Announced Care Inspection Report
28 February 2017

Kircubbin Dental Practice

Type of service: Independent Hospital (IH) – Dental Treatment
Address: 70 Main Street, Kircubbin, BT22 2SP
Tel no: 028 4273 8729
Inspector: Norma Munn

1.0 Summary

An announced inspection of Kircubbin Dental Practice took place on 28 February 2017 from 10:00 to 13:50.

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 Ms Anne Abraham, 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. Four requirements have been made that relate to staffing levels, the provision of dental instruments, the decontamination of dental instruments and fire safety. One recommendation stated during the previous inspection in relation to the issuing of contracts of employment/agreements has been stated for a second time. Two recommendations have been made in relation to infection prevention and control and the periodic testing of decontamination equipment.

Is care effective?

Observations made, review of documentation and discussion with Ms Abraham 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 Ms Abraham 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 identified that further development is needed to ensure that effective leadership and governance arrangements are in place and 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, insurance arrangements and the registered provider's understanding of their role and responsibility in accordance with legislation. As discussed above a number of issues were identified which relate to quality assurance and good governance. 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	4	4

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Abraham as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 06 November 2015.

There were no further actions required to be taken following the most recent inspection.

2.0 Service details

Registered organisation/registered person: Den.Co.Down Ltd Ms Anne Abraham	**Registered manager:** Mrs Alison Rainey
Person in charge of the practice at the time of inspection: Ms Anne Abraham	**Date manager registered:** 17 June 2012
Categories of care: Independent Hospital (IH) – Dental Treatment	**Number of registered places:** 2

3.0 Methods/processes

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

During the inspection the inspector met with Ms Anne Abraham, registered person, the practice manager, one associate dentist 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 06 November 2015

The most recent inspection of the practice 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 06 November 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 19 (2) Schedule 2 **Stated:** First time	The registered person must ensure that staff personnel files for newly recruited staff, including self-employed staff contain all information as specified in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005. In addition the registered person must ensure that proof of identity including a recent photograph is added to the identified staff personnel file.	**Met**
	Action taken as confirmed during the inspection: A review of the submitted staffing information and discussion with Ms Abraham confirmed that no new staff have been recruited since the previous inspection. However, Ms Abraham 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. It was confirmed that proof of identity has been added to the identified staff personnel file.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 12.4 **Stated:** First time	It is recommended that oropharyngeal airways and clear face masks suitable for use with children should be provided.	**Met**
	Action taken as confirmed during the inspection: Oropharyngeal airways and clear face masks suitable for use with children had been provided.	
Recommendation 2 **Ref:** Standard 12.4 **Stated:** First time	It is recommended that more robust arrangements are implemented to ensure emergency medicines and equipment do not exceed their expiry date.	**Met**
	Action taken as confirmed during the inspection: A review of records confirmed that a more robust system has been implemented to ensure emergency medicines and equipment does not exceed their expiry date.	
Recommendation 3 **Ref:** Standard 12.1 **Stated:** First time	It is recommended that the policy for the management of medical emergencies is further developed in line with best practice.	**Met**
	Action taken as confirmed during the inspection: The policy for the management of medical emergencies was reviewed and is in line with best practice.	
Recommendation 4 **Ref:** Standard 11.3 **Stated:** First time	It is recommended that a record of induction and a copy of the job description are retained in staff personnel files.	**Met**
	Action taken as confirmed during the inspection: Ms Abraham confirmed that no new staff have been recruited since the previous inspection. However, Ms Abraham confirmed that should staff be recruited in the future a record of induction and copy of the job description will be retained and available for inspection.	

Recommendation 5 **Ref:** Standard 11.1 **Stated:** First time	It is recommended that all staff who work in the practice, including self-employed staff should be provided with a contract/agreement. Records of contracts/agreements should be retained in the personnel files of any new staff recruited.	**Not Met**
	Action taken as confirmed during the inspection: Discussion with Ms Abraham and an associate dentist confirmed that not all staff had been issued contracts of employment/agreement. This recommendation has not been addressed and has been stated for a second time.	

