Announced Care Inspection Report
7 and 9 June 2016

Lisburn Road Dental & Implant Clinic

Service type: Independent Hospital (IH) - Dental Treatment

Address: 424 Lisburn Road, Belfast, BT9 6GN
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Inspector: Carmel McKeegan

1.0 Summary

An announced inspection of Lisburn Road Dental & Implant Clinic took place on 7 June 2016 from 10:30 to 1:15. Due to unforeseen circumstances, some documentation could not be accessed on the day, therefore the inspection continued on 9 June 2016 from 12.45 to 13.30.

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 Mr Finnegan, Registered Person and staff demonstrated that improvements are needed to ensure that care to patients is safe and avoids and prevents harm. Areas reviewed included staffing, recruitment and selection, safeguarding, management of medical emergencies, infection prevention control and decontamination, radiology and the general environment. One requirement was made to ensure staff have received appropriate training in the sedation technique being used and two requirements have been made in relation to radiology and radiation safety.

Thirteen recommendations were also made including two recommendations that have been stated for a second time, of which, one related to staff recruitment records and one related to Access NI records. One recommendation has been made in relation to staff inductions, two in relation to infection control issues, three in relation to recording the results of periodic testing in respect of decontamination equipment and two in relation to radiation safety. Three further recommendations related to the provision of appropriate cleaning equipment, to undertake an up to date fire risk assessment and to undertake a legionella risk assessment.

Is care effective?

Observations made, review of documentation and discussion with Mr Finnegan and staff demonstrated that effective systems were in place in relation to the management of clinical records and the practice's health promotion strategy. However, there was limited evidence to confirm that there were arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to patients at appropriate intervals. Recommendations were made to establish a programme of audit to monitor and review the effectiveness and quality of care delivered to patients and to establish regular staff meetings.

Is care compassionate?

Observations made, review of documentation and discussion with Mr Finnegan 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, alerts, insurance arrangements and the registered person's understanding of their role and responsibility in accordance with legislation. A recommendation has been made to establish a process of systematic review of practice policies and procedures, on at least a three yearly basis or more frequently as required, the date of implementation and the planned date of review should be recorded on all policies and procedures.

A significant number of requirements and recommendations have been made to address the deficits identified including two recommendations which have been stated for a second time. In addition, other areas identified as requiring improvement were addressed during or immediately after the inspection.

Mr Finnegan must review the current governance and oversight arrangements and ensure that any future arrangements address the issues identified and ensure improvements are sustained. A requirement has been made in this regard

The findings of the inspection was discussed with Lynn Long , senior inspector in RQIA, following which a decision was made to undertake a follow-up inspection in order to seek assurances that the issues identified in the Quality Improvement Plan (QIP) have been addressed. Mr Finnegan was informed that an unannounced follow-up inspection will be undertaken at Lisburn Road Dental and Implant Clinic.

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	16

Details of the QIP within this report were discussed with Mr Greg Finnegan, registered person, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent care inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last inspection.

2.0 Service details

Registered organisation/registered person: Mr Greg Finnegan	**Registered manager:** Mr Greg Finnegan
Person in charge of the service at the time of inspection: Mr Greg Finnegan	**Date manager registered:** 22 October 2012
Categories of care: Independent Hospital (IH) – Dental Treatment	**Number of registered places:** 3

3.0 Methods/processes

Questionnaires were provided to patients and staff prior to the inspection by the practice on behalf of the RQIA. Staffing information and a complaints declaration was provided at the time of the inspection. RQIA did not receive any completed documentation or completed patient and staff questionnaires prior to the inspection.

