Announced Care Inspection Report
3 March 2017

Bangor Orthodontics

Type of service: Independent Hospital (IH) – Dental Treatment
Address: 2 Bingham Lane, Bangor, BT20 5DR
Tel no: 028 9127 1026
Inspector: Norma Munn

1.0 Summary

An announced inspection of Bangor Orthodontics took place on 03 March 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 Mr Armstrong, 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. One requirement has been made in relation to the validation of the decontamination equipment. Six recommendations have been made relating to staff appraisal, staff training records, providing safeguarding training for staff, the development of safeguarding policies and procedures, x-ray equipment servicing and fire safety training. Issues in relation to staffing levels and staff cover during periods of annual leave were identified. This is discussed further in the well led domain.

Is care effective?

Observations made, review of documentation and discussion with Mr Armstrong and staff demonstrated that further development is needed to ensure that care provided in the establishment is effective. Areas reviewed included clinical records, health promotion, audits and communication. No requirements or recommendations have been made.

Is care compassionate?

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

Is the service well led?

Information gathered during the inspection evidenced some deficits in terms of leadership and governance arrangements. Areas reviewed included organisational and staff working arrangements, the arrangements for policy and risk assessment reviews, the arrangements for dealing with complaints, incidents and alerts, insurance arrangements and the registered providers' understanding of their roles and responsibilities in accordance with legislation. A recommendation has been made to review and update the statement of purpose to reflect the current registration of the practice.

One requirement and seven recommendations have been made to address the deficits identified. The registered persons 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

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	2	7

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mr Armstrong, 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 QIP there were no further actions required to be taken following the most recent inspection on 29 February 2016.

2.0 Service details

Registered organisation/registered person: Bangor Orthodontics Miss Maeve McCroary Mr Peter Turner Miss Judith Finlay Mr Conor Armstrong	**Registered manager:** Mr Conor Armstrong
Person in charge of the practice at the time of inspection: Mr Conor Armstrong	**Date manager registered:** 18 April 2016
Categories of care: Independent Hospital (IH) – Dental Treatment	**Number of registered places:** 5

3.0 Methods/processes

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

During the inspection the inspector met with Mr Armstrong, registered person, two dental nurses and one receptionist. The inspector also spoke briefly with Mr Peter Turner, registered person. A tour of some areas 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 29 February 2016

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 29 February 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 The Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003 **Ref**: Article 12 (1) **Stated:** First Time	A full and completed registered manager application must be submitted to RQIA in respect of Mr Conor Armstrong.	**Met**
	Action taken as confirmed during the inspection: A full and completed registered manager application was submitted to RQIA following the inspection and registration in respect of Mr Conor Armstrong as registered manager was approved on 18 April 2016.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 12.1 **Stated:** First time	The policy for the management of medical emergencies should be further developed in line with best practice. The policy should include the provision of emergency medications and equipment, checking procedures, how to summon help, incident documentation and staff debriefing. The protocols for dealing with medical emergencies should be reviewed in line with best practice.	**Met**
	Action taken as confirmed during the inspection: The policy for the management of medical emergencies reflected best practice guidance. Some of the protocols displayed for dealing with medical emergencies were not in keeping with current best practice. Mr Armstrong agreed to remove all out of date protocols displayed and replace these with current protocols.	
Recommendation 2 **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. A record of the contract/agreement should be retained in the personnel files of any new staff recruited.	**Met**
	Action taken as confirmed during the inspection: Mr Armstrong confirmed that all staff have been issued with a contract of employment or an agreement. Three members of staff spoken with confirmed that they had contracts of employment and copies of contracts were also reviewed in two staff personnel files.	

4.3 Is care safe?

Staffing

Five dental surgeries are in operation in this practice. Discussion with staff and a review of the responses contained in completed staff questionnaires identified that on occasions there was not always sufficient staff on duty. However, staff confirmed that patients' treatment had not been compromised and the needs of the patients and the practice had been fulfilled.

Staff confirmed that management do not take an active role in ensuring adequate staffing cover is available during periods of absence. The responsibility for this lies with the individual member of staff. As outlined in legislation the responsibility for adequate staff cover lies with the registered persons. During discussion with Mr Armstrong and staff, it was identified that each individual registered person manages their own staff in isolation of the other registered persons and reception staff are not clear as to who they directly report to. These issues were discussed with Mr Armstrong who agreed to review the responsibilities for the management of staff. This is discussed further in section 4.6 of the report and a requirement has been made.

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

Mr Armstrong and staff confirmed that staff appraisals had not been undertaken. A recommendation has been made that a system should be implemented for appraising staff performance at least on an annual basis.

Staff spoken with confirmed that they keep themselves updated with their GDC continuing professional development (CPD) requirements. However, not all training records confirming staff training had been undertaken were retained and available for inspection. A recommendation 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

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

There was a recruitment policy and procedure available. The policy was amended on the day of the inspection to include the procedure in relation to obtaining AccessNI checks. The amended policy was comprehensive and reflected best practice guidance.

Safeguarding

Staff spoken with were generally aware of the types and indicators of abuse and the actions to be taken in the event of a safeguarding issue being identified. However not all staff were aware of who the nominated safeguarding lead was. Mr Armstrong has agreed to ensure that one nominated person is identified as a safeguarding lead. The name of the individual identified as the safeguarding lead should be shared with staff and included in the safeguarding policy.

Mr Armstrong confirmed that not all staff had received training in safeguarding children and adults as outlined in the Minimum Standards for Dental Care and Treatment 2011. A recommendation has been made.

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

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

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

A recommendation has been made that the policies and procedures in respect of safeguarding children and adults at risk of harm and abuse should be updated to ensure they fully reflect the regional policies and guidance documents. The name of the nominated individual responsible for safeguarding should be included and once updated the policies and procedures should be shared with staff.

Management of medical emergencies

A review of medical emergency arrangements evidenced that emergency medicines were provided in keeping with the British National Formulary (BNF), and that emergency equipment as recommended by the Resuscitation Council (UK) guidelines was retained. A robust system was in place to ensure that emergency medicines and equipment do not exceed their expiry date. There was an identified individual with responsibility for checking emergency medicines and equipment.

Review of training records and discussion with staff confirmed that the management of medical emergencies is included in the induction programme 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.

As previously discussed, some of the protocols displayed for dealing with medical emergencies were not in keeping with current best practice. Mr Armstrong agreed to remove any out of date protocols displayed and replace these with current protocols. .

Infection prevention control and decontamination procedures

Clinical and decontamination areas were tidy and uncluttered and work surfaces were intact and easy to clean. Fixtures, fittings, dental chairs and equipment were free from damage, dust and visible dirt. Staff were observed to be adhering to best practice in terms of the uniform and hand hygiene policies.

Discussion with staff demonstrated that they had an understanding of infection prevention and control policies and procedures and were aware of their roles and responsibilities. Staff confirmed that they have received training in infection prevention and control and decontamination in keeping with best practice. However, training records were not available for inspection. As previously discussed, a recommendation has been made.

There was a nominated lead who had responsibility for infection control and decontamination in the practice.

Two decontamination rooms, separate from patient treatment areas and dedicated to the decontamination process, were available. Appropriate equipment, including two washer disinfectors and five steam sterilisers have been provided to meet the practice requirements. A review of documentation evidenced that not all the equipment used in the decontamination process had been validated annually in keeping with best practice. Two of the sterilisers had not been validated since January 2016. This was discussed with Mr Armstrong and a requirement has been made to ensure that all decontamination equipment is validated annually. On completion a copy of the validation certificates should be submitted to RQIA.

A review of equipment logbooks evidenced that periodic tests are undertaken and recorded in keeping with Health Technical Memorandum (HTM) 01-05 Decontamination in primary care dental practices.

It was confirmed that the practice continues to audit compliance with HTM 01-05 using the Infection Prevention Society (IPS) audit tool. The dental nurse confirmed that the most recent IPS audit was completed during September 2016.

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

Radiography

The practice has an orthopan tomogram machine (OPG), which is located in a separate room from the surgeries.

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 x-ray audits and digital x-ray processing.

A copy of the local rules was on display near the 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.

Mr Armstrong confirmed that the x-ray equipment had not been serviced and maintained in accordance with manufacturer's instructions. A recommendation has been made.

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 good standard of maintenance and décor.

Detailed cleaning schedules and a colour coded cleaning system was in place, however, the colour coded system was not the same colour coding as recommended by the National Patient Safety Agency (NPSA) cleanliness guidance. It was suggested that the NPSA colour coding is adopted and the dental nurse readily agreed to address this.

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

Mr Armstrong confirmed that the legionella risk assessment had been reviewed annually and water temperatures are monitored and recorded as recommended.

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

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

Patient and staff views

Five patients submitted questionnaire responses to RQIA. All of the patients indicated that they felt safe and protected from harm.

One comment was included as follows:

- "Yes, I trust my orthodontist."

Four staff submitted questionnaire responses. All indicated that they felt that patients are safe and protected from harm. Staff spoken with during the inspection concurred with this.

Comments provided in submitted questionnaire responses included the following:

- "I have never had an appraisal. Not enough staff to cover holidays etc."
- "I feel on occasions we need more staff to cover holidays and I have never had an appraisal."
- "I feel we do not have enough staff for the practice as we all find it difficult to take holidays or get off work for other reasons due to a bare minimum of staff, however, this does not affect patient care. I feel it is still of a high standard. I have never had an appraisal and do not know if there is an induction programme."

Areas for improvement

A system should be implemented for appraising staff performance at least on an annual basis.

Records of staff training should be retained and available for inspection.

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

Policies and procedures in respect of safeguarding children and adults at risk of harm and abuse should be updated to ensure they fully reflect the regional policies and guidance documents. The name of the nominated individual responsible for safeguarding should be included and once updated the policies and procedures should be shared with staff.

All equipment used in the decontamination process must be validated on an annual basis. On completion a copy of the validation certificates for the identified sterilisers should be submitted to RQIA with the returned QIP.

Establish arrangements to ensure that the x-ray equipment is serviced and maintained in keeping with manufacturer's instructions.

Fire safety training should be provided on an annual basis.

Number of requirements	1	Number of recommendations	6

4.4 Is care effective?

Clinical records

Mr Armstrong 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. There was information displayed on a notice board in the waiting area and a range of information leaflets available in regards to health promotion. Mr Armstrong confirmed that oral health is actively promoted on an individual level with patients during their consultations.

Audits

There were arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to patients at appropriate intervals which included:

- x-ray quality grading
- x-ray justification and clinical evaluation recording
- IPS HTM 01-05 compliance
- review of complaints/accidents/incidents

Communication

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

Staff confirmed that meetings are held on a monthly basis to discuss clinical and practice management issues and minutes of the most recent staff meeting had been retained.

During discussion with staff and a review of staff questionnaire responses it was demonstrated that not all staff are aware of who the nominated individual with overall responsibility for the day to day management of the practice is or who they should speak to if they had a concern. This is discussed further in section 4.6 of the report.

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

Patient and staff views

All five patients who submitted questionnaire responses indicated that they get the right care, at the right time and with the best outcome for them.

One comment was included as follows:

- "Yes I do get the right care."

All four submitted staff questionnaire responses indicated that they felt that patients get the right care, at the right time and with the best outcome for them. Staff spoken with during the inspection concurred with this. No comments were included in submitted questionnaire responses.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

Dignity, respect and involvement in decision making

Staff spoken with demonstrated a good understanding of the core values of privacy, dignity, respect and patient choice. Comments in the returned staff questionnaires made reference to the open plan waiting area and the difficulties this poses to maintaining confidentiality. Staff confirmed that they are aware of the importance of maintaining confidentiality and are aware if they need to speak privately with a patient that arrangements can be provided to ensure the patient's privacy is respected. Staff discussed how they converse with patients and conduct telephone enquiries in a professional and confidential manner.

The importance of emotional support needed when delivering care to patients who were very nervous or fearful of dental treatment was clear.

It was confirmed that treatment options, including the risks and benefits, were discussed with each patient. This ensures patients understand 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. The most recent patient satisfaction report was not reviewed during this inspection. Mr Armstrong confirmed that the practice pro-actively seeks the views of patients about the quality of treatment and other services provided. Patient feedback whether constructive or critical, is used by the practice to improve, as appropriate.

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

Patient and staff views

All five patients who submitted questionnaire responses 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 four 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.

Comments provided in submitted questionnaire responses included the following:

- "We do have patient questionnaires but they are not filled out very often."
- "Reception area is open and all in waiting room can hear everything said"
- "Regarding confidentiality it is sometimes difficult to speak to patients as waiting room very open."

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

During discussion with staff and a review of staff questionnaire responses it was demonstrated that not all staff are aware of who the nominated individual with overall responsibility for the day to day management of the practice is or who they should speak to if they had a concern. A requirement has been made to review the overall management structure of the practice, including roles and responsibilities to address the issues identified during the inspection including reporting arrangements and staffing levels.

The names of the registered persons listed in the statement of purpose did not reflect all of the registered persons. Clarification was sought as to who the registered persons are currently and a recommendation has been made to review and update the statement of purpose to reflect the current registration of the practice.

Policies and procedures were available for staff reference. Mr Armstrong confirmed that policies and procedures were indexed, dated and reviewed. Staff spoken with were aware of the policies and how to access them.

Arrangements were in place to review risk assessments.

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

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

Mr Armstrong 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.

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

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. Two requirements and seven recommendations have been made in order to progress improvement in identified areas. The registered persons must review the current governance and oversight arrangements and ensure that any future arrangements address the issues identified and ensure improvements are sustained.

