A

Announced Care Inspection Report
18 September 2017

McDonough & Garrett Dental Care

Type of Service: Independent Hospital (IH) – Dental Treatment
Address: 107 Hamilton Road, Bangor BT20 4LN
Tel No: 028 9127 0657
Inspector: Mr Gerry Colgan

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered dental practice with 3 registered places, providing general dental services.

3.0 Service details

Organisation/Registered Provider: Mr David McDonough Mrs Sheila Garrett	**Registered Manager:** Mr David McDonough
Person in charge at the time of inspection: David McDonough	**Date manager registered:** 13 June 2012
Categories of care: Independent Hospital (IH) – Dental Treatment	**Number of registered places:** 3

4.0 Inspection summary

An announced inspection took place on 18 September 2017 from 09.45 to 13.00. The practice manager facilitated the inspection.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003; 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).

The inspection assessed progress with any areas for improvement identified 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.

There were examples of good practice found in relation to staff recruitment, induction, and staff appraisal. Despite a number of deficits identified with the policy, clinical records, health promotion strategies and ensuring effective communication between patients and staff were being managed well. There were also examples of good practice found in relation to maintaining good working relationships, maintaining patient confidentiality, ensuring the core values of privacy and dignity were upheld and providing the relevant information to allow patients to make an informed choice.

A number of areas of improvement against the regulations were identified. These related to: radiology and radiation safety; safeguarding training for staff; ensuring that the walls in the decontamination room are effectively repaired to enable effective cleaning; and to ensure that the statement of purpose and patient guide are kept under review and updated as required. An area for improvement, to review the current governance and oversight arrangements, and address the issues identified as part of this inspection and ensure the improvements are sustained, was stated for the second time.

In addition, a number of areas of improvement against the standards were identified. These related to undertaking audits in respect of infection prevention and control and radiology; developing policies in relation to safeguarding; medical emergencies; statutory notification of

incidents and deaths and records management; and ensuring regional safeguarding policies are available for staff.

The findings of this report will provide the practice with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

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.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	5	7

Details of the Quality Improvement Plan (QIP) were discussed with the practice manager and Mr David McDonough, registered person, as part of the inspection process. The timescales for completion commence from the date of inspection.

4.2 Action/enforcement taken following the most recent care inspection dated 27 May 2016

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 27 May 2016.

5.0 How we inspect

Prior to the inspection a range of information relevant to the practice was reviewed. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the establishment
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report
- submitted staffing information
- submitted complaints declaration

Questionnaires were provided to patients and staff prior to the inspection by the practice on behalf of RQIA. Returned completed patient and staff questionnaires were also analysed prior to the inspection.

A poster informing patients that an inspection was being conducted was displayed.

During the inspection the inspector met with Mr McDonough and three staff. A tour of the premises was also undertaken.

A sample of records was examined during the inspection in relation to the following areas:

- staffing
- recruitment and selection
- safeguarding
- management of medical emergencies
- infection prevention and control and decontamination
- radiography
- clinical record recording arrangements
- health promotion
- management and governance arrangements
- maintenance arrangements

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as 'met', 'partially met', or 'not met'.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 27 May 2016

The most recent inspection of the practice was an announced care inspection. The completed QIP was returned and approved by the care inspector.

6.2 Review of areas for improvement from the last care inspection dated 27 May 2016

<table>
<tr><th colspan="3">Areas for improvement from the last care inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005</th><th>Validation of compliance</th></tr>
<tr><td>Area for improvement 1

Ref: Regulation 15 (2) (b)

Stated: First time</td><td>The registered person must ensure that all of the equipment used in the decontamination process has been validated.

Action taken as confirmed during the inspection:
Review of records confirmed that all equipment used in the decontamination process had been validated in September 2017.</td><td>Met</td></tr>
<tr><td>Area for improvement 2

Ref: Regulation 15 (2) (b)

Stated: First time</td><td>The registered person must ensure that separate machine log books are established for both of the sterilisers, the washer and the disinfector and the ultrasonic cleaner.

