Announced Care Inspection Report
13 March 2017

Keady Dental Surgery

Type of service: Independent Hospital (IH) – Dental Treatment
Address: 56 Kinelowen Street, Keady, BT60 3SU
Tel no: 028 37531057
Inspector: Norma Munn

1.0 Summary

An announced inspection of Keady Dental Surgery took place on 13 March 2017 from 10:45 to 14:30.

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 Eamon Mallon, 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. Five recommendations have been made relating to staff appraisal, providing safeguarding training for staff, the development of safeguarding policies and procedures, infection prevention and control and fire safety.

A requirement had been made during a previous care inspection on 28 January 2015 in relation to AccessNI enhanced disclosure checks. This requirement had previously been addressed however, during this inspection issues of concern were again identified in relation to AccessNI enhanced disclosure checks.

A recommendation made during the previous care inspection on 19 November 2015 in relation to the recruitment of staff has not been addressed. During this inspection issues of concern were again identified in relation to the recruitment of staff.

RQIA is concerned that the safeguards to protect and minimise risk to patients, during recruitment, are being compromised.

Following consultation with senior management in RQIA, it was agreed that a meeting would be held with the registered person with the intention of issuing a failure to comply (FTC) notice.

A meeting was held on 23 March 2017 at the offices of RQIA. As a result a FTC notice was issued on 24 March 2017. The FTC notice relates to staff recruitment practices and the unmet recommendation in relation to staff recruitment has been subsumed into the notice. The date by which compliance must be achieved is 26 May 2017.

Is care effective?

Observations made, review of documentation and discussion with Mr Mallon, registered person and staff demonstrated that systems and processes were in place to ensure that care provided in the establishment was effective. Areas reviewed included clinical records, health promotion, audits and communication. No requirements or recommendations have been made.

Is care compassionate?

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

Is the service well led?

Information gathered during the inspection evidenced some deficits in terms of leadership and governance arrangements. 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 person's understanding of their role and responsibility in accordance with legislation.

Whilst Mr Mallon demonstrated a clear understanding of his role and responsibility in accordance with legislation and registration with RQIA, as a result of the issues identified during this inspection, a failure to comply notice has been issued to Keady Dental Surgery in relation to staff recruitment practices.

Several recommendations have been made to address the deficits identified during this inspection. In addition a recommendation has been made to review 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	0	6

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mr Mallon, registered person, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action resulted 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 19 November 2015.

2.0 Service details

Registered organisation/registered person: Mr Eamon Mallon Mrs Anne Marie Mallon	**Registered manager:** Mr Eamon Mallon
Person in charge of the practice at the time of inspection: Mr Eamon Mallon	**Date manager registered:** 29 October 2012
Categories of care: Independent Hospital (IH) – Dental Treatment	**Number of registered places:** 4

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 Mallon, registered person, two associate dentists, a dental hygienist, three dental nurses and a trainee dental nurse. A tour of some 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 19 November 2015

The most recent inspection of the establishment was an announced 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 19 November 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 12.4 **Stated:** First time	Paediatric pads for use with the automated external defibrillator (AED) should be provided. **Action taken as confirmed during the inspection**: Separate paediatric pads had not been provided for the AED in the practice. Mr Mallon confirmed that the pads that are already provided are suitable for use with a child. Mr Mallon has agreed to discuss this issue further with the practice's external training provider and has agreed to purchase paediatric pads if needed. The actions taken to address this recommendation are considered to be satisfactory.	**Met**
Recommendation 2 **Ref:** Standard 11.1 **Stated:** First time	Information as outlined in Regulation 19 (2), Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 should be retained in the personnel files of any new staff recruited to include: • positive proof of identity, including a recent photograph; • 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; and • criminal conviction declaration.	**Not Met and subsumed into a failure to comply notice**