4.3 Is care safe?

Staffing

Two dental surgeries are in operation in this practice. Discussion with staff and a review of the responses contained in completed staff questionnaires identified that there was not always sufficient staff on duty to meet the needs of the patients and the practice. As outlined in legislation the responsibility for adequate staff cover lies with the registered person. Ms Abraham confirmed that she has been actively trying to recruit staff without success. Mrs Abraham has agreed to review the current staffing levels to ensure that sufficient staff are provided to meet the needs of the practice and patients. A requirement has been made in this regard.

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.

Procedures were in place for appraising staff performance and staff confirmed that appraisals had taken place. Staff confirmed that they felt supported and involved in discussions about their personal development. There was a system in place to ensure that all staff 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

As previously discussed, 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.

As previously discussed, not all staff have been issued with a contract of employment or an agreement. A recommendation made during the previous inspection in this regard has not been addressed and has been stated for a second time.

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.

Review of records and discussion with Ms Abraham demonstrated that all staff had received training in safeguarding children and adults as outlined in the Minimum Standards for Dental Care and Treatment 2011.

Policies and procedures were in place for the safeguarding and protection of children and adults 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 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) has been provided for staff reference. Ms Abraham has agreed to review the safeguarding children and adults policies to reflect the new regional guidance.

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. An automated external defibrillator (AED) was not available in the practice and Ms Abraham confirmed that an AED is available at the nearby medical practice in close proximity to the practice and can be accessed in a timely manner. The use of the AED has been incorporated within the practice emergency procedures. As previously discussed, a more robust system has been implemented 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 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.

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.

Infection prevention control and decontamination procedures

Clinical and decontamination areas were tidy and uncluttered and work surfaces were intact and easy to clean. In the main, fixtures and fittings were free from damage, dust and visible dirt.

Issues were identified in the environment that relate to infection prevention and control as follows:

- a damp area was observed on the wall in surgery one
- a damaged dental chair was observed in surgery one
- hand towels dispensers in clinical areas were not all restocked
- sharps boxes were not all signed and dated on assembly

A recommendation has been made to address the issues identified.

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 were aware of best practice in terms of the uniform and hand hygiene policies. 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 a washer disinfector and three steam sterilisers have been provided. A review of documentation evidenced that equipment used in the decontamination process has been appropriately validated.

Staff confirmed that due to the stock of reusable dental instruments available and the demands of the practice, that they routinely manually clean instruments prior to sterilisation, as opposed to processing them in the washer disinfector. This is not in keeping with best practice guidance which specifies that all compatible dental instruments must be processed using an automated system such as a washer disinfector and that manual cleaning should only be used as a temporary measure. These issues were discussed with Ms Abraham. A requirement has been made to review and increase the provision of reusable dental instruments and a further requirement has been made to ensure that the practice of routinely manually cleaning dental instruments ceases with immediate effect.

A review of equipment logbooks evidenced that, in the main, periodic tests are undertaken and recorded in keeping with Health Technical Memorandum (HTM) 01-05 Decontamination in primary care. The washer disinfector logbook evidenced that a protein residue test is undertaken every six weeks. This is not in keeping with best practice guidance which specifies that a protein residue test should be undertaken weekly. A recommendation has been made to address this.

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 January 2017. Given the issues identified during the inspection the IPS audit should be revisited to ensure it is meaningful in identifying issues in relation to infection prevention and control. An action plan should be developed and embedded into practice to address any shortfalls identified during the audit process.

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

Radiography

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

A dedicated radiation protection file containing the relevant local rules, employer's procedures and other additional information was retained. 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 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.

Discussion with staff and a review of the responses contained in completed staff questionnaires identified issues in relation to the environment and emergency exit. These issues were discussed with Ms Abraham.

On the day of the inspection the entrance to the premises was easily accessible, any hazards in relation to steps were clearly identified. The emergency exits were generally clear however, the room leading to the emergency exit at the rear of the premises was cluttered with various items stored on the floor. Ms Abraham was advised to de clutter this area to ensure that the escape route and emergency exit is kept clear at all times. A requirement has been made to ensure that all emergency escape routes and fire exits are kept clear at all times.

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

Arrangements were in place for maintaining the environment. This included servicing of the fire detection system, firefighting equipment and portable appliance testing (PAT) of electrical equipment.

A legionella risk assessment had been undertaken and water temperatures are monitored and recorded as recommended.