Log books should contain the following information:

• details of the machine and location
• commissioning report
• daily/weekly test records
• quarterly test records (if required)
• annual service/validation certification
• fault history
• relevant contacts e.g. service engineer

Action taken as confirmed during the inspection:
Review of documentation confirmed that separate machine log books had been established for both of the sterilisers, the washer disinfector and the ultrasonic cleaner. The machine log books contained all the relevant information.</td><td>Met</td></tr>
<tr><td>Area for improvement 3

Ref: Regulation 15 (2) (b)

Stated: First time</td><td>The registered person must ensure that periodic testing as outlined in HTM 01-05, for all of the equipment used in the decontamination process, is undertaken and recorded.</td><td>Met</td></tr>
</table>

	Action taken as confirmed during the inspection: It was confirmed that periodic testing as outlined in HTM 01-05, for all of the equipment used in the decontamination process, was undertaken and recorded.	
Area for improvement 4 **Ref**: Regulation 15 (1) (b) **Stated: First time**	The registered person must ensure that the recommendations made by the appointed Radiation Protection Advisor (RPA) have been addressed. Records to confirm that the recommendations have been addressed should be retained.	**Not Met**
	Action taken as confirmed during the inspection: Review of documentation and discussion with the practice manager confirmed that the recommendations made by the appointed RPA in their June 2015 report had been addressed and records retained. However, the appointed RPA had undertaken a visit and prepared a report with recommendations in August 2017. The recommendations made in August 2017 had not been addressed. This area for improvement has not been met and has been stated for the second time.	
Area for improvement 5 **Ref**: Regulation 15 (1) (b) **Stated: First time**	The registered person must review the current governance and oversight arrangements and ensure that any future arrangements address the issues identified as part of this inspection and ensure the improvements are sustained.	**Not met**
	Action taken as confirmed during the inspection: The findings of this inspection evidenced that governance and oversight arrangements have yet to be reviewed and actions taken to address the identified deficits. This is discussed further in Section 6.7. This area for improvement has not been met and has been stated for the second time.	

Action required to ensure compliance with The Minimum Standards for Dental Care and Treatment (2011)		Validation of compliance
Area for improvement 1 **Ref**: Standard 11.1 **Stated: Second time**	It is recommended that the following information should be retained in the personnel files of any newly recruited staff: • two written references, including one from the most recent employer • details of full employment history, including an explanation of any gaps in employment • evidence of current GDC registration, where applicable • criminal conviction declaration on application • confirmation that the person is physically and mentally fit to fulfil their duties • completed contracts of employment/ agreement	**Met**
	Action taken as confirmed during the inspection: No new staff have been recruited since the last care inspection. Review of the recruitment policy and checklist, and discussion with the practice manager, confirmed that new staff would be recruited in line with Regulation 19 (2) Schedule 2 of The Independent. Health Care Regulations (Northern Ireland) 2005.	
Recommendation 2 **Ref**: Standard 11.3 **Stated: Second time**	It is recommended that written inductions are in place for all newly recruited staff. The induction programme should facilitate the inductor and inductee to sign and date when induction topics have been discussed.	**Met**
	Action taken as confirmed during the inspection: A written induction has been developed and the practice manager confirmed that the inductor and inductee will sign and date when induction topics have been discussed.	

Recommendation 3 **Ref**: Standard 9 **Stated: Second time**	It is recommended that a survey of patient satisfaction is undertaken on an annual basis. **Action taken as confirmed during the inspection**: A patient satisfaction survey was last undertaken in September 2016 and the practice manager confirmed that a further survey is planned to be undertaken again during September 2017.	**Met**
Recommendation 4 **Ref**: Standard 12.1 **Stated: First time**	A copy of the content of any training which has been delivered in-house to staff should be retained. **Action taken as confirmed during the inspection**: A copy of the content of all training delivered in-house to staff was available for inspection.	**Met**
Recommendation 5 **Ref**: Standard 11.4 **Stated: First time**	All staff should be facilitated to attend refresher training in infection prevention and control and the decontamination process. **Action taken as confirmed during the inspection**: A review of the records and discussion with staff confirmed that refresher training in infection prevention and control and the decontamination process had been completed in September 2017. During the inspection in May 2016 a significant number of issues were identified in relation to infection prevention and control and decontamination practices. As a result a recommendation was made to ensure that all staff received refresher training in this area. The timescale for completion of this refresher training was August 2016. It is disappointing to note that the refresher training did not take place until September 2017.	**Met**
Recommendation 6 **Ref**: Standard 13 **Stated: First time**	The procedure for cleaning dental hand pieces should be reviewed. Hand pieces should be cleaned in line with manufacturer's guidance or best practice as outlined in HTM 01-05.	**Met**