	Action taken as confirmed during the inspection: Mr Mallon confirmed that two staff had commenced work in Keady Dental Surgery since the previous inspection. One of the staff members had commenced employment on 30 March 2016. However, a satisfactory AccessNI enhanced disclosure check had not been received until 19 May 2016, some six weeks later. The second staff member had commenced employment in September 2016. However, application for an AccessNI enhanced disclosure check had not been made until 23 February 2017, some five months following commencement of employment and at the time of the inspection a satisfactory AccessNI enhanced disclosure check had still not been received. Review of the identified staff personnel files evidenced that not all documentation as specified in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 had been sought and retained. The personnel files did not contain a criminal conviction declaration, an employment history to include an explanation of any gaps in employment, qualifications or a copy of the job description. One file contained only one written reference and the second file did not contain any written references. Proof of identification was included in one file only. Despite having raised these matters during the previous inspections RQIA are concerned that the safeguards to protect and minimise risk to patients, during recruitment, are being compromised. Following consultation with senior management in RQIA, it was agreed that a meeting would be held with the registered person with the intention of issuing a FTC notice. A meeting was held on 23 March 2017 at the offices of RQIA. As a result a FTC notice was issued on 24 March 2017. The date by which compliance must be achieved is 26 May 2017. This recommendation has not been met and has been subsumed into the failure to comply notice.	

Recommendation 3 **Ref**: Standard 11.1 **Stated:** First time	Enhanced AccessNI disclosure certificates must be disposed of in keeping with AccessNI's code of practice and a record retained of the dates the check was applied for and received, the unique identification number and the outcome of the check.	**Met**
	Action taken as confirmed during the inspection: An AccessNI disclosure certificate was observed in one of the files reviewed. This was discussed with Mr Mallon. Mr Mallon was advised to dispose of the certificate in keeping with AccessNI's code of practice and retain a record of the dates the check was applied for and received, the unique identification number and the outcome of the check. Following the inspection Mr Mallon confirmed that the AccessNI certificate had been disposed of. Mr Mallon forwarded to RQIA a copy of the record of the AccessNI check which included dates the check was applied for and received, the unique identification number and the outcome of the check.	
Recommendation 4 **Ref:** Standard11.1 **Stated:** First time	A staff register should be developed and kept updated containing staff details including, name, date of birth, position; dates of employment; and details of professional qualification and professional registration with the GDC, where applicable.	**Met**
	Action taken as confirmed during the inspection: Mr Mallon confirmed that a staff register had been developed. A copy of the staff register was forwarded to RQIA following the inspection. The register contained staff details including, name, position, dates of employment, details of professional qualification and professional registration with the GDC, where applicable. Mr Mallon has agreed to also include dates of birth.	

Recommendation 5 **Ref:** Standard 11.3 **Stated:** First time	Formal written induction programmes should be developed relevant to specific roles within the practice for new staff. Completed induction forms should be retained in staff personnel files.	**Met**
	Action taken as confirmed during the inspection: Mr Mallon confirmed that written induction templates had been developed for different roles within the practice. A review of two staff personnel files evidenced that induction programmes had been completed and retained. Mr Mallon was advised that the completed inductions should be signed by both the inductor and the member of staff being inducted.	

4.3 Is care safe?

Staffing

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

Mr Mallon confirmed that induction programme templates were in place relevant to specific roles and responsibilities. As previously discussed induction programmes had been completed when new staff joined the practice. Mr Mallon was advised that the completed inductions should be signed by both the inductor and the member of staff being inducted.

Mr Mallon and staff confirmed that formal staff appraisals had not been undertaken. Staff confirmed that they felt supported and involved in discussions about their personal development. A recommendation has been made that a system should be implemented for appraising staff performance at least on an annual basis.

Staff spoken with confirmed that they keep themselves updated with their General Dental Council (GDC) continuing professional development (CPD) requirements. Training records confirming staff training had been undertaken were retained and available for inspection with the exception of safeguarding training. This is discussed further in the safeguarding section of the report.

A review of records confirmed that a robust system was in place to review the registration status and professional indemnity of all clinical staff.