During the inspection the inspector met with Mr Greg Finnegan, Registered Person, a senior dental nurse who also undertakes practice management duties and a dental nurse. 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 22 May 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 22 May 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 19 (2) Schedule 2 (2) **Stated:** First time	The registered person must ensure that an enhanced AccessNI check is undertaken and received prior to any new staff, including associate dentists, commencing work in the practice.	**Met**
	Action taken as confirmed during the inspection: Since the previous inspection three staff members have commenced employment. Review of the three staff member's recruitment documentation confirmed that an enhanced AccessNI check had been undertaken prior to each individual commencing work in the practice.	
Requirement 2 **Ref:** Regulation 21 (3) **Stated:** First time	The registered person must ensure that a record of all documentation relating to the recruitment process is retained in the practice for three years.	**Met**
	Action taken as confirmed during the inspection: Review of records verified that recruitment documentation was retained in the practice.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 13.2 **Stated:** Second time	It is recommended that the overflow on the hand washing basin in the decontamination room should be blanked off using a stainless steel plate and sealed with anti-bacterial mastic.	**Met**
	Action taken as confirmed during the inspection: The overflow of the decontamination room hand washing basin was blanked off using a stainless steel plate and sealed with anti-bacterial mastic.	
Recommendation 2 **Ref**: Standard 11.1 **Stated:** First time	It is recommended that the recruitment and selection policy is further developed to ensure that the recruitment and selection of staff is undertaken in accordance with best practice and should include; • the procedure for obtaining an enhanced AccessNI check prior to commencement; • the provision of two written references, including a reference from the applicant's most recent employer; and • assurance that a written criminal conviction declaration is made by the applicant; and	**Met**
	Action taken as confirmed during the inspection: The recruitment policy was updated during the inspection to provide the information as recommended. A template was also developed to provide the criminal conviction declaration in respect of new staff members.	

Recommendation 3 **Ref**: Standard 11.1 **Stated:** First time	It is recommended that staff personnel files for newly recruited staff should include all relevant documentation as specified in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005.	**Not Met**
	Action taken as confirmed during the inspection: Review of three staff personnel files identified the following; In two files reviewed the documentation as specified in Schedule 2 had been provided with the exception of two written references. Both staff files provided two recorded verbal references which had been obtained prior to appointment. The senior nurse confirmed that written references had been verbally requested from the respective referees but had not been provided. The senior nurse agreed to submit a written request to the referees for both staff members in respect of written references. The third staff member was self-employed, the only documentation available was verification that an AccessNI enhanced disclosure check had been undertaken and GDC registration had been verified. Mr Finnegan was informed that The Independent Health Care Regulations (Northern Ireland) 2005 apply equally to employed and self-employed personnel and therefore the same documentation should be retained. A criminal conviction declaration was not provided in any files reviewed. Whilst some improvement is noted, this recommendation has not been met and has been stated for a second time.	

Recommendation 4 **Ref**: Standard 11.1 **Stated:** First time	It is recommended that AccessNI disclosure certificates are handled in keeping with the AccessNI code of practice, and a record retained of the date the check was applied for and received, the unique identification number and the outcome.	**Partially Met**
	Action taken as confirmed during the inspection: Review of documentation verified that a record of the date each Access NI application form had been submitted to the umbrella organisation, the unique Access NI identification number and the date each completed check had been issued by the umbrella organisation were retained. However, a record of the date the enhanced disclosure was received or the date and outcome of the registered person's consideration of each certificate was not retained. This recommendation has been partially met, and has been stated for the second time	
Recommendation 5 **Ref**: Standard 11.1 **Stated:** First time	It is recommended that a staff register 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, should be available in the practice.	**Met**
	Action taken as confirmed during the inspection: A staff register was provided as recommended.	

4.3 Is care safe?

Staffing

There are three dental surgeries in this practice, however it was confirmed that only surgery one and two were in operation. Discussion with staff demonstrated that there was sufficient numbers of staff in various roles to fulfil the needs of the practice and patients.

A record of induction had not been completed for any of the new staff members. All new staff including self-employed staff should be provided with a structured programme of induction relevant to their duties and responsibilities, a record should be retained to evidence the content of the induction undertaken. A recommendation was made in this regard.

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.