	Action taken as confirmed during the inspection: It was confirmed that all the hand pieces are now cleaned in the washer disinfector which was in line with manufacturer's guidance or best practice as outlined in HTM 01-05.	
Recommendation 7 **Ref**: Standard 13 **Stated: First time**	The wipeable wall covering in the decontamination room, where it is peeling away from the wall, should be repaired and the pull cord light switch should be replaced and retained clean.	**Partially Met**
	Action taken as confirmed during the inspection: The pull cord light switch has been replaced. The wipeable wall covering in the decontamination room, where it was peeling away from the wall, has not been adequately repaired and further deterioration was observed. This area for improvement has not been met and as a result of the further deterioration it has now been identified as an area for improvement against the regulations.	
Recommendation 8 **Ref**: Standard 13 **Stated: First time**	The cycle parameter information contained on the data loggers of decontamination equipment is uploaded and reviewed on a monthly basis or more frequently if required.	**Met**
	Action taken as confirmed during the inspection: It was confirmed that the cycle parameter information contained on the data loggers of the decontamination equipment is now uploaded and reviewed on a monthly basis.	
Recommendation 9 **Ref**: Standard 14.4 **Stated: First time**	Evidence should be retained confirming that the x-ray equipment has been serviced and maintained in accordance with manufacturer's instructions.	**Met**
	Action taken as confirmed during the inspection: Review of documentation confirmed that x-ray equipment has been serviced and maintained in accordance with manufacturer's instructions.	

Recommendation 10 **Ref**: Standard 13 **Stated: First time**	The Infection Prevention Society HTM 01-05 audit should be undertaken six monthly. Any issues identified as a result of the audit should be addressed.	**Not Met**
	Action taken as confirmed during the inspection: The Infection Prevention Society HTM 01-05 audit had not been undertaken six monthly This area of improvement has not been met and has been stated for the second time.	
Recommendation 11 **Ref**: Standard 13 **Stated: First time**	X-ray quality audits must be undertaken and recorded on a six monthly basis. Justification and clinical evaluation recording audits must be undertaken annually and recorded.	**Partially Met**
	Action taken as confirmed during the inspection: X-ray quality audits are undertaken and recorded on a six monthly basis. However, there was no evidence that justification and clinical evaluation recording audits are being undertaken annually and recorded. This area of improvement has been partially met and the relevant section has been stated for the second time.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Staffing

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

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 take place on a six monthly basis. Staff confirmed that they felt supported and involved in discussions about their personal development. A review of a sample of two evidenced that appraisals had been completed.

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 the practice manager 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 comprehensive and reflected best practice guidance.

Safeguarding

Review of records demonstrated that staff had not received training in safeguarding children and adults as outlined in the Minimum Standards for Dental Care and Treatment 2011 and in line with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016). This was discussed with the practice manager and an area for improvement against the regulations has been made to address this training deficit.

One overarching policy was in place for the safeguarding and protection of adults and children at risk of harm. A review of the policy confirmed that it needs to be further developed to include the types and indicators of abuse and distinct referral pathways in the event of a safeguarding issue arising with an adult or child, and the relevant contact details for onward

referral to the local Health and Social Care Trust should a safeguarding issue arise. This has been identified as an area for improvement against the standards.

Copies of the regional policy entitled 'Co-operating to safeguard children and young people in Northern Ireland' (March 2016) and the regional guidance document entitled 'Adult Safeguarding Prevention and Protection in Partnership' (July 2015) were not available at the time of inspection. This has also been identified as an area for improvement against the standards.

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.

The policy for the management of medical emergencies was available for staff; however the policy and procedural guidance requires to be reviewed and updated in relation to the management of medical emergencies to include: staff training; provision of equipment and emergency medicine; checking procedures; how to summon help; incident documentation and debriefing; and the protocols for dealing with Anaphylaxis, Asthma, Cardiac Emergencies, Epileptic Seizures, Hypoglycaemia and Syncope (Adult and Children). This has been identified as an area for improvement against the standards.