Recruitment and selection

During a previous announced inspection on 28 January 2015 it was identified that a member of staff had commenced employment without the required AccessNI enhanced disclosure check having been received. Mr Mallon was advised that an AccessNI enhanced disclosure check must be undertaken and received for each new staff member prior to commencement of employment and a requirement was made.

During the announced inspection on 19 November 2015 two personnel files of staff recruited since registration were reviewed. Not all documentation relating to recruitment of staff was

available for inspection and not all of the information as listed in Schedule 2 of the Independent Health Care Regulations (Northern Ireland) 2005 as amended, had been obtained and retained for the staff employed. However, the requirement in relation to AccessNI enhanced disclosure checks had been addressed. A recommendation was made to address the other recruitment issues.

During this inspection it was identified that two staff members had commenced employment since the previous inspection on 19 November 2015.

A review of the records evidenced that not all of the documents relating to the recruitment process had been obtained prior to commencement of employment.

As previously discussed one of the staff members had commenced employment on 30 March 2016. However, a satisfactory AccessNI enhanced disclosure check had not been received until 19 May 2016, some six weeks later. The second staff member had commenced employment in September 2016. However, application for an AccessNI enhanced disclosure check had not been made until 23 February 2017, some five months following commencement of employment and at the time of the inspection a satisfactory AccessNI enhanced disclosure check had still not been received.

In addition, not all of the information as listed in Schedule 2 of the Independent Health Care Regulations (NI) 2005 as amended, had been obtained and retained for the identified staff.

RQIA is concerned that the safeguards to protect and minimise risk to patients, during recruitment, are being compromised.

Following consultation with senior management in RQIA, it was agreed that a meeting would be held with the registered person with the intention of issuing a failure to comply notice.

A meeting was held on 23 March 2017 at the offices of RQIA. As a result a FTC notice was issued on 24 March 2017. The FTC notice relates to staff recruitment practices and the unmet recommendation in relation to staff recruitment has been subsumed into the notice. The date by which compliance must be achieved is 26 May 2017.

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

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.

Mr Mallon confirmed that not all staff had received training in safeguarding children and adults as outlined in the Minimum Standards for Dental Care and Treatment 2011. Some staff confirmed that they had attended safeguarding training however; records had not been retained. A recommendation has been made.

Two separate policies and procedures were in place for the safeguarding and protection of children and adults at risk of harm. The policies had not been updated to fully reflect the new regional safeguarding policies and procedural guidance. Copies of the new regional policies and guidance were not available for staff reference.

Following the inspection the following documentation was forwarded to Mr Mallon by email:

- 'Adult Safeguarding Prevention and Protection in Partnership' (July 2015)
- 'Adult Safeguarding Operational Procedures Adults at Risk of Harm and Adults in Need of Protection' (September 2016)
- 'Co-operating to Safeguard Children and Young People in Northern Ireland' (issued March 2016)

A recommendation has been made that the policies and procedures in respect of safeguarding children and adults at risk of harm and abuse should be updated to ensure they fully reflect the regional policies and guidance documents.

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 with the exception of separate paediatric pads for the AED as previously discussed. Mr Mallon has agreed to discuss this issue further with the practice's external training provider and has agreed to purchase paediatric pads if needed.

A system was in place to ensure that emergency medicines and equipment do not exceed their expiry date. However, two of the oropharyngeal airways provided had exceeded their expiry dates. Mr Mallon agreed to replace these and gave assurances that the expiry date checking system would be more robust in the future. 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. Staff had not attended medical emergency training since December 2015. This was discussed with Mr Mallon who confirmed that medical emergency training had been arranged to take place on 5 April 2017. Mr Mallon was advised that medical emergency training should 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.

The policy for the management of medical emergencies reflected best practice guidance. Protocols were available for staff reference outlining the local procedure for dealing with the various medical emergencies. Some of the protocols displayed for dealing with medical emergencies were not in keeping with current best practice. Mr Mallon agreed to remove any out of date protocols displayed and replace these with current protocols.

