Announced Care Inspection Report
03 May 2016

D E (Belmont Road) Ltd

Service Type: Dental Practice
Address: 115 – 117 Belmont Road, Belfast, BT4 2AD
Tel No: 028 9047 1503
Inspector: Stephen O'Connor

1.0 Summary

An announced inspection of D E (Belmont Road) Ltd took place on 03 May 2016 from 09:50 to 13:10.

The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the service 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 staff demonstrated that a number of issues need to be addressed 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. Three requirements were made in relation to retention of recruitment documents, undertaking and receiving an enhanced AccessNI check prior to commencement of employment and issues identified in relation to radiology and radiation safety. Three recommendations were made in relation to staff appraisals, retaining confirmation that the fire detection system has been serviced and to establish routine testing of the fire detection system. Two recommendations made during the previous care inspection in relation to the Patient Guide and the provision of pedal operated clinical waste bins have been stated for the second time.

Is care effective?

Observations made, review of documentation and discussion with staff demonstrated that further development in the systems and processes to ensure that care provided in the establishment is effective is necessary. Areas reviewed included clinical records, health promotion, audits and communication. A recommendation was made that a rolling programme of audits should be developed and implemented.

Is care compassionate?

Observations made, review of documentation and discussion with 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 identified that a number of issues need to be addressed to ensure that effective leadership and governance arrangements are in place to create 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 and insurance arrangements. As discussed above a number of issues were identified within the domains of is care safe and is care effective, which relate to quality assurance and good governance. In addition two recommendations made during the previous inspection were either partially met or not met. There is a lack of governance arrangements within the practice and the requirements and recommendations made during this inspection must be actioned to ensure improvements are made. It is also important that these are kept under review to ensure improvements are sustained. A recommendation was made to review the current monitoring systems to ensure effective quality assurance and governance arrangements are in operation.

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	3	7

Details of the QIP within this report were discussed with Mrs Beryl MaGowan, practice manager, 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 previous QIP there were no further actions required to be taken following the last inspection.

2.0 Service details

Registered organisation/registered person: D E (Belmont Road) Limited/ Mr Chris McHale	**Registered manager:** Mr Chris McHale
Person in charge of the service at the time of inspection: Mrs Beryl MaGowan	**Date manager registered:** 18 November 2015
Categories of care: Independent Hospital (IH) – Dental Treatment	**Number of registered places:** 8

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 Mrs Beryl MaGowan, the practice manager, two associate dentists 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 17 September 2015

The most recent inspection of the establishment was a pre-registration care inspection. The completed QIP was returned and approved by the care inspector.

4.2 Review of requirements and recommendations from the last care inspection dated 17 September 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 15 (3) **Stated:** First time	In keeping with the DHSSPS policy directive as outlined in Professional Estates Letter (PEL) (13) 13 issued on the 1 October 2013 all compatible reusable dental instruments must be processed using an automated validated process. Compatible dental handpieces must be processed in the washer disinfector. Should problems be identified the steps as outlined in PEL (13) 13 Addendum 1 issued on 24 March 2015 to check handpiece/washer disinfector/detergent compatibility should be followed.	**Met**
	Action taken as confirmed during the inspection: A dental nurse confirmed that all compatible handpieces are being processed in the washer disinfector. It was observed that each of the washer disinfectors in use have handpiece ports.	
Requirement 2 **Ref**: Regulation 25 (2) (d) **Stated:** First time	The registered person must ensure that cleaning materials are appropriately stored in keeping with Control of Substances Hazardous to Health (COSHH) regulations and staff should be made aware of their responsibilities under COSHH regulations.	**Met**
	Action taken as confirmed during the inspection: During the tour of the premises it was observed that cleaning materials were being stored appropriately. Staff were aware of their responsibilities under COSHH regulations.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 1 **Stated:** First time	It is recommended that the patient guide is updated to reflect the change in ownership of the practice. The patient guide should fully reflect the key areas and themes specified in regulation 8 of The Independent Health Care Regulations (Northern Ireland) 2005.	**Partially Met**
	Action taken as confirmed during the inspection: Review of the patient guide demonstrated that it had been updated to reflect the change in ownership of the practice. However, the patient guide did not include the contact details of RQIA or information on how to access the most recent RQIA report. This recommendation has been partially addressed and the unaddressed component has been stated for the second time.	
Recommendation 2 **Ref**: Standard 13 **Stated:** First time	It is recommended that the details of the daily automatic control test (ACT) are recorded in the steam steriliser logbooks.	**Met**
	Action taken as confirmed during the inspection: Review of steam steriliser logbooks evidenced that the details of the daily ACT have been recorded.	
Recommendation 3 **Ref**: Standard 13 **Stated:** First time	It is recommended that all clinical waste bins are pedal operated.	**Not Met**
	Action taken as confirmed during the inspection: The clinical waste bin in the decontamination room was pedal operated. However, the clinical waste bins in surgeries five and eight were not pedal operated. This recommendation has not been addressed and it has been stated for the second time.	
Recommendation 4 **Ref**: Standard 12.5 **Stated:** First time	It is recommended that all staff undertake fire awareness refresher training.	**Met**
	Action taken as confirmed during the inspection: Review of records evidenced that staff had completed fire awareness training delivered by an external company during January 2016.	