Infection prevention control and decontamination procedures

Clinical 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 received training in infection prevention and control and decontamination in September 2017. Training records were available for inspection. There was a nominated lead with responsibility for infection control and decontamination.

A decontamination room separate from patient treatment areas and dedicated to the decontamination process was available. At the last care inspection it was observed that the wipeable wall covering in the decontamination room was peeling away from the wall and as a result an area for improvement against the standards was made to address this issue. This

area for improvement has not been adequately actioned and further deterioration was observed. As a result of this deterioration, effective cleaning could not be undertaken in this area. This has now been identified as an area for improvement against the regulations.

Appropriate equipment, including a washer disinfector and two steam sterilisers, has been provided to meet the practice requirements. A review of documentation evidenced that equipment had been validated in September 2017. 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.

The practice manager confirmed that the practice has not been auditing compliance with HTM 01-05 using the Infection Prevention Society (IPS) audit tool. This has been identified as an area for improvement against the standards, for the second time.

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

Radiography

The practice has three 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. It was evidenced that all measures are taken to optimise dose exposure. This included the use of rectangular collimation, x-ray quality audits and digital x-ray processing.

The radiation protection advisor (RPA) completes a quality assurance check every three years. At the last care inspection in May 2016 it was identified that the recommendations made by the appointed RPA during their visit in June 2015 had not been addressed and subsequently an area for improvement against the regulations was made. Review of documentation and discussion with the practice manager confirmed that the recommendations from the RPA's report dated June 2015 had been addressed. However, the appointed RPA had undertaken a further visit and prepared a report with recommendations in August 2017. The recommendations included: ensuring staff have received local training in relation to their duties, amending the local rules and ensuring staff have signed to confirm that they have read and understood them. These recommendations had not been addressed. This area for improvement has not been met and has been stated for the second time.

The x-ray equipment has been serviced and maintained in accordance with manufacturer's instructions.

At the last care inspection in May 2016 an area for improvement against the standards was made to ensure that x-ray quality audits are undertaken and recorded on a six monthly basis, and that justification and clinical evaluation recording audits are undertaken annually and recorded. A review of the records and discussion with the practice manager confirmed that x-ray quality audits had been undertaken and recorded on a six monthly basis; however, there was no evidence that justification and clinical evaluation recording audits are being undertaken annually and recorded. This has been identified as an area of improvement against the standards for the second time.

Environment

The environment was maintained to a good standard of maintenance and décor, with the exception of the already stated decontamination room.

Detailed cleaning schedules were in place for all areas which were signed on completion. A colour coded cleaning system was in place.

Arrangements are in place for maintaining the environment. The gas boiler was serviced in March 2017, and fixed electrical and portable electric appliances were tested in September 2017. A legionella risk assessment was last undertaken in September 2017 and water temperatures are monitored and recorded as recommended.

A fire risk assessment had been undertaken in June 2017 and staff confirmed that fire training and fire drills had been completed. Staff demonstrated that they were aware of the action to take in the event of a fire.

Pressure vessels were tested in September 2017 under the written scheme of examination.

It was confirmed that robust arrangements are in place for the management of prescription pads/forms and that written security policies are in place to reduce the risk of prescription theft and misuse.

Patient and staff views

Sixteen patients submitted questionnaire responses to RQIA. All indicated that they felt safe and protected from harm. Fourteen patients indicated they were very satisfied with this aspect of care and two indicated they were satisfied. The following comments were provided:

- "Safe as far as I know."
- "Staff are very helpful, the clinic is clean. Excellent care."

Seven staff submitted questionnaire responses. All indicated that they felt that patients are safe and protected from harm. Six staff indicated they were very satisfied with this aspect of care and one indicated they were satisfied. No comments were included in submitted questionnaire responses.

Areas of good practice

There were examples of good practice found in relation to staff recruitment, induction, training and appraisal.

Areas for improvement

The following areas for improvement against the regulations were identified:

- Ensure that the recommendations made by the appointed Radiation Protection Advisor (RPA) have been addressed.
- All staff should receive training in safeguarding children and adults as outlined in the Minimum Standards for Dental Care and Treatment 2011 and in line with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016).