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. Several issues identified, which are not in keeping with best practice in relation to infection prevention and control, are as follows:

- the floor and work surfaces in the orthopan tomogram machine (OPG) room should be cleared and remain clear to allow for effective cleaning to take place
- the overflow in the identified hand wash basin should be blanked off and sealed using a stainless steel plate and anti-bacterial mastic and the plug should be removed
- repair or replace the identified damaged/ripped operators chairs
- provide pedal or sensor operated waste bins in clinical areas
- all posters in clinical areas should be laminated to allow effective cleaning

These issues were discussed with Mr Mallon and a recommendation to address them has been made.

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 two washer disinfectors and two 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 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 March 2017.

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

Radiography

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

A dedicated radiation protection file containing the relevant local rules, employer's procedures and other additional information was retained. 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, x-ray audits and digital processing.

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 demonstrated that the recommendations made have been addressed.

The x-ray equipment has been serviced and maintained 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 fair standard of maintenance and décor. The use of wallpaper in the surgeries was discussed and it was agreed that this would be removed or cladded over during the next refurbishment.

Detailed cleaning schedules and a colour coded cleaning system was in place.

Arrangements were in place for maintaining the environment. This included routine servicing of the fire detection system and firefighting equipment. Portable appliance testing (PAT) of electrical equipment was undertaken during March 2017 and arrangements are in place to ensure the fixed electrical wiring installation are inspected.

A legionella risk assessment was last undertaken in 2015 and had been reviewed during 2016 and water temperatures are monitored and recorded as recommended.

A fire risk assessment had been undertaken and reviewed in 2016. Staff demonstrated that they were aware of the action to take in the event of a fire. Mr Mallon and staff confirmed that fire training and fire drills had not taken place for some time. A recommendation has been made in this regard.

Patient and staff views

Thirteen patients submitted questionnaire responses to RQIA. All indicated that they felt safe and protected from harm. One comment provided included the following:

- "Yes, at all times."

Six 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 implemented for appraising staff performance at least on an annual basis.

Safeguarding training to include adults and children should be provided as outlined in the Minimum Standards for Dental Care and Treatment (2011). Training records should be retained and available for inspection.

Policies and procedures in respect of safeguarding children and adults at risk of harm and abuse should be updated to ensure they fully reflect the regional policies and guidance documents.

Issues identified in relation to infection prevention and control should be addressed.

Staff should be provided with fire safety awareness training and fire drills should be undertaken annually.

Number of requirements	0	Number of recommendations	5

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 it was confirmed that treatment plans are developed in consultation with patients. It was confirmed that patients are informed about the cost of treatments, choices and options.

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

Policies were available in relation to records management, data protection and confidentiality and consent.

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

Health promotion

The practice has a strategy for the promotion of oral health and hygiene. A range of health promotion information leaflets were available in the reception area. A dedicated health promotion area for patients was observed in one of the surgeries displaying the amount of sugar contained in various items of food, cereals and drinks. Mr Mallon confirmed that oral health is actively promoted on an individual level with patients during their consultations. A dental hygienist service is available within the practice for patients to attend if required.

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 compliance
- review of complaints/accidents/incidents

Communication

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

Staff meetings are held on a frequent 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 13 patients who submitted questionnaire responses indicated that they get the right care, at the right time and with the best outcome for them. No comments were included in submitted questionnaire responses.

All six 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

No areas for improvement were identified during the inspection.

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

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 demonstrated how they 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 ensures that patients understand what treatment is available to them and can make an informed choice.

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.

A policy and procedure was in place in relation to confidentiality.

Patient and staff views

All 13 patients who submitted questionnaire responses indicated that they are treated with dignity and respect and are involved in decision making affecting their care. One comment provided included the following:

- "Yes, all staff are brilliant always. No matter how busy they are!"

All six 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

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

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 Mallon has 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.