The practice offers intravenous sedation to patients. However, it was established that none of the dental nurses in the practice have an accredited qualification in conscious sedation. All members of the dental team providing treatment under Conscious Sedation must have received appropriate supervised theoretical, practical and clinical training before undertaking independent practice in keeping with Conscious Sedation in The Provision of Dental Care (2003). A requirement has been made.

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

Three staff members had been recruited since the previous inspection and individual staff personnel files had been established. However, the cupboard in which staff personnel information was stored could not be unlocked on 7 June 2016. Arrangements were made for a locksmith to rectify the problem and the inspector returned to the practice on 9 June 2016 to review staff personnel documentation.

Review of the three new staff member's personnel files identified the following;

Two staff files reviewed contained two recorded verbal references which had been obtained prior to appointment. The senior nurse confirmed that written references had been verbally requested from the referees but had not yet been provided. The senior nurse confirmed that a written request would be made to the referees for both staff members in respect of written references. The senior nurse was advised to retain a copy of this correspondence.

The third staff member was self-employed, the only documentation available was verification that an AccessNI enhanced disclosure check had been undertaken and GDC registration had been verified. It was also noted that a criminal conviction declaration was not provided in any staff files.

Mr Finnegan was informed that The Independent Health Care Regulations (Northern Ireland) 2005 apply equally to employed and self-employed personnel and therefore the same documentation should be retained and include;

- positive proof of identity, including a recent photograph
- evidence that an enhanced AccessNI check was received prior to commencement of employment
- two written references were provided in two staff files
- a criminal conviction declaration
- employment history with reasons for leaving previous employment, where applicable
- documentary evidence of qualifications, where applicable
- evidence of current GDC registration, where applicable
- confirmation that the person is physically and mentally fit to fulfil their duties and
- evidence of professional indemnity insurance, where applicable

A recommendation in this regard has been stated for a second time.

The recruitment policy and procedure was updated during the inspection to reflect 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.

Staff confirmed that they had received training in safeguarding children and adults as outlined in the Minimum Standards for Dental Care and Treatment 2011. A copy of the new regional guidance issued in July 2015 entitled 'Adult Safeguarding Prevention and Protection in Partnership' was available for staff reference.

Policies and procedures were in place for the safeguarding and protection of adults and children. The policy 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 senior dental nurse confirmed that the adult safeguarding policy will be reviewed to reflect the new regional adult safeguarding guidance.

Management of medical emergencies

A review of medical emergency arrangements evidenced that, in the main, emergency medicines were provided in keeping with the British National Formulary (BNF). It was observed that Midazolam was provided in ampoule format however this is not the format recommended by the Health and Social Care Board (HSCB). Mr Finnegan was advised that Buccolam pre-filled syringes as recommended by the HSCB should be provided for the emergency management of an epileptic seizure. On 24 June 2016 Mr Finnegan confirmed by telephone that Buccolam pre-filled syringes had been obtained. Glucagon medication was not stored in a fridge and a revised expiry date had not been recorded on the medication packaging or expiry date checklist to reflect this. Mr Finnegan and the senior nurse were advised that if Glucagon is stored out of a fridge, a revised expiry date of 18 months should be marked on the medication packaging and expiry date checklist to reflect that the cold chain has been broken. The senior nurse confirmed that the Glucagon medication had been replaced recently and a revised expiry date was recorded on the Glucagon medication during the inspection.

Emergency equipment as recommended by the Resuscitation Council (UK) guidelines was retained.

A 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.

The management of medical emergencies training is updated on an annual basis in keeping with best practice guidance. As previously stated an induction programme should be completed for the three new members of staff, which should include the management of medical emergencies.

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. Mr Finnegan and staff advised that only surgery one and surgery two are used to treat patients. Fixtures, fittings, dental chairs and equipment in these surgeries were free from damage, dust and visible dirt. Fabric covered chairs were observed in surgeries one and two, a recommendation was made to either; reupholster the chairs with an impervious cleanable covering or replace with seating in keeping with Health Technical Memorandum (HTM) 01-05 guidance.

It was observed that a dental chair in surgery three had a small tear. Mr Finnegan confirmed there are no immediate plans to use surgery three and stated he was considering changing this surgery into a patient consultation facility. Mr Finnegan was advised that a change to the practice registration status must be notified to RQIA. In the interim, should dental surgery three become operational, the dental chair should be reupholstered to provide an intact surface to facilitate effective cleaning. A recommendation has been made in relation to this.

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. Staff were observed to be adhering to best practice in terms of uniform and hand hygiene policies

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, a steam steriliser and a DAC Universal have been provided to meet the practice requirements. A review of documentation evidenced that equipment used in the decontamination process has been validated annually, and revalidation for 2016 is planned for.

It was confirmed that templates were used to record the results of periodic tests in respect of equipment used during the decontamination process. However, review of the templates demonstrated that all information as outlined in HTM 01-05, regarding periodic testing, was not recorded. The following issues were identified and discussed with Mr Finnegan and the senior nurse.

- a daily steam penetration test was undertaken for the steriliser however a daily automatic control test (ACT) for the steriliser was not recorded as the automatic print out function of the steriliser was not working
- the cycle parameters stored on the data loggers for the washer disinfector and the DAC were not being uploaded to a practice computer and reviewed
- records for the washer disinfector confirmed that a weekly protein residue test and a monthly soil test were completed however records were not retrained to confirm that the filters and strainers are inspected and cleaned on a daily basis
- the only test recorded in respect of the DAC Universal was a daily steam penetration test

A recommendation has been made to ensure that periodic tests are undertaken and recorded in keeping with (HTM) 01-05 for all equipment used in the decontamination process. Templates used for recording periodic tests should be further developed in keeping with HTM 01-05, or consideration should be given to the implementation of a pre-printed logbook for each machine. A recommendation has been made to ensure a daily automatic control test is undertaken and recorded in the logbook for the steriliser. The automatic print out function of the steriliser should be repaired and print out records retained. A further recommendation was made to ensure the cycle parameter information on the data loggers of decontamination equipment is uploaded to the practice computer and reviewed on a monthly basis or more frequently as required.

Mr Finnegan and staff confirmed that the practice had not audited compliance with HTM 01-05, and were unaware of the Infection Prevention Society (IPS) audit tool. Advice was provided to Mr Finnegan and the IPS (2013 edition) audit tool was completed and available for review on 9 June 2016.

Radiography

The practice has three surgeries, each of which has an intra-oral x-ray machine and an orthopan tomogram machine (OPG) is located in a separate room. In addition Mr Finnegan confirmed a hand held x-ray device is also provided.

The practice had a dedicated radiation protection file containing the relevant local rules, employer's procedures and other information, however the file was incomplete and was not up to date. A requirement has been made to review the radiation protection file to ensure it remains relevant and effective.

A copy of the local rules was on display near each x-ray machine however there was no record to confirm that appropriate staff had read and understood these.

A review of the radiation protection file confirmed that staff have been authorised by the radiation protection supervisor (RPS) for their relevant duties however there was no record to show that relevant staff have received local training in relation to these duties.

A radiation protection advisor (RPA) has been appointed, and a critical examination check and RPA report was in place relating to the intra oral x-ray unit in surgery two and the hand held x-ray unit, which were dated 14 October 2015 and 2 December 2014, respectively. There were no critical examination checks or report for the intra oral x-ray units in surgeries one and three or the OPG. Mr Finnegan advised the intra oral x-ray unit in surgery two and hand held x-ray unit are the only radiology equipment used. Arrangements should be in place to ensure the radiation protection advisor (RPA) completes a critical examination check of each x-ray unit, provided in the practice, every three years. A requirement has been made to address this.

Mr Finnegan advised that he and the associate dentist were reviewing x-ray quality and recording the justification and evaluation for x-rays undertaken however there were no records available to verify that audits had been completed in this regard. A recommendation has been made.