A fire risk assessment had been undertaken and staff confirmed fire drills had been completed. Staff demonstrated that they were aware of the action to take in the event of a fire. As previously discussed all fire exits must be kept clear at all times.

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

Patient and staff views

One patient submitted a questionnaire response to RQIA. The patient indicated that they felt safe and protected from harm. No comments were included in submitted questionnaire responses.

Three staff submitted questionnaire responses. Two staff indicated that they felt that patients are safe and protected from harm and one did not feel that patients were safe and protected from harm. Staff made comments in relation to the environment, emergency exit and staffing levels.

Some comments provided included the following:

- "I am not happy with the disabled access: narrow doorways, step inside the door, and saddle boards at surgery one and reception, difficult for wheelchairs and a tripping hazard for patients with impaired mobility and impaired vision. Not well maintained, emergency exit often blocked with rubbish."
- "Not enough staff to cover if someone is off/sick/holidays."
- "Understaffed at Kircubbin Dental leaving no time for many important needs."

As previously discussed, the issues identified in the questionnaires were discussed with Ms Abraham during the inspection. Ms Abraham has agreed to investigate and address any issues identified.

Areas for improvement

Staffing levels must be reviewed to ensure that sufficient staff are provided to meet the needs of the practice and patients.

All staff who work in the practice, including self-employed staff should be provided with a contract/agreement. Records of contracts/agreements should be retained in the personnel files of any new staff recruited.

Address the issues identified in relation to infection prevention and control.

The provision of dental instruments must be reviewed and increased to meet the needs of the practice requirements.

Ensure that the routine practice of manually cleaning dental instruments prior to sterilisation as opposed to using an automated process such as a washer disinfector ceases with immediate effect. All compatible reusable dental instruments must be cleaned using an automated process.

The protein residue test should be undertaken weekly and recorded in the washer disinfector logbook.

All emergency escape routes and fire exits must be kept clear at all times.

Number of requirements	4	**Number of recommendations**	3

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. Oral health is actively promoted on an individual level with patients during their consultations. A range of health promotion information leaflets and products to purchase were available in the practice. Ms Abraham discussed how the practice has published information in relation to the promotion of oral health and hygiene in a local advertising newspaper.

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

As previously discussed, the IPS audit should be revisited to ensure it is meaningful in identifying issues in relation to infection prevention and control. An action plan should be developed and embedded into practice to address any shortfalls identified during the audit process.

Communication

Ms Abraham confirmed that arrangements are in place for onward referral in respect of specialist treatments.

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.

A breaking bad news policy in respect of dentistry was in place.

Patient and staff views

The patient who submitted a questionnaire response 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 three 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.

One comment provided included the following:

- "The staff strive to provide the best treatment they can, and show care towards patients and compassion."

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 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 ensures patients understand what treatment is available to them and can make an informed choice. Staff demonstrated how consent would be obtained.

A review of the one of the responses contained in the completed staff questionnaires identified an issue in relation to patient satisfaction surveys. This was discussed with Ms Abraham and the practice manager. The practice manager confirmed that the practice undertakes patient satisfaction surveys on an annual basis. A suggestion box was observed in the waiting area for patients to access.

The most recent patient satisfaction report was not reviewed during this inspection however, the practice manager confirmed that the practice pro-actively seeks the views of patients about the quality of treatment and other services provided. It was also confirmed that patient feedback whether constructive or critical, is used by the practice to improve, as appropriate. The most recent patient satisfaction report should be made available for both staff and patients to access.

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

Patient and staff views

The patient who submitted a questionnaire response indicated that they are treated with dignity and respect and are involved in decision making affecting their care. No comments were included in submitted questionnaire responses.

All three 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.

One comment provided included the following:

- "I am not sure that we frequently encourage patient satisfaction surveys, or have a suggestion box that is acted upon."

As previously discussed, the issue identified in the questionnaire was discussed with Ms Abraham and the practice manager during the inspection. The practice manager has agreed to address the issue raised.

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

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 generally responsive to any suggestions or concerns raised. However, a review of a response contained in one completed staff questionnaire identified an issue in relation to the management of the practice. This was discussed with Ms Abraham who has agreed to address the issue raised.

Mrs Alison Rainey is the registered manager for Kircubbin Dental Surgery and also the registered manager for Ards Dental Surgery. Ms Abraham confirmed that although Mrs Rainey works mainly in Ards she has regular telephone contact with the practice manager in Kircubbin and assists the practice manager in the day to day management of the practice. Ms Abraham also works in Kircubbin one day each week.