Recommendation 5 **Ref**: Standard 12.4 **Stated:** First time	It is recommended that if Glucagon is stored in a fridge, fridge temperatures should be monitored and recorded to evidence that it is maintained within 2 and 8 degrees celsius. If Glucagon is stored out of a fridge a revised 18 month expiry date should be marked on the medication packaging and expiry date checklist to reflect that the cold chain has been broken.	**Met**
	Action taken as confirmed during the inspection: Review of emergency medicines retained evidenced that Glucagon is stored at room temperature and a revised expiry date has been recorded to reflect that the cold chain has been broken.	
Recommendation 6 **Ref**: Standard 12.4 **Stated:** First time	It is recommended that the following issues in relation to medical emergency equipment are addressed: • clear face masks suitable for use with children should be provided; and • Mr Mc Hale should consult with his medical legal provider in regards to the provision of an automated external defibrillator (AED). Any recommendations made should be addressed.	**Met**
	Action taken as confirmed during the inspection: Review of medical emergency equipment retained evidenced that clear face masks suitable for use with children and an AED were available in the practice.	

4.3 Is care safe?

Staffing

Eight dental surgeries are in operation in this practice. Three of the 11 staff questionnaires included comments indicating that the practice did not have sufficient staff. This was discussed with Mrs MaGowan who confirmed that the practice is actively recruiting three additional dental nurses and a receptionist. On discussion staff were aware that the practice is in the process of recruiting additional staff and they confirmed that they felt they were coping well with the current staffing compliment.

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

It was confirmed that staff appraisals have not been implemented. The practice has consulted with an external company in regards to developing a staff appraisal and development programme. Model staff appraisal templates have been provided by this external company for review and consideration. It is envisaged that a staff appraisal and development programme will be implemented over the next two to three months once a decision has been made in

regards to the appraisal documents to be used. Staff confirmed that they felt supported and involved in discussions about their personal development. A recommendation has been made to implement annual staff appraisals.

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 Mrs MaGowan confirmed that six staff have been recruited since the previous inspection. Three staff personnel files were reviewed. The following was noted:

- positive proof of identity, including a recent photograph in two files
- evidence that enhanced AccessNI checks had been undertaken
- details of full employment history, including an explanation of any gaps in employment in two files
- evidence of current GDC registration, where applicable
- confirmation that the person is physically and mentally fit to fulfil their duties
- evidence of professional indemnity insurance, where applicable
- two written references in one of the three files

None of the files reviewed included documentary evidence of qualifications or a criminal conviction declaration by the applicant. Mrs MaGowan was advised that staff personnel files must contain all information as specified in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 and a requirement has been made in this regard.

The arrangements for enhanced AccessNI checks were also reviewed. In one of the files it was identified that the enhanced Access NI check was received after the staff member commenced work. This was discussed with Mrs MaGowan and a requirement has been made in this regard.

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 records demonstrated that safeguarding children and adults training is included in the induction programme. Mrs MaGowan confirmed that the practice has not provided refresher training in safeguarding children and vulnerable adults since the new owner took over the operation of the practice during September 2015. Arrangements are in place to ensure that refresher training will be provided as outlined in the Minimum Standards for Dental Care and Treatment 2011.

It was confirmed that separate policies and procedures were in place for the safeguarding and protection of adults and children.

Management of medical emergencies

A review of medical emergency arrangements evidenced that emergency medicines were provided in keeping with the British National Formulary (BNF), and that emergency equipment as recommended by the Resuscitation Council (UK) guidelines was retained. 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 training records and discussion with staff confirmed that the management of medical emergencies is included in the induction programme. As the practice has been in operation for less than a year under the current owner it was confirmed that training will be 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.

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.

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 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 three washer disinfectors and four steam sterilisers 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 confirmed that when additional dental nurses are recruited it is envisaged that a dental nurse will be assigned to the decontamination room.

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 April 2016.

As identified in section 4.2 clinical waste bins in two of the surgeries reviewed were not pedal operated. This is not in keeping with best practice guidance as outlined in HTM 07-01 and a recommendation has been stated for the second time to address this.

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

Radiography

The practice has eight surgeries, each of which has an intra-oral x-ray machine. In addition there is a cone beam computed tomography (CBCT) machine which is located in a separate room.

A dedicated radiation protection file containing the relevant local rules, employer's procedures and other additional information was retained. A review of the file identified a number of issues as follows:

- Critical examination certificates dated the 26 April 2014 were available in respect of the eight intra-oral x-ray machines. However, the radiation protection advisors report (RPA) could not be located and therefore RQIA was unable to establishment if recommendations made by the RPA had been addressed
- a RPA critical examination report in respect of the CBCT dated 18 December 2015 was retained in the file, however, confirmation that the recommendations made within the report had been actioned was not available
- it was observed that the local rules for the CBCT had not been signed by the appropriate staff to confirm they had read and understood them
- staff confirmed that x-ray quality grading audits and justification and clinical evaluation recording audits had not been completed in keeping with best practice guidance

These issues were discussed with Mrs MaGowan and a requirement has been made to address them.

It was evidenced that some measures are taken to optimise dose exposure. This included the use of rectangular collimation and digital x-ray processing. As discussed previously x-ray quality grading audits have not been completed.

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, with the exception of the local rules for the CBCT machine as previously discussed. 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 good 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. Review of documents demonstrated that the air conditioning units and stair lift have been serviced in keeping with the manufacturer's instructions.

A legionella risk assessment was last undertaken during February 2014 and water temperatures are monitored and recorded as recommended.

Review of documentation evidenced that the firefighting equipment was serviced during February 2016. Mrs MaGowan confirmed that she thought the external company had also serviced the fire detection system. However, the servicing of the fire detection system was not listed on the documents provided by the external company. Records to confirm the most recent servicing of the fire detection system were dated 9 March 2015. A recommendation was made that records confirming that the fire detection system has been serviced in keeping with manufacturer's instructions should be retained. It was also established that there are no routine checks in place in regards to the fire detection system. A recommendation was made that arrangements should be established to ensure that routine testing of the fire detection system are implemented including testing of emergency break glass points and emergency lighting.

Patient and staff views

Fifteen patients submitted questionnaire responses to RQIA. All indicated that they felt safe and protected from harm. The following comments were provided:

- "A good team that have coped with a lot of changes recently"
- "Friendly welcoming dentist, nurses very professional and friendly"

Eleven staff submitted questionnaire responses. All indicated that they felt that patients are safe and protected from harm. The following comments were provided:

- "Requires improvement in regards to extra staff"
- "Sometimes need extra staff"
- "Needs more staff, especially for disinfection and decontamination"

Comments on returned patient and staff questionnaires were shared with Mrs MaGowan.

Areas for improvement

Staff personnel files should include all documents as listed in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005

Enhanced AccessNI check must be undertaken and received prior to new staff, including self-employed staff commencing work in the practice

Identified issues in relation to radiology and radiation safety must be addressed

Staff appraisals should be implemented

Clinical waste bins should be pedal operated.

Confirmation that the fire detection panel has been serviced in keeping with the manufacturer's instruction should be implemented

Routine testing of the fire detection system should be implemented

Number of requirements:	3	Number of recommendations:	4

4.4 Is care effective?

Clinical records

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

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

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.

It was confirmed that 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 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. There was information available in regards to oral health and hygiene in the waiting area of the practice. A TV has recently been installed in the waiting area and it was confirmed that it will play slideshows with information in regards to the dental practice, treatments available and oral health and hygiene. The associate dentists confirmed that they actively promote oral health on an individual basis with patients during their consultations. An Oral Health Foundation teaching puppet was observed in one of the dental surgeries. This puppet is used to demonstrate brushing techniques.

Audits

Mrs MaGowan confirmed that the only audit to be completed was the IPS HTM 01-05 compliance audit. A recommendation was made that a rolling programme of audits should be developed and implemented to review the effectiveness and quality of care delivered. If applicable an action plan should be developed to address any shortfalls identified during the audit process.

Communication

Two associate dentists confirmed that arrangements are in place for onward referral in respect of specialist treatments.

Staff meetings have recently been implemented and Mrs MaGowan confirmed that they will be held on a monthly basis to discuss clinical and practice management issues. Minutes of staff meetings will be retained.

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. The following comments were provided:

- "Very happy with the care"
- "Excellent service"

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. No staff comments were included on submitted questionnaires.

Areas for improvement

A rolling programme of audits should be developed and implemented.

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 in order that they 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 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.

Patient and staff views

Fourteen of the 15 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 indicated that they did not feel that they were treated with dignity and respect. The following comment was provided:

- "I am treated with dignity"

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. The following comment was provided:

- "Patients always come first"

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements:	0	Number of recommendations:	0

4.6 Is the service well led?

Management and governance arrangements

Since taking ownership of the practice Mr McHale has computerised the practice and implemented electronic patient records, a CBCT x-ray machine and digital x-ray processing system has been installed, one of the dental surgeries has been refurbished and a rolling programme to refurbish the remaining dental surgeries has been established. The practice opening hours have been extended to provide late night opening and Saturday appointments and an email and SMS appointment reminder service is now in operation. Office, reception and patient waiting areas have been redecorated to include new floor coverings, and the external façade of the building has been redecorated and new signage fitted. A range of new treatment options including implants and endodontic treatments are now available in the practice.

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 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 displayed in the practice. Staff demonstrated a good awareness of complaints management. A complaints questionnaire was forwarded by RQIA to the practice for completion. Review of the completed complaints return, complaints records and discussion with staff evidenced 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.

As discussed previously arrangements to monitor, audit and review the effectiveness and quality of care delivered to patients at appropriate intervals have yet to be developed. The only audit routinely undertaken is the IPS HTM 01-05 compliance audit.

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

Information requested by RQIA has been submitted within specified timeframes. It was confirmed that the Statement of Purpose is kept under review, revised and updated when necessary and available on request. As discussed previously in section 4.2 a review of the Patient Guide demonstrated that it should be further developed to include the contact details of RQIA and information detailing how the most recent RQIA report can be accessed. A recommendation stated for the second time has been made in this regard.

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

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

Evidence gathered during the inspection has identified a number of issues which could affect the delivery of safe and effective care, all of which have an impact on quality assurance and good governance. Three requirements and six recommendations have been made in order to progress improvement in identified areas. There is a lack of governance arrangements within the practice and the requirements and recommendations made during this inspection must be actioned to ensure improvements are made. It is important these are kept under review to ensure improvements are sustained. An additional recommendation was made to review current monitoring systems to ensure effective quality assurance and governance arrangements are in operation.

Patient and staff views

Thirteen patients who submitted questionnaire responses indicated that they feel that the service is well managed; one patient indicated that they felt that the service is not well managed and one patent did not respond. The following comment was provided:

- "Is now being brought up to date. A nice facility with new technology"

A comment made by one patient regarding customer service was discussed with Mrs MaGowan who agreed to address the issue.

All submitted staff questionnaire responses indicated that they felt that the service is well managed. The following comment was provided:

- "The team we have are very good at explaining to us all. Great team to work with"

Areas for improvement

The Patient Guide should be reviewed to ensure it fully reflects the key themes in Regulation 8 of The Independent Health Care Regulations (Northern Ireland) 2005.

Review current monitoring systems to ensure quality assurance and governance arrangements are in operation.

Number of requirements:	0	Number of recommendations:	2

5.0 Quality improvement plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Beryl MaGowan, practice manager as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the 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 person 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 the DHSSPS Minimum Standards for Dental Care and Treatment (2011). They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed by the registered manager. Once fully completed, the QIP will be returned to Independent.Healthcare@rqia.org.uk and assessed 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 person/manager 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 person/manager 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 19 (2) Schedule 2 **Stated:** First time **To be completed by:** 03 May 2016	The registered person must ensure that staff personnel files for any newly recruited staff includes all information as specified in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005.
	Response by registered person detailing the actions taken: A new check-list that includes the information specified in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 has been applied to each personnel folder and we are currently requesting details that were previously omitted from the files.
Requirement 2 **Ref:** Regulation 19 (2) Schedule 2 **Stated:** First time **To be completed by:** 03 May 2016	The registered person must ensure that enhanced AccessNI checks are undertaken and received prior to new staff, including self-employed staff commencing work in the practice.
	Response by registered person detailing the actions taken: Access NI is now being applied for and obtained before staff start working in the practice.
Requirement 3 **Ref:** Regulation 15 (1) (b) **Stated:** First time **To be completed by:** 03 May 2016	The registered person must ensure that the following issues in relation to radiology and radiation safety are addressed: • A copy of the most recent RPA report in regards to the eight intra-oral x-ray machine should be retained in the radiation protection file. Recommendations made by the RPA should be signed and dated by the RPS to confirm they have been addressed • the RPS should sign and date to confirm that the recommendations made in the RPA report for the critical examination of the CBCT x-ray machine have been addressed • the RPS should ensure that the local rules for the CBCT x-ray machine are signed and dated by all appropriate staff to confirm that they have read and understood them • the RPS should ensure that x-ray quality grading audits are undertaken at least every six months and audits of justification and clinical evaluation recording are undertaken at least on an annual basis. All dentists who take x-rays should complete these audits
	Response by registered person detailing the actions taken: We have contact Estelle Walker for a copy of the most recent RPA report for the 8 intra-oral x-ray machines. Upon receipt the recommendations will be addressed and signed. The next inspection by the RPA is due in May 2017. The recommendations made in the CBCT report have been noted, some are already implemented and others are in the process of being implemented. We have also completed x-ray quality grading audits and have scheduled audit for justification and clinical evaluation.

Recommendations	
Recommendation 1 **Ref**: Standard 1 **Stated:** Second time **To be completed by:** 03 June 2016	The patient guide should fully reflect the key areas and themes specified in regulation 8 of The Independent Health Care Regulations (Northern Ireland) 2005.
	Response by registered person detailing the actions taken: .A sticker stating how to obtain a copy of RQIA report and the contact details for RQIA has been applied to all existing patient guides and the guide now fully reflects the key areas and themes specified in regulation 8 of the independent health care regulations (Northern Ireland) 2005
Recommendation 2 **Ref**: Standard 13 **Stated:** Second time **To be completed by:** 03 June 2016	It is recommended that all clinical waste bins are pedal operated.
	Response by registered person detailing the actions taken: We have obtained x8 60 litre pedal bins .
Recommendation 3 **Ref**: Standard11.8 **Stated:** First time **To be completed by:** 03 August 2016	All staff should have an annual appraisal. Records of appraisal should be retained for inspection.
	Response by registered person detailing the actions taken: Appraisals were started on the 25/5/16 and are now completed.
Recommendation 4 **Ref**: Standard 14.2 **Stated:** First time **To be completed by:** 03 June 2016	Records confirming that the fire detection system has been serviced in keeping with manufacturer's instructions should be retained.
	Response by registered person detailing the actions taken: A certificate of service was obtained for the inspection that was carried out on the 25/3/16 by FGM Fire Protection.
Recommendation 5 **Ref**: Standard 14.2 **Stated:** First time **To be completed by:** 03 June 2016	Arrangements should be established to ensure that routine testing of the fire detection system are implemented including testing of emergency break glass points and emergency lighting.
	Response by registered person detailing the actions taken: We have implementated a weekly testing schedule of the fire detection system which includes the break glass points and emergency lighting.

Recommendation 6 **Ref**: Standard 11.8 **Stated:** First time **To be completed by:** 03 June 2016	A rolling programme of audits should be developed and implemented to review the effectiveness and quality of care delivered. If applicable an action plan should be developed to address any shortfalls identified during the audit process.
	Response by registered person detailing the actions taken: We are working in close partnership with Dentex (a compliance company) to ensure that we understand and have in place the audits necessary to be able to identifiy and address any shortfalls that may arise from the auditing procedure .
Recommendation 7 **Ref**: Standard 8 **Stated:** First time **To be completed by:** 03 June 2016	The registered person should review current monitoring systems to ensure effective quality assurance and governance arrangements are in operation.
	Response by registered person detailing the actions taken: Our current monitoring systems are being review to ensure that we are addressing any issues and to ensure that we remain compliant and provide well led, effective , safe care for our patients.

The Regulation and Quality Improvement Authority

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