Mr Finnegan was unsure of the servicing requirements of the x-ray equipment provided in the practice. It was agreed that Mr Finnegan would consult the manufacturer's instructions and take appropriate action. A recommendation has been made to establish service arrangements for each x-ray machine in accordance with respective manufacturer's instructions, the arrangements should be confirmed to RQIA upon return of the QIP.

Mr Finnegan confirmed that arrangements will be made to improve quality assurance systems and processes which were not in place to ensure that all matters relating to x-rays reflect legislative and best practice guidance.

Environment

The environment was maintained to a high standard of maintenance and décor. The practice was observed to be clean and tidy in all areas, however a cleaning schedule was not in place. Following the inspection a copy of The National Patient Safety Agency cleanliness guidelines was sent to Mr Finnegan by electronic mail. On 9 June 2016 a detailed cleaning schedule was observed to have been developed and implemented. However colour coded cleaning equipment was not in place and a recommendation has been made to address this.

Arrangements are in place for maintaining the environment. Review of documentation confirmed that portable appliance testing (PAT) had been undertaken in January 2016, firefighting equipment had been serviced in February 2016 and the pressure vessels had been inspected during August 2015 in keeping with the written scheme of examination.

A fire risk assessment had been undertaken in August 2008, there was no record to verify that the fire risk assessment had been reviewed in the intervening years. Mr Finnegan was provided with advice and guidance in relation to fire safety. A recommendation has been made to ensure an up to date fire risk assessment is undertaken and reviewed annually or more frequently as required.

Mr Finnegan confirmed that a legionella risk assessment had not been undertaken. Following the inspection Mr Finnegan was provided with advice and references in this regard. A recommendation has been made to undertake a legionella risk assessment and address any recommendations as applicable.

Patient and staff views

Questionnaires were provided to patients and staff prior to the inspection by the practice on behalf of the RQIA, no completed patient or staff questionnaires were received by RQIA. The senior nurse confirmed that patient and staff questionnaires had been distributed.

Areas for improvement

All new staff including self-employed staff should be provided with a structured programme of induction relevant to their duties and responsibilities, a record should be retained to evidence the content of the induction undertaken.

All members of the dental team providing treatment under Conscious Sedation must have received appropriate training in the sedation technique being used.

Staff personnel files for newly recruited staff should include all relevant documentation as specified in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005.

A number of infection prevention and control issues were identified. These related to the fabric covered chairs in surgeries one and two, the dental chair covering in surgery three and the provision of colour coded cleaning equipment. A number of issues in relation to the decontamination of reusable dental instruments were also identified. These related to periodic testing, the recording of periodic tests, ensuring a daily automatic control test is undertaken and recorded for the steriliser and the cycle parameter information retained on the data loggers being uploaded and reviewed regularly. Seven recommendations have been made to address these issues

A number of issues were identified in relation to radiology and radiation safety. These related to ensuring the RPA undertakes a critical examination check of each x-ray unit, every three years and establishing arrangements to service and maintain x-ray equipment. In addition the radiation protection file should be reviewed and updated, and x-ray quality grading audits and justification and clinical evaluation recording audits should be undertaken and re-audited on a six monthly and annual basis respectively. Two requirements and two recommendations have been made in this regard.

An up to date fire risk assessment should be undertaken by a competent person and reviewed annually.

A legionella risk assessment should be undertaken and any recommendations made therein should be addressed.

Number of requirements:	3	Number of recommendations:	13

4.4 Is care effective?

Clinical records

Mr Finnegan 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.

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

The practice is registered with the Information Commissioner's Office (ICO). On 7 June 2016 a Freedom of Information Publication Scheme could not be located. A model Freedom of Information Publication Scheme was forwarded to Mr Finnegan on 8 June 2016 and a Freedom of Information Publication Scheme was available on 9 June 2016.

Health promotion

The practice has a strategy for the promotion of oral health and hygiene. There was information available in regards to the promotion of good oral health and hygiene. Mr Finnegan confirmed that oral health is actively promoted on an individual level with patients during their consultations.