Patient and staff views

All five patients who submitted questionnaire responses indicated that they felt that the service is well managed. No comments were included in submitted questionnaire responses.

Three out of four submitted staff questionnaire responses indicated that they felt that the service is well led. One member of staff was unsure if the service is well managed.

Comments in submitted questionnaire responses provided included the following:

- "We do not have a line manager. If you have any concerns you speak to the orthodontist."
- "Have no line manager."
- "We do not have a line manager to talk to, but we can talk to any of the orthodontists."
- "We do not have a line manager to go to with a problem."

Areas for improvement

Review the overall management structure of the practice, including roles and responsibilities to address the issues identified during the inspection including reporting arrangements and staffing levels.

Review and update the statement of purpose in line with the registration of the practice.

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

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mr Armstrong, registered person as part of the inspection process. The timescales commence from the date of inspection.

The registered providers/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 providers 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 providers meet 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 providers should confirm that these actions have been completed and return the completed QIP via web portal 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 13 (1) **Stated: First Time** **To be Completed by:** 3 May 2017	The registered persons must review the overall management structure of the practice, including roles and responsibilities to address the issues identified during the inspection which includes reporting arrangements and staffing levels.
	Response by registered provider detailing the actions taken: Staff now aware of management structure. It is very rare that "there is not always sufficient staff on duty". As all the staff work part time hours, cover can be arranged. It is a rare event that someone is ill and cover cannot be arranged at such short notice. I would take issue with the statement "bare minimum of staff" in staff views as the practice has the appropriate level of reception and nursing staff to orthodontist. All staff receive their holiday entitlement and if a specific request is made for time off then this is considered in terms of how it will affect patient care.
Requirement 2 **Ref:** Regulation 15(2) **Stated:** First time **To be completed by:** 3 April 2017	The registered persons must ensure that all equipment used in the decontamination process is validated on an annual basis. On completion a copy of the validation certificates for the identified sterilisers should be submitted to RQIA with the returned (Quality Improvement Plan) QIP.
	Response by registered provider detailing the actions taken: -Validation now completed
Recommendations	
Recommendation 1 **Ref:** Standard 11 **Stated:** First time **To be completed by:** 3 June 2017	A system should be implemented for appraising staff performance at least on an annual basis. Records should be retained and available for inspection.
	Response by registered provider detailing the actions taken: An appraisal system will commence this year
Recommendation 2 **Ref:** Standard 11.4 **Stated:** First time **To be completed by:** 3 June 2017	Records of staff training are to be retained and available for inspection.
	Response by registered provider detailing the actions taken: Records will now be kept of staff training

Recommendation 3 **Ref:** Standard 15.3 **Stated:** First time **To be completed by:** 3 June 2017	Training in safeguarding adults at risk of harm and safeguarding children should be provided to all staff as outlined in the Minimum Standards for Dental Care and Treatment (2011). The new regional guidance 'Adult Safeguarding Prevention and Protection in Partnership' (July 2015) and 'Co-operating to Safeguard Children and Young People in Northern Ireland' (March 2016) should be included in the training provided.
	Response by registered provider detailing the actions taken: We are exploring all the different options as to how this can be delivered to the staff
Recommendation 4 **Ref:** Standard 15.3 **Stated:** First time **To be completed by:** 3 May 2017	The policies and procedures in respect of safeguarding children and adults at risk of harm and abuse should be updated to ensure they fully reflect the regional policies and guidance documents. The name of the nominated individual responsible for safeguarding should be included and once updated the policies and procedures should be shared with staff.
	Response by registered provider detailing the actions taken: Policy and procedures being updated
Recommendation 5 **Ref:** Standard 14.4 **Stated:** First time **To be completed by:** 3 May 2017	Establish arrangements to ensure that the x-ray equipment is serviced and maintained in keeping with manufacturer's instructions.
	Response by registered provider detailing the actions taken: Equipment now serviced and will be undertaken annually in line with maufacturers recommendations
Recommendation 6 **Ref:** Standard 14.2 **Stated:** First time **To be completed by:** 3 June 2017	Fire safety training should be provided for all staff on an annual basis.
	Response by registered provider detailing the actions taken: Fire safety training for all staff will be provided on a yearly basis
Recommendation 7 **Ref:** Standard 1 **Stated:** First time **To be completed by:** 3 April 2017	The statement of purpose should be reviewed and updated in line with the registration of the practice.
	Response by registered provider detailing the actions taken: Statement of purpose updated

Please ensure this document is completed in full and returned via web portal

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