As a result of the issues identified during this inspection, Mrs Abraham has agreed to review the overall day to day management of the practice to ensure that effective quality assurance and governance arrangements are in operation. Four requirements and three recommendations have been made in order to progress improvement in identified areas. There has been 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. Therefore, an additional recommendation has made to review current monitoring systems to ensure effective quality assurance and governance arrangements are in operation.

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.

Ms Abraham 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.

Ms Abraham demonstrated a clear understanding of her 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

The patient who submitted a questionnaire response indicated that they felt that the service is well managed. No comments were included in submitted questionnaire responses.

All three submitted staff questionnaire responses indicated that they felt that the service is well led. Staff spoken with during the inspection concurred with this.

One comment provided included the following:

- "As best as possible with short staffing issues."

As previously discussed, a response contained in one completed staff questionnaire identified an issue in relation to the management of the practice. This was discussed with Ms Abraham who has agreed to address the issue raised.

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 Ms Anne Abraham, registered person, as part of the inspection process. The timescales commence from the date of inspection.

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

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

5.1 Statutory requirements

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

5.2 Recommendations

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

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to independent.healthcare@rqia.org.uk for assessment by the inspector.

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

Quality Improvement Plan	
Statutory requirements	
Requirement 1 **Ref:** Regulation 18 (1) **Stated:** First time **To be completed by:** 28 March 2017	The registered person must review the staffing levels to ensure that there is sufficient staff employed in the practice at all times to meet the needs of the patients and practice.
	Response by registered provider detailing the actions taken: Interviewing nurse, dentist going off on maternity. This eases staffing situation.
Requirement 2 **Ref:** Regulation 15 (1) (c) **Stated:** First time **To be completed by:** 28 March 2017	The registered person must review and increase the provision of dental instruments to meet the needs of the practice requirements.
	Response by registered provider detailing the actions taken: Completed.
Requirement 3 **Ref:** Regulation 15 (3) **Stated:** First time **To be completed by:** 28 February 2017	The registered person must ensure that the routine practice of manually cleaning dental instruments prior to sterilisation as opposed to using an automated process such as a washer disinfector must cease with immediate effect. All compatible reusable dental instruments must be cleaned using an automated process.
	Response by registered provider detailing the actions taken: Completed.
Requirement 4 **Ref:** Regulation 25 (4) (b) **Stated:** First time **To be completed by:** 28 February 2017	The registered person must ensure that all emergency escape routes and fire exits are kept clear at all times.
	Response by registered provider detailing the actions taken: Completed.

Recommendations	
Recommendation 1 **Ref:** Standard 11.1 **Stated:** Second time **To be completed by:** 28 April 2017	It is recommended that all staff who work in the practice, including self-employed staff should be provided with a contract/agreement. Records of contracts/agreements should be retained in the personnel files of any new staff recruited.
	Response by registered provider detailing the actions taken: Will be completed by 28th April.
Recommendation 2 **Ref**: Standard 13.2 **Stated:** First time **To be completed by:** 28 April 2017	The following issues identified in relation to infection prevention and control should be addressed: • the cause of the damp area on the wall in surgery one should be investigated and made good • the damaged dental chair in surgery one should be repaired/reupholstered • hand towels dispensers in clinical areas should well stocked • sharps boxes should be signed and dated on assembly
	Response by registered provider detailing the actions taken: Builder has investigated this damp area, further investigations being carried out. Dispensers now filled. Sharps boxes are now being signed and dated. Chair booked for 27th April to be re upholstered.
Recommendation 3 **Ref:** Standard 13.4 **Stated:** First time **To be completed by:** 28 February 2017	The protein residue test should be undertaken weekly and recorded in the washer disinfector logbook.
	Response by registered provider detailing the actions taken: Completed
Recommendation 4 **Ref:** Standard 11.8 **Stated:** First time **To be completed by:** 28 April 2017	Review current monitoring systems to ensure effective quality assurance and governance arrangements are in operation.
	Response by registered provider detailing the actions taken: Staff meetings every 6 weeks to review/discuss/improve our service.

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

The Regulation and Quality Improvement Authority

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