Audits

There was limited evidence to confirm that there were arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to patients.

As outlined in the previous domain, areas for improvement have been identified. Issues in relation to infection control should have been identified and addressed through regular six monthly auditing using the IPS HTM 01-05 audit.

The previous domain also identified that x-ray quality grading audits and justification and clinical evaluation recording audits need to be implemented with a record retained.

Mr Finnegan confirmed that an audit specific to implant work had been undertaken earlier in the year.

A recommendation has been made to implement arrangements to establish a programme of audit to monitor and review the effectiveness and quality of care at appropriate intervals. It was suggested that the following should be included in the first instance.

- x-ray quality grading
- x-ray justification and clinical evaluation recording
- IPS HTM 01-05 compliance
- clinical waste management
- clinical records
- review of complaints/accidents/incidents, if applicable.

Communication

Mr Finnegan confirmed that limited onward referrals in respect of specialist treatments are made as specialist treatments are provided at Lisburn Road Dental and Implant Clinic. A procedure and template referral letters have been established for onward referral as and when required.

Mr Finnegan and staff advised that staff meetings are held on an 'ad hoc' basis to discuss clinical and practice management issues. Minutes of staff meetings, when held, were not recorded. Mr Finnegan and staff stated that there was effective communication in the practice, but also agreed that regular staff meeting would be beneficial. A recommendation was made that staff meetings should be held on a regular basis and minutes retained.

Staff confirmed that there are good working relationships and there is an open and transparent culture within the practice.

Patient and staff views

As previously stated RQIA did not receive any completed patient or staff questionnaires.

Areas for improvement

A programme of audit should be established to monitor and review the effectiveness and quality of care delivered to patients.

Staff meetings should be held on a regular basis and minutes retained.

Number of requirements:	0	Number of recommendations:	2

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. A passenger lift is also provided and is of sufficient capacity to accommodate a person requiring the use of a wheel chair.

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

The practice undertakes patient satisfaction surveys on an annual basis. Review of the most recent patient satisfaction 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

As previously stated RQIA did not receive any completed patient or staff questionnaires.

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 an 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 Finnegan is the nominated individual with overall responsibility for the day to day management of the practice.

Policies and procedures were available for staff reference. Observations made confirmed that policies and procedures were indexed, dated and available in a format easily accessible for staff and staff were aware of the policies and how to access them. A process has not been developed to systematically review policies and procedures on a three yearly basis in accordance with best practice guidance. A recommendation has been made in this regard.

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. The questionnaire was returned to the inspector, evidence provided in the returned questionnaire indicated that complaints have been managed in accordance with best practice.

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

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

Review of the Statement of Purpose and Patient's Guide confirmed that these documents were up to date and available for patients and other interested parties.

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 Finnegan demonstrated a clear understanding of his role and responsibility in accordance with legislation, however, as outlined in the previous domains of safe and effective care, a number of issues were identified which indicate that improvement is required in the day to day governance and oversight arrangements and processes in place at this practice. Evidence gathered during the inspection also identified a number of issues which could affect the delivery of safe and effective care. There was limited evidence of regular auditing of systems and processes. Regular auditing and review of processes would enable the registered person to identify the issues outlined and improve the overall quality of the service being provided.

Mr Finnegan must review the current governance and oversight arrangements and ensure that any future arrangements address the issues identified and ensure improvements are sustained. A requirement has been made in this regard.

Patient and staff views

Questionnaires were provided to patients and staff prior to the inspection by the practice on behalf of the RQIA, as previously stated RQIA did not receive any completed patient or staff questionnaires.

Areas for improvement

Establish a process of systematic review of practice policies and procedures, on at least a three yearly basis or more frequently as required. The date of implementation and the planned date of review should be recorded on all policies and procedures.

Current governance and oversight arrangements must be reviewed and improved to ensure that any future arrangements address the issues identified and ensure improvements are sustained.