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

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

Mr Mallon 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.

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.

Mr Mallon demonstrated a clear understanding of his role and responsibility in accordance with legislation. However, as discussed a review of documentation and discussion with Mr Mallon evidenced areas of concern in relation to the recruitment and selection of staff. Robust governance arrangements to ensure that staff will be recruited in keeping with legislative requirements have yet to be developed and a failure to comply notice has been issued to address this.

Evidence gathered during the inspection has identified a number of issues which could affect the delivery of safe care, all of which have an impact on quality assurance and good governance. Five recommendations have been made in order to progress improvement in identified areas. There is a lack of governance arrangements within the practice and the 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 has been made to review current monitoring systems to ensure effective quality assurance and governance arrangements are in operation.

Patient and staff views

All 13 patients who submitted questionnaire responses indicated that they felt that the service is well managed. One comment provided included the following:

- "Excellent service."

All six 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

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

Number of requirements	0	**Number of recommendations**	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mr Mallon, 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

Recommendations	
Recommendation 1 **Ref:** Standard 11 **Stated:** First time **To be completed by:** 13 May 2017	A system should be implemented for appraising staff performance at least on an annual basis. Records should be retained and available for inspection.
	Response by registered provider detailing the actions taken: Annual structured interview of staff members each April,including performance,training needs and remuneration has been the norm for many years,long pre-dating RQIA.However we will endeavour to record these interviews in a format RQIA can relate to
Recommendation 2 **Ref:** Standard 15.3 **Stated:** First time **To be completed by:** 13 June 2017	Training in safeguarding adults at risk of harm and safeguarding children should be provided to all staff as outlined in the Minimum Standards for Dental Care and Treatment (2011). Training records should be retained and available for inspection 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) should be included in the training provided.
	Response by registered provider detailing the actions taken: Four members of staff have attended a recent course organised by NMDTA.Two are undertaking an on-line course.Two key members of staff are on maternity leave,one recently retired. New regional guidance already in place.
Recommendation 3 **Ref:** Standard 15.3 **Stated:** First time **To be completed by:** 13 June 2017	The policies and procedures in respect of safeguarding children and adults at risk of harm and abuse should be updated to ensure they fully reflect the regional policies and guidance documents.
	Response by registered provider detailing the actions taken: As above
Recommendation 4 **Ref:** Standard 13 **Stated:** First time **To be completed by:** 13 May 2017	Address the following issues identified in relation to infection prevention and control: • the floor and work surfaces in the OPG room should be cleared and remain clear to allow for effective cleaning to take place • the overflow in the identified hand wash basin should be blanked off and sealed using a stainless steel plate and anti-bacterial mastic and the plug should be removed • repair or replace the identified damaged/ripped operators chairs • provide pedal or sensor operated waste bins in clinical areas • all posters in clinical areas should be laminated to allow for effective cleaning to take place

	Response by registered provider detailing the actions taken: Delivery of two cardboard boxes containing gloves etc awaiting availability of staff member to unpack and cupboard space. Plumber contacted. Small tear in Operator's chair.. ,covering replaced,though not exactly a threat to patient wellbeing. Bins are already pedal operated. Two posters coloured in by child patients removed from notice board. A little insight into day to day running of a busy practice and perspective perhaps..
Recommendation 5 **Ref:** Standard 12.5 **Stated:** First time **To be completed by:** 13 June 2017	Staff should be provided with fire safety awareness training and fire drills should be undertaken annually.
	Response by registered provider detailing the actions taken: Training update organised with external providers for late July.Annual Fire drills are reorded and documented documented by RQIA each year.
Recommendation 6 **Ref:** Standard 8 **Stated:** First time **To be completed by:** 13 June 2017	Mr Mallon should review current monitoring systems to ensure effective quality assurance and governance arrangements are in operation.
	Response by registered provider detailing the actions taken: Changes made to Clinical Assurance File as requested

The Regulation and Quality Improvement Authority

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