- The wipeable wall covering in the decontamination room should either be repaired or replaced to ensure the walls are sound and all joints appropriately sealed.

The following areas for improvement against the standards were identified:

- Ensure that the Infection Prevention Society HTM 01-05 audit is undertaken six monthly.
- Ensure that justification and clinical evaluation recording audits are undertaken annually and recorded.
- Further develop the safeguarding and protection of adults and children at risk of harm policy.
- Ensure copies of the regional policy entitled 'Co-operating to safeguard children and young people in Northern Ireland' (March 2016) and the regional guidance document entitled 'Adult Safeguarding Prevention and Protection in Partnership' (July 2015) are available for staff reference.
- Further develop the policy for the management of medical emergencies.

	Regulations	Standards
Total number of areas for improvement	3	5

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Clinical records

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

The manager confirmed that 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.

Manual records are maintained. Despite the records management policy needing to be reviewed and updated appropriate systems and processes were in place for the management of records and maintaining patient confidentiality.

The records management policy requires to be reviewed and updated to include: the creation, storage, recording, retention and disposal of records management arrangements; data protection; confidentiality and consent. This has been identified as an area for improvement against the standards.

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

Health promotion

The practice has a strategy for the promotion of oral health and hygiene. There was information available in the reception and waiting areas in regards to oral health promotion.

The practice employs a hygienist two days each week and a dentist goes out to local nursery schools. In addition, the practice organises a children's oral health promotion day twice yearly. Mr McDonough confirmed that oral health is actively promoted on an individual level with patients during their consultations.

Audits

There are some arrangements in place to monitor, audit and review the effectiveness of quality of care delivered to patients. However, as discussed in Section 6.4, x-ray justification and clinical evaluation audits and the IPS HTM 01-05 audits had not been completed despite previous areas of improvement being identified. There was no evidence that the practice has been taking a proactive approach to audit or identifying the benefits of audit. The benefit of utilising audit as a tool to improve practice was discussed with the practice manager. The deficits identified with audit should be addressed within the overarching area for improvement, against the regulations, which has been stated for the second time, in relation to the governance and oversight arrangements at this practice.

Communication

The practice manager confirmed that arrangements are in place for onward referral in respect of specialist treatments.

Staff meetings are held on a monthly 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

All of the 16 patients who submitted questionnaire responses indicated that they get the right care, at the right time and with the best outcome for them. Thirteen patients indicated they were very satisfied with this aspect of care and three indicated they were satisfied. The following comments were provided:

- "Excellent all round."
- "Excellent dental care at all times."
- "If I don't understand they explain it to me."
- "No complaints whatsoever."

Seven 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. Six staff indicated they were very satisfied with this aspect of care and one indicated they were satisfied. Staff spoken with during the inspection concurred with this. The following comment was provided:

- "There are regular updates with staff meetings."

Areas of good practice

There were examples of good practice found in relation to the management of clinical records, health promotion strategies and ensuring effective communication between patients and staff.

Areas for improvement

The following area for improvement against the standards was identified:

- The records management policy requires to be reviewed and updated, to include the creation, storage, recording, retention and disposal of records management arrangements; data protection; confidentiality and consent.

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Dignity, respect and involvement in decision making

Staff demonstrated a good understanding of the core values of privacy, dignity, respect and patient choice. Staff confirmed that if they needed to speak privately with a patient that arrangements are provided to ensure the patient's privacy is respected. Staff were observed to converse with patients and conduct telephone enquiries in a professional and confidential manner.

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

It was confirmed that treatment options, including the risks and benefits, were discussed with each patient. This ensured patients understood what treatment is available to them 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.

A policy and procedure was in place in relation to confidentiality which included the arrangements for respecting patients' privacy and dignity, and providing compassionate care and treatment.

Patient and staff views

Sixteen patients who submitted questionnaire responses indicated that they are treated with dignity and respect and are involved in decision making affecting their care. Fourteen patients

indicated they were very satisfied with this aspect of care and two indicated they were satisfied. The following comments were included in submitted questionnaire responses:

- "Very friendly staff, very professional."
- "I am completely satisfied with the way they treat me and my children."
- "They keep me up to date with all new treatments."
- "Every time I have been feeling uneasy about dental work I have always been reassured."