Number of requirements:	**1**	**Number of recommendations:**	**1**

5.0 Quality improvement plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mr Greg Finnegan, Registered Person 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/s 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(s) 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 38 (a) **Stated:** First time **To be completed by:** 9 August 2016	The registered person must ensure that all members of the dental team providing treatment under Conscious Sedation have received appropriate supervised theoretical, practical and clinical training before undertaking independent practice in keeping with Conscious Sedation in The Provision of Dental Care (2003). **Response by registered person detailing the actions taken:** Staff member booked on sedation course which start Saturday 3/9/2016
Requirement 2 **Ref:** Regulation 19 (1) (b) **Stated:** First time **To be completed by:** 9 August 2016	The registered person must ensure that the radiation protection file is reviewed. The radiation protection file should include: • the name of the appointed RPA • a copy of the relevant local rules signed by all appropriate staff to confirm they have read and understood them • a copy of the employer's procedures for the practice to include all aspects as required under the Ionising Radiation (Medical Exposure) Regulations (Northern Ireland) 2000 as amended • a record of staff entitlements • audits of x-ray quality grading (to be completed every six months) • audits of justification and clinical evaluation recording (to be completed annually) • a copy of the most recent RPA report(s) and confirmation that any recommendations made within the report(s) have been addressed • records pertaining to the servicing and maintenance of radiology equipment • records of radiology training • the radiology file should only include current information; information which is no longer applicable should be removed and filed appropriately **Response by registered person detailing the actions taken:** New folder was order - information updated.
Requirement 3 **Ref:** Regulation 19 (1) (b) **Stated:** First time **To be completed by:** 9 July 2016	The registered person must ensure the RPA completes a critical examination check of each x-ray unit provided in the practice every three years. Any recommendations therein must be addressed and a record retained in this regard. **Response by registered person detailing the actions taken:** Critical examinations have been carried out. We are waiting on 2 reports.

Requirement 4 **Ref:** Regulation 17 (1) **Stated:** First time **To be completed by:** 9 August 2016	The registered person must review the current governance and oversight arrangements and ensure future arrangements address the issues identified during this inspection and ensure that improvements are made and sustained.
	Response by registered person detailing the actions taken: We have taken all requirements and Recommendation on board - we now have Protocols in place to maintain improvements
Recommendations	
Recommendation 1 **Ref**: Standard 11.1 **Stated:** Second time **To be completed by:** 9 June 2016	It is recommended that staff personnel files for newly recruited staff should include all relevant documentation as specified in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005.
	Response by registered person detailing the actions taken: This is now done.
Recommendation 2 **Ref**: Standard 11.1 **Stated:** Second time **To be completed by:** 9 June 2016	It is recommended that AccessNI disclosure certificates are handled in keeping with the AccessNI code of practice, and a record retained of the date the check was applied for and received, the unique identification number and the outcome.
	Response by registered person detailing the actions taken: This is now done and template saved for any other staff that may employed
Recommendation 3 **Ref**: Standard 11.3 **Stated:** First time **To be completed by:** 9 July 2016	All new staff including self-employed staff should complete a recorded structured programme of induction relevant to their duties and responsibilities. The record of induction should facilitate the inductor and inductee to sign and date each induction topic.
	Response by registered person detailing the actions taken: A Recorded Structured induction programme is in place and staff sign to say this has been done.
Recommendation 4 **Ref**: Standard 13 **Stated:** First time **To be completed by:** 9 August 2016	Fabric covered chairs in dental surgeries one and two should be reupholstered with an impervious cleanable covering or replaced with seating in keeping with Health Technical Memorandum (HTM) 01-05 guidance.
	Response by registered person detailing the actions taken: New chairs have been ordered.

Recommendation 5 **Ref**: Standard 13 **Stated:** First time **To be completed by:** 9 August 2016	Should dental surgery three become operational, the dental chair should be reupholstered to provide an intact surface to facilitate effective cleaning.
	Response by registered person detailing the actions taken: If Surgery 3 becomes operational we will reupholster the chair.
Recommendation 6 **Ref**: Standard 13.2 **Stated:** First time **To be completed by:** 9 July 2016	Periodic testing as outlined in HTM 01-05 for all equipment used in the decontamination process, must be undertaken. Templates used for recording periodic tests should be further developed in keeping with HTM 01-05, or consideration should be given to the implementation of a pre-printed logbook for each machine.
	Response by registered person detailing the actions taken: Templates have now been updated in line with HTM 01-05
Recommendation 7 **Ref**: Standard 13.2 **Stated:** First time **To be completed by:** 9 July 2016	A daily automatic control test should be undertaken and recorded in the logbook for the steriliser. The automatic print out function of the steriliser should be repaired and print out records retained.
	Response by registered person detailing the actions taken: This is now done.
Recommendation 8 **Ref**: Standard 13 **Stated:** First time **To be completed by:** 9 July 2016	The cycle parameter information on the data loggers of decontamination equipment should be uploaded to the practice computer and reviewed on a monthly basis or more frequently as required.
	Response by registered person detailing the actions taken: This is in place - on the 1st of every month the information is loaded onto the computer
Recommendation 9 **Ref**: Standard 8.3 **Stated:** First time **To be completed by:** 9 July 2016	Arrangements should be established to ensure that all x-ray equipment is serviced and maintained in keeping with manufacturer's instructions. The arrangements should be confirmed to RQIA in the returned QIP.
	Response by registered person detailing the actions taken: x-ray equipment is serviced by Dekark.

Recommendation 10 **Ref**: Standard 8.3 **Stated:** First time **To be completed by:** 9 July 2016	X-ray quality grading audits should be undertaken and recorded on a six monthly basis. Justification and clinical evaluation recording audits should be undertaken annually and recorded
	Response by registered person detailing the actions taken: Audits have been carried out and [redacted] information recorded.
Recommendation 11 **Ref**: Standard 13.2 **Stated:** First time **To be completed by:** 9 August 2016	Colour coded cleaning equipment should be provided and used in keeping with The National Patient Safety Agency cleanliness guidelines.
	Response by registered person detailing the actions taken: All cleaning equipment is now colour coded.
Recommendation 12 **Ref**: Standard 13.2 **Stated:** First time **To be completed by:** 9 August 2016	An up to date fire risk assessment should be undertaken by a competent person and reviewed annually.
	Response by registered person detailing the actions taken: This has now been done.
Recommendation 13 **Ref**: Standard 13.2 **Stated:** First time **To be completed by:** 9 August 2016	A legionella risk assessment should be undertaken and any recommendations made therein addressed.
	Response by registered person detailing the actions taken: A Risk assessment has now been carried out.

Recommendation 14 **Ref**: Standard 8.1 **Stated:** First time **To be completed by:** 9 September 2016	A programme of audit should be established to monitor and review the effectiveness and quality of care delivered to patients. It is suggested that the following is include in the first instance: • x-ray quality grading • x-ray justification and clinical evaluation recording • IPS HTM 01-05 compliance • clinical waste management • clinical records • review of complaints/accidents/incidents, if applicable. An action plan should be developed and embedded into practice to address and shortfalls identified during the audit process.
	Response by registered person detailing the actions taken: Audits now take place with a system in place to make sure they continue to take Place
Recommendation 15 **Ref**: Standard 11.6 **Stated:** First time **To be completed by:** 9 July 2016	Regular staff meetings should be established and minutes of staff meetings should be retained and shared with any staff who were unable to attend the meeting.
	Response by registered person detailing the actions taken: Regular staff do happen - the minutes of these meeting are now taken and kept.
Recommendation 16 **Ref**: Standard 8 **Stated:** First time **To be completed by:** 9 September 2016	Establish a process of systematic review of practice policies and procedures, on at least a three yearly basis or more frequently as required. The date of implementation and the planned date of review should be recorded on all policies and procedures.
	Response by registered person detailing the actions taken: All policies have now been updated with review dates.

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

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