and maintained in keeping with manufacturer's instructions. The arrangements should be confirmed to RQIA in the returned QIP.	**Met**
	Action taken as confirmed during the inspection: Review of records confirmed that x-ray equipment had been serviced on 20 June 2017.	
Recommendation 6 **Ref**: Standard 12.5 **Stated:** First time	A record of fire safety training should be retained for all staff.	**Met**
	Action taken as confirmed during the inspection: Records evidenced that all staff had attended fire safety training on 2 December 2017.	

Recommendation 7 **Ref**: Standard 9 **Stated:** First time	The complaints procedure should be further developed to include the following: • details of the Health and Social Care Board and General Dental Council (GDC) as agencies that may be utilised within the complaints investigation process • details of the Northern Ireland Commissioner for complaints and the GDC Dental Complaints Service in the event of dissatisfaction about the outcome of the complaints investigation for NHS and private patients respectively • the details of RQIA, as an oversight body	**Not met**
	Action taken as confirmed during the inspection: The complaints policy had not been updated as outlined. Subsequently, an area for improvement against the regulations has been made.	

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

There are two dental surgeries in this practice, however Mr Harper confirmed that only one dental surgery is operational. Discussion with Mr Harper and 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.

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

Mr Harper and staff confirmed that arrangements have been established for appraising staff performance. As previously stated, the purpose and value of the appraisal process was discussed with the practice manager and a suggestion was made to review the appraisal process in the future.

Staff confirmed there was a system in place to ensure that they receive appropriate training to fulfil the duties of their role.

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 Harper and the practice manager, confirmed that no new staff have been recruited since the previous inspection. It was confirmed that, should staff be recruited in the future robust systems and processes have been developed to ensure that all recruitment documentation as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 would be sought and retained for inspection.

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

Safeguarding

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

Review of records demonstrated that all staff had received training in safeguarding children and adults as outlined in the Minimum Standards for Dental Care and Treatment 2011. Mr Harper is the safeguarding lead and has completed level 2 training in safeguarding children. Mr Harper confirmed that he will also complete formal level 2 training in safeguarding adults in keeping with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016).

Policies and procedures were in place for the safeguarding and protection of adults and children at risk of harm. 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. The adult safeguarding policy needs to be further developed to fully reflect the regional 'Adult Safeguarding Prevention and Protection in Partnership policy' (July 2015) and 'Adult Safeguarding Operational Procedures' (2016). An area for improvement against the standards has been made in this regard.

It was 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 for staff reference.

Following the inspection the following documentation was forwarded to the practice by email:

- 'Adult Safeguarding Operational Procedures' (September 2016)
- Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016).
- Adult protection gateway contact information

Management of medical emergencies

A review of medical emergency arrangements evidenced that emergency medicines were, in the main, provided in keeping with the British National Formulary (BNF). The Glucagon medication was stored out of the fridge and the expiry date had not been revised on the packaging and the expiry date check list in accordance with the manufacturer's instruction. Mr Harper confirmed a revised expiry date would be recorded in keeping with manufacturer's instruction.

A discussion took place in relation to the procedure for the safe administration of Buccolam pre-filled syringes and the various doses and quantity needed as recommended by the Health and Social Care Board (HSCB). Mr Harper advised that Buccolam will be administered safely in the event of an emergency as recommended by the HSCB and in keeping with the BNF.

Emergency equipment as recommended by the Resuscitation Council (UK) guidelines was retained with the exception of an automated external defibrillator (AED). Mr Harper and staff confirmed that an AED was available at the fire station within close proximity to the practice. A discussion took place in relation as to how the practice should ensure there is timely access to the AED in accordance with the Resuscitation Council (UK) guidelines. It was identified that location of the AED had not been incorporated into the practice's medical emergency policy and procedure. An area of improvement against the standards was made in this regard.

Review of training records and discussion with staff confirmed that the management of medical emergencies is included in the induction programme and training is updated on an annual basis in keeping with best practice guidance.

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.

Protocols for the management of medical emergencies outlining the local procedures were not available. A copy of the Resuscitation Council (UK) guidelines was provided to the practice following the inspection.

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.