Seven 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. Six staff indicated they were very satisfied with this aspect of care and one indicated they were satisfied. Staff spoken with during the inspection concurred with this. No comments were included in submitted questionnaire responses.

Areas of good practice

There were examples of good practice found in relation to maintaining patient confidentiality, ensuring the core values of privacy and dignity were upheld and providing the relevant information to allow patients to make informed choices.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Management and governance arrangements

There was a clear organisational structure within the practice, and staff were able to describe their roles and responsibilities and were aware of whom 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.

Mrs Olivia Armstrong, practice manager, supports Mr McDonough and Ms Garret in the day to day management of the dental practice.

A statutory notification of incidents and deaths policy, to guide and direct staff regarding the management of notifiable events, including ensuring that notifiable events are investigated and reported to RQIA or other relevant bodies as appropriate, had not been developed. This was identified as an area for improvement against the standards.

Most policies and procedures were available for staff reference. As identified previously a number of policies and procedures require to be either developed or updated to reflect best practice guidance. 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.

A statement of purpose and patient's guide were available. However, a review of the documents confirmed that they do not reflect the current staffing, including staff roles and responsibilities. This was discussed with the practice manager and an area for improvement against the regulations has been made.

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 2016 to 31 March 2017.

A system was in place to ensure that urgent communications, safety alerts and notices are reviewed, and where appropriate made available to key staff in a timely manner.

As outlined in the previous domains of safe and effective care a number of issues were identified which indicate that the governance and oversight arrangements at this practice are not robust. There was limited evidence of regular auditing, to enable the registered persons to identify the issues outlined, and improve the overall quality of the service being provided. A number of areas of improvement against the regulations and standards have been made to address the identified areas of noncompliance. An area for improvement, against the regulations, to review the current governance and oversight arrangements at this practice has been stated for the second time.

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

Information requested by RQIA has been submitted within specified timeframes.

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

Sixteen patients who submitted questionnaire responses indicated that they felt that the service is well led. Fourteen patients indicated they were very satisfied with this aspect of the service and two indicated they were satisfied. Comments provided included the following:

- "Patients always come first."
- "Excellently led by a sincere and professional dentist."
- "Completely satisfied. Visits to the dentist are now a happy experience."
- "I have been a member of this practice now for 35 years. I would not go anywhere else."

Seven submitted staff questionnaire responses indicated that they felt that the service is well led. Six staff indicated they were very satisfied with this aspect of the service and one indicated they were satisfied. Staff spoken with during the inspection concurred with this. No comments were included in submitted questionnaire responses.

Areas of good practice

There were examples of good practice found in relation to maintaining good working relationships.

Areas for improvement

The following areas for improvement against the regulations were identified:

- Update the statement of purpose and patient's guide to accurately reflect the organisational structure of the practice and the arrangements for dealing with complaints.
- Review the current governance and oversight arrangements and ensure that any future arrangements address the issues identified as part of this inspection and ensure the improvements are sustained.

The following area for improvement against the standards was identified:

- Develop a statutory notification of incidents and deaths policy.

	Regulations	Standards
Total number of areas for improvement	2	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Olivia Armstrong registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with 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).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP **via Web Portal** for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 15 (1) (b) **Stated:** Second time **To be completed by:** 18 October 2017	The registered person must ensure that the recommendations made by the appointed Radiation Protection Advisor (RPA) have been addressed. Records to confirm that the recommendations have been addressed should be retained. Ref: 6.4
	Response by registered person detailing the actions taken: COMPLIED WITH
Area for improvement 2 **Ref**: Regulation 15 (1) (b) **Stated:** Second time **To be completed by:** 18 December 2017	The registered person shall review the current governance and oversight arrangements and ensure that any future arrangements address the issues identified as part of this inspection and ensure the improvements are sustained. Ref: 6.7
	Response by registered person detailing the actions taken: COMPLIED WITH
Area for improvement 3 **Ref**: Regulation 18 (2) (a) **Stated:** First time **To be completed by:** 18 December 2017	The registered person shall ensure that all staff receive training in safeguarding children and adults as outlined in the Minimum Standards for Dental Care and Treatment 2011, and in line with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016). Ref: 6.4
	Response by registered person detailing the actions taken: COMPLIED WITH