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 a steam steriliser have been provided to meet the practice requirements. A review of documentation evidenced that equipment used in the decontamination process has been appropriately validated. A review of equipment logbooks evidenced that periodic tests are undertaken and recorded in keeping with Health Technical Memorandum (HTM) 01-05 Decontamination in primary care dental practices. It was noted that one logbook had been completed in pencil, staff readily agreed to complete all future recordings using black ink.

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 December 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 however Mr Harper confirmed only one dental surgery is operational, this surgery 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. A review of the file confirmed that staff have been authorised by the radiation protection supervisor (RPS) for their relevant duties and have received local training in relation to these duties. It was evidenced that all measures are taken to optimise dose exposure. This included the use of rectangular collimation and x-ray audits.

A copy of the local rules was on display near each x-ray machine and appropriate staff had signed to confirm that they had read and understood these. 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 on 23 September 2015, demonstrated that the recommendations made have been addressed.

The x-ray equipment had been serviced and maintained in June 2017 in accordance with manufacturer's instructions.

Quality assurance systems and processes were in place to ensure that all matters relating to x-rays reflect legislative and best practice guidance.

Environment

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

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

Arrangements are in place for maintaining the environment. Portable appliance testing (PAT) of electrical equipment is undertaken every two years and was last undertaken on 22 February 2018.

A fire detection system was provided and records confirmed that the fire detection system is serviced and maintained in keeping with the manufacturer's instructions.

A fire risk assessment was completed and records reviewed confirmed this has been reviewed annually. Fire drills are routinely undertaken and recorded and all staff have completed fire safety awareness training.

Mr Harper and the practice manager confirmed that a legionella risk assessment had been undertaken, however it could not be located. An area for improvement against the standards was made in this regard.

Review of documentation evidenced that the pressure vessels in the practice have been inspected in keeping with the written scheme of examination of pressure vessels.

It was confirmed that robust arrangements are in place for the management of prescription pads/forms however a written security policy to reduce the risk of prescription theft and misuse had not been developed. An area of improvement against the standards was made in this regard.

Patient and staff views

Five patients submitted questionnaire responses to RQIA. All indicated that they felt safe and protected from harm and indicated a high level of satisfaction with this aspect of care.

No staff questionnaire responses were received

Areas of good practice

There were examples of good practice found in relation to staff recruitment, induction, training, infection prevention control and decontamination procedures and radiology.

Areas for improvement

The policy and procedure for Adult Safeguarding should be in keeping with the regional 'Adult Safeguarding Prevention and Protection in Partnership policy' (July 2015) and 'Adult Safeguarding Operational Procedures' (2016).

The arrangements for accessing the AED should be incorporated into the medical emergency policy and procedure.

Mr Harper should locate the completed legionella risk assessment and ensure that any recommendations contained therein are addressed.

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

	Regulations	Standards
Total number of areas for improvement	0	4

6.5 Is care effective?

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

Clinical records

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

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

Both manual and computerised records are maintained. Electronic records have different levels of access afforded to staff dependent on their role and responsibilities. Appropriate systems and processes were in place for the management of records and maintaining patient confidentiality.

Policies were available in relation to records management, data protection and confidentiality and consent. The records management policy includes the arrangements in regards to the creation, storage, recording, retention and disposal of records and data protection. The policy is in keeping with legislation and best practice guidance.

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. Mr Harper and staff confirmed that oral health is actively promoted on an individual basis during treatment sessions by the dentist and the dental nurse. A range of oral health promotion leaflets were available at reception and the patients' waiting area. A range of oral healthcare products were also available to purchase.

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
- IPS HTM 01-05

Communication

Mr Harper 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 a regular basis to discuss clinical and practice management issues. Review of documentation demonstrated that minutes of staff meetings are retained. Staff spoken with confirmed that meetings also facilitated informal 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 of the patients who submitted questionnaire responses indicated that they get the right care, at the right time and with the best outcome for them and indicated a high level of satisfaction with this aspect of care.

No staff questionnaire responses were received.

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 conduct telephone enquiries in a professional and confidential manner, patients were not present during the inspection.

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 manager confirmed that a patient satisfaction survey had been undertaken. However, the most recent survey had been undertaken during 2016. The practice manager was advised to ensure that patient satisfaction surveys include the quality of treatment and other services provided and should be undertaken on at least an annual basis. A summary report should be collated and made available to patients. An area for improvement against the standards has been made in this regard.

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 of the patients who submitted questionnaire responses indicated that they are treated with dignity and respect and are involved in decision making affecting their care and indicated a high level of satisfaction with this aspect of care.

No staff questionnaire responses were received.

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

Patient satisfaction surveys to include the quality of treatment and other services provided should be undertaken on at least an annual basis. A summary report should be collated and made available to patients.

	Regulations	Standards
Total number of areas for improvement	0	1

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.

Mr Harper is the nominated individual with overall responsibility for the day to day management of the practice.

Policies and procedures were available for staff reference. Observations made confirmed that policies and procedures were indexed, 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.

An area of improvement against the standards had been made at the previous inspection to update the complaints procedure in order to provide clear guidance for NHS and private patients. However, it was identified that this had not been addressed and subsequently an area of improvement against the regulations has been made in this regard.

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.

Mr Harper 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.

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 Harper demonstrated an understanding of his role and responsibility in accordance with legislation. 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 of the patients who submitted questionnaire responses indicated that they felt that the service is well led and indicated a high level of satisfaction with this aspect of the service.

No staff questionnaire responses were received.

Areas of good practice

There were examples of good practice found in relation to governance arrangements, management of incidents, quality improvement and maintaining good working relationships.

Areas for improvement

The complaints procedure should be further developed as outlined.

	Regulations	Standards
Total number of areas for improvement	1	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 Mr Harper, 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 and The Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011 and the Department of Health, Social Services and Public Safety (DHSSPS) Minimum Standards for Dental Care and Treatment (2011).

7.2 Actions to be taken by the service

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

Quality Improvement Plan

Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 23 (1) **Stated:** First time **To be completed by:** 30 April 2018	The complaints procedure should be further developed to include the following: • details of the Health and Social Care Board and General Dental Council (GDC) as agencies that may be utilised within the complaints investigation process • details of the Northern Ireland Commissioner for complaints and the GDC Dental Complaints Service in the event of dissatisfaction about the outcome of the complaints investigation for NHS and private patients respectively • the details of RQIA, as an oversight body
	Response by registered person detailing the actions taken: The complaints procedure is currently being further devoloped and updated.
Action required to ensure compliance with The Minimum Standards for Dental Care and Treatment (2011)	
Area for improvement 1 **Ref**: Standard 15 **Stated:** First time **To be completed by:** 30 April 2018	The registered person shall ensure the adult safeguarding policy is updated to fully reflect the regional 'Adult Safeguarding Prevention and Protection in Partnership policy' (July 2015) and 'Adult Safeguarding Operational Procedures' (2016). Ref: 6.4
	Response by registered person detailing the actions taken: Level 2 adult safeguarding is currently underway.
Area for improvement 2 **Ref:** Standard 14 **Stated:** First time **To be completed by**: 30 April 2018	The registered person should locate the legionella risk assessment and address any recommendations contained therein. Ref: 6.4
	Response by registered person detailing the actions taken: The legionella risk assessment is being re-assessed and any recommendations will be implemented.

Area for improvement 3 **Ref:** Standard 12 **Stated:** First time **To be completed by**: 30 April 2018	The registered person shall ensure that the arrangement for accessing the automated external defibrillator (AED) is clearly documented within the practice's medical emergency policy and procedure. Ref: 6.4
	Response by registered person detailing the actions taken: Arrangements for access of the AED is currently being documented into the appropriate policy.
Area for improvement 4 **Ref**: Standard 14 **Stated:** First time **To be completed by:** 30 April 2018	The registered person shall ensure that a written security policy to reduce the risk of prescription theft and misuse is developed and shared with staff. Ref: 6.4
	Response by registered person detailing the actions taken: RE-assement of the appropriate policy is currently being undertaken.
Area for improvement 5 **Ref**: Standard 9 **Stated:** First time **To be completed by:** 30 June 2018	The registered person shall ensure that patient satisfaction surveys to include the quality of treatment and other services provided are undertaken on at least an annual basis. A summary report should be collated and made available to patients. Ref: 6.4
	Response by registered person detailing the actions taken: This will be addressed annually.

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