Area for improvement 4 **Ref**: Regulation 25 (2) (c) **Stated:** First time **To be completed by:** 30 November 2017	The registered person shall ensure that the wipeable wall covering in the decontamination room is either repaired or replaced to ensure the walls are sound and all joints appropriately sealed. Ref: 6.4
	Response by registered person detailing the actions taken: COMPLIED WITH
Area for improvement 5 **Ref:** Regulation 9 **Stated:** First time **To be completed by:** 18 October 2017	The registered person shall ensure that the statement of purpose and patient guide are kept under review, revised and updated to accurately reflect the organisational structure of the practice and arrangements for dealing with complaints. Ref: 6.7
	Response by registered person detailing the actions taken: COMPLIED WITH
Action required to ensure compliance with The Minimum Standards for Dental Care and Treatment (2011)	
Area for improvement 1 **Ref**: Standard 13 **Stated:** Second time **To be completed by:** 31 October 2017	The registered person shall ensure that the Infection Prevention Society HTM 01-05 audit is undertaken six monthly. Ref: 6.2, 6.4 &6.7
	Response by registered person detailing the actions taken: COMPLIED
Area for improvement 2 **Ref**: Standard 13 **Stated:** Second time **To be completed by:** 31 October 2017	The registered person shall ensure that justification and clinical evaluation recording audits are undertaken annually and recorded. Ref: 6.2, 6.4, 6.5 & 6.7
	Response by registered person detailing the actions taken: COMPLIED

Area for improvement 3 **Ref**: Standard 15 **Stated:** First time **To be completed by:** 18 December 2017	The registered person shall further develop the safeguarding and protection of adults and children at risk of harm policy in line with the regional policies, Co-operating to safeguard children and young people in Northern Ireland' (March 2016) and the regional guidance document entitled 'Adult Safeguarding Prevention and Protection in Partnership' (July 2015). The policy should include the types and indicators of abuse and distinct referral pathways, including the relevant contact details for onward referral to the local Health and Social Care Trust should a safeguarding issue arise with an adult or child. Ref: 6.4
	Response by registered person detailing the actions taken: COMPLIED WITH
Area for improvement 4 **Ref**: Standard 15 **Stated:** First time **To be completed by:** 18 December 2017	The registered person shall ensure copies of the regional policy entitled 'Co-operating to safeguard children and young people in Northern Ireland' (March 2016) and the regional guidance document entitled 'Adult Safeguarding Prevention and Protection in Partnership' (July 2015) are available for staff reference. Ref: 6.4
	Response by registered person detailing the actions taken: COMPLIED WITH
Area for improvement 5 **Ref**: Standard 12.1 **Stated:** First time **To be completed by:** 18 December 2017	The registered person shall review and update the policy and procedural guidance in relation to: management of medical emergencies to include: staff training; provision of equipment and emergency medicine; checking procedures; how to summon help; incident documentation and debriefing; and the protocols for dealing with Anaphylaxis, Asthma, Cardiac Emergencies, Epileptic Seizures, Hypoglycaemia and Syncope (Adult and Children). Ref: 6.4
	Response by registered person detailing the actions taken: COMPLIED WITH
Area for improvement 6 **Ref**: Standard 10 **Stated:** First time **To be completed by:** 18 December 2017	The registered person shall update policies and procedures to include the creation, storage, recording, retention and disposal of records; management arrangements; data protection; confidentiality and consent. Ref: 6.5
	Response by registered person detailing the actions taken: COMPLIED WITH

Area for improvement 7 **Ref**: Standard 10 **Stated:** First time **To be completed by:** 18 December 2017	The registered person shall develop a statutory notification of incidents and deaths policy to guide and direct staff regarding the management of notifiable events, including ensuring that notifiable events are investigated and reported to RQIA or other relevant bodies as appropriate. Ref: 6.7
	Response by registered person detailing the actions taken: COMPLIED WITH

Please ensure this document is completed in full and returned via Web Portal

The Regulation and Quality Improvement Authority

9th Floor

Riverside Tower
5 Lanyon Place
BELFAST

BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews