Announced Care Inspection Report
27 March 2017

Shankill Dental Care

Type of service: Independent Hospital (IH) – Dental Treatment
Address: 244 Shankill Road, Belfast, BT13 2BL
Tel no: 028 9033 1298
Inspector: Norma Munn

1.0 Summary

An announced inspection of Shankill Dental Care took place on 27 March 2017 from 10:05 to 13:35.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the practice was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

Observations made, review of documentation and discussion with Ms Lynn Browne, 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 stated during the previous inspection that relates to recruitment and selection has not been fully addressed and has been stated for a second time. Three further requirements have been made in relation to validation of the decontamination equipment, radiation safety and fire safety. Three recommendations have been made in relation to staff training records, the provision of safeguarding training for staff and the servicing of the x-ray units.

Is care effective?

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

Is the service well led?

Information gathered during the inspection identified that further development is needed to ensure that effective leadership and governance arrangements are in place and create a culture focused on the needs of patients in order to deliver safe, effective and compassionate care. Areas reviewed included organisational and staff working arrangements, the arrangements for policy and risk assessment reviews, the arrangements for dealing with complaints, incidents and alerts, insurance arrangements and the registered provider's understanding of their role and responsibility in accordance with legislation. As discussed above a number of issues were identified within the domain of is care safe which relate to quality assurance and good governance. A recommendation has been made to review current monitoring systems to ensure effective quality assurance and governance arrangements are in operation.

This inspection was underpinned by The Independent Health Care Regulations (Northern Ireland) 2005, The Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011 and the Department of Health, Social Services and Public Safety (DHSSPS) Minimum Standards for Dental Care and Treatment (2011).

While we assess the quality of services provided against regulations and associated DHSSPS care standards, we do not assess the quality of dentistry provided by individual dentists.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	4	4

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Browne, 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 April 2015.

2.0 Service details

Registered organisation/registered person: Ms Lynn Browne Mr Stephen Bailie Ms Anne McIlhagger	**Registered manager:** Ms Lynn Browne
Person in charge of the practice at the time of inspection: Ms Lynn Browne	**Date manager registered:** 8 November 2011
Categories of care: Independent Hospital (IH) – Dental Treatment	**Number of registered places:** 4

3.0 Methods/processes

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

During the inspection the inspector met with Ms Browne, Ms Anne McIhagger and Mr Stephen Bailie, registered persons, along with two associate dentists, three dental nurses and two trainee dental nurses. A tour of some of the premises was also undertaken.

Records were examined during the inspection in relation to the following areas:

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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 29 April 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 29 April 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 27 (3) (d) **Stated:** First time	The registered persons must ensure that their indemnity cover includes employees of the practice. Copies of the indemnity certificates for the registered providers and associate dentists must be retained in the practice. A robust system should be established to review the professional indemnity status of registered dental professionals who require individual professional indemnity cover.	**Met**
	Action taken as confirmed during the inspection: Ms Browne confirmed that a system has been developed to review the professional indemnity status of registered dental professionals who require individual professional indemnity cover. Review of records and discussion with Ms Browne confirmed that copies of the indemnity certificates were retained in the practice.	

Requirement 2 **Ref:** Regulation 19 (2) (d) Schedule 2 **Stated:** First time	The registered persons must ensure that all information outlined in Schedule 2 of the Independent Health Care Regulations (Northern Ireland) 2005 is retained within staff personnel files for all newly recruited staff. In regards to the staff employed after the practice registered with RQIA the following information should be included in their personnel files: • positive proof of identity, including a recent photograph; • evidence that an enhanced AccessNI check was received; • details of full employment history, including an explanation of any gaps in employment; • evidence of current GDC registration, where applicable; • confirmation that the person is physically and mentally fit to fulfil their duties; and • contracts of employment/agreement and job description.	**Not Met**
	Action taken as confirmed during the inspection: A review of the submitted staffing information and discussion with Ms Browne confirmed that four staff have been recruited since the previous inspection. A review of the personnel files for three of these staff members demonstrated that all the relevant information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 has been sought and retained with the exception of confirmation of physically and mentally fitness for all three staff members and two written references for one staff member. This requirement has not been fully met and has been stated for a second time. This is further discussed in section 4.3 of the report.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 13 **Stated:** Second time	Cabinetry should be sealed where it meets the flooring in the decontamination room and surgeries.	**Met**
	Action taken as confirmed during the inspection: Discussion with Ms Browne and observation of the decontamination room and three of the surgeries confirmed that the cabinetry has been sealed where it meets the flooring.	

Recommendation 2 **Ref:** Standard 13 **Stated:** Second time	A paper towel dispenser should be installed in the area of the dedicated hand wash basin in the decontamination room.	**Met**
	Action taken as confirmed during the inspection: A paper towel dispenser had been installed in the area of the hand wash basin in the decontamination room.	
Recommendation 3 **Ref:** Standard 13 **Stated:** Second time	The DAC universal logbook should be further developed to include the periodic tests for both a washer disinfector and steriliser and a weekly protein test should be undertaken and recorded.	**Met**
	Action taken as confirmed during the inspection: Review of records confirmed that the periodic tests for both a washer disinfector and steriliser have been undertaken and recorded in the DAC Universal log book.	
Recommendation 4 **Ref:** Standard 12.4 **Stated:** First time	It is recommended that Glucagon medication is stored in keeping with the manufacturer's instructions. If stored at room temperature a revised expiry date of 18 months from the date of receipt should be recorded on the medication packaging and expiry date checklist to reflect that the cold chain has been broken. If stored in a fridge, daily fridge temperatures should be taken and recorded to evidence that the cold chain has been maintained.	**Met**
	Action taken as confirmed during the inspection: The Glucagon medication was stored in keeping with the manufacturer's instructions. It was observed to be stored at room temperature and a revised expiry date of 18 months from the date of receipt was recorded on the medication packaging and expiry date checklist.	
Recommendation 5 **Ref:** Standard 12.4 **Stated:** First time	It is recommended that a review of the Resuscitation Council (UK) Minimum equipment list for cardiopulmonary resuscitation - primary dental care is undertaken to ensure that the practice has oropharyngeal airways and clear face masks for self-inflating bags in the different sizes specified.	**Met**

	Action taken as confirmed during the inspection: It was observed that oropharyngeal airways and clear face masks for self-inflating bags in the different sizes specified were provided. However, a self- inflating bag with reservoir suitable for use with a child had not been provided. Following the inspection RQIA received confirmation that this item had been ordered.	
Recommendation 6 **Ref:** Standard 12.4 **Stated:** First time	It is recommended that advice and guidance is sought from the medico-legal advisor in regards to the provision of an automated external defibrillator (AED) in the practice. Any recommendations made should be actioned.	**Met**
	Action taken as confirmed during the inspection: Following advice from the medico legal advisor an AED has been provided in the practice and staff have been trained in its use.	
Recommendation 7 **Ref:** Standard 11 **Stated:** First time	It is recommended that the following issues in relation to recruitment are addressed: • contracts should be further developed to include the arrangements in relation to overtime/additional hours, sickness/absence, pension and notice of termination; and • ensure all staff who work in the practice have been provided with a contract.	**Met**
	Action taken as confirmed during the inspection: Discussion with Ms Browne and a review of records confirmed that contracts of employment/ agreements include the arrangements in relation to overtime/additional hours and sickness/absence. Contracts/agreements have been provided to all staff who work in the practice.	

Recommendation 8 **Ref:** Standard 11 **Stated:** First time	It is recommended that a robust system is established in regards to the arrangements for undertaking enhanced AccessNI checks. This system must ensure that checks are received prior to new staff commencing work in the practice, and that the procedure for handling AccessNI disclosure certificates is in keeping with AccessNI's Code of Practice. A record should be retained in respect of each check, prior to disposal, of the dates the check was applied for and received, the unique identification number and the outcome of the check.	**Met**
	Action taken as confirmed during the inspection: Ms Browne confirmed that a system has been established to record the dates the AccessNI check was applied for and received, the unique identification number and the outcome of the check. A record of the AccessNI checks was retained in three personnel files of staff recently recruited. The AccessNI checks had been undertaken and received prior to the staff commencing work in the practice and the AccessNI disclosure certificates were handled in keeping with the AccessNI's Code of Practice.	

4.3 Is care safe?

Staffing

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

Induction programmes had been completed and retained in two of the three personnel files reviewed, however it was confirmed that an induction had not been completed of the most recent member of staff employed. Following the inspection RQIA received confirmation that the induction had been completed for the identified staff member. Ms Browne has agreed to ensure that all new staff have an induction completed and records retained for inspection.

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.

Staff spoken with confirmed that they keep themselves updated with their General Dental Council (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 GDC registration status and professional indemnity of all clinical staff.

Recruitment and selection

A review of the submitted staffing information and discussion with Ms Browne confirmed that four staff have been recruited since the previous inspection. A review of the personnel files for three of these staff members demonstrated that not all the relevant information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 has been sought and retained.

The following was noted in the three personnel files reviewed:

- positive proof of identity, including a recent photograph
- evidence that an enhanced AccessNI check had been received
- two written references in two of the files
- details of full employment history, including an explanation of any gaps in employment
- documentary evidence of qualifications
- evidence of current GDC registration
- completed induction in two of the files

One file did not contain any written references however; Ms Browne stated that one telephone reference had been sought. None of the files contained confirmation of physical and mental fitness. Ms Browne was advised that staff personnel files must contain all information as specified in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005. As previously discussed the requirement made during the previous inspection in relation to personnel files has not been fully addressed and has been stated for a second time.

The recruitment policy and procedure was not available to review. Ms Browne agreed to develop a recruitment policy and following the inspection RQIA received confirmation that a recruitment policy had been developed. A copy of the new recruitment policy submitted to RQIA was found to be comprehensive and reflected best practice guidance.

Safeguarding

Staff spoken with were aware of the types and indicators of abuse and the actions to be taken in the event of a safeguarding issue being identified, including who the nominated safeguarding lead was.

One staff member recently attended safeguarding adults training with the Northern Ireland Medical and Dental Training Agency (NIMDTA) and shared up to date information with staff at a staff meeting. However, Ms Browne 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.

Policies and procedures were in place for safeguarding children and adults at risk of harm. The policies included the types and indicators of abuse and distinct referral pathways in the event of a safeguarding issue arising with an adult or child. The relevant contact details for onward referral to the local Health and Social Care Trust should a safeguarding issue arise were included.

The new regional policy 'Adult Safeguarding Prevention and Protection in Partnership' (July 2015) was available for staff reference. This has been shared with staff during a recent staff meeting. The practice's safeguarding adults at risk policy has been reviewed to reflect the new regional policy.

Ms Browne has agreed to provide the new regional policy 'Co-operating to safeguard children and young people in Northern Ireland' (March 2016) for staff reference. Ms Browne has also agreed to review the practice's safeguarding children policy to reflect the new regional policy.

Management of medical emergencies

A review of medical emergency arrangements evidenced that emergency medicines were provided in keeping with the British National Formulary (BNF), and that emergency equipment as recommended by the Resuscitation Council (UK) guidelines was retained with the exception of a self-inflating bag with reservoir suitable for use with a child. As previously discussed following the inspection RQIA received confirmation that the self- inflating bag with reservoir suitable for use with a child had been ordered.

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 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 generally tidy and uncluttered and work surfaces were intact and easy to clean. The open shelving in one of the surgeries was cluttered with various items. Staff were advised that all work surfaces and shelving should remain uncluttered to allow for effective cleaning to take place. Ms Browne has agreed to address this issue.

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.

A decontamination room separate from patient treatment areas and dedicated to the decontamination process was available. Appropriate equipment, including a washer disinfector, a DAC Universal and two steam sterilisers have been provided to meet the practice requirements. Ms Browne confirmed that one of the steam sterilisers was not operational and was being replaced with a new steriliser on the day of the inspection. A review of documentation evidenced that not all the equipment used in the decontamination process had been validated in keeping with best practice. The washer disinfector, DAC Universal and the steam steriliser in operation had not been validated since June 2014. This was discussed with Ms Browne and a requirement has been made to ensure that all decontamination equipment is validated in keeping with Health Technical Memorandum (HTM 01-05). On completion a copy of the validation certificates should be submitted to RQIA. Following the inspection RQIA received confirmation that the decontamination equipment is to be validated on 4 April 2017.

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

It was confirmed that the practice continues to audit compliance with HTM 01-05 using the Infection Prevention Society (IPS) audit tool. The most recent IPS audit was completed during June 2016. Ms Browne was advised that the IPS audit should be completed every six months in keeping with best practice. Ms Browne has agreed to complete this every six months and following the inspection RQIA received confirmation that an IPS audit had been completed on 28 March 2017 and a copy of the results was submitted to RQIA.

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

Radiography

The practice has four surgeries, each of which has an intra-oral x-ray machine. In addition there is an orthopan tomogram machine (OPG), which is located in a separate room. Ms Browne confirmed that the OPG has been decommissioned.

The radiation protection advisor (RPA) completes a quality assurance check every three years. The most recent visit by the RPA was undertaken during January 2015. Evidence was not available to confirm that all recommendation in the RPA report had been addressed.

A dedicated radiation protection file containing the relevant local rules, employer's procedures and other additional information was retained. A copy of the local rules was on display near each x-ray machine and staff spoken with demonstrated sound knowledge of the local rules and associated practice. The radiation protection file did not contain the following:

- confirmation that all of the recommendations made by the RPA have been addressed
- the local rules signed by all appropriate staff to confirm they have read and understood them
- 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)
- records pertaining to the servicing and maintenance of radiology equipment

It was evidenced that measures are taken to optimise dose exposure. This included the use of rectangular collimation. Ms Browne confirmed that x-ray audits had been undertaken however, copies of these had not been retained in the radiation protection file. Ms Browne was advised that x-ray quality grading audits should be completed every six months and justification and clinical evaluation recording audits should be completed annually and records retained for inspection.

A requirement has been made to address the issues identified.

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

Environment

The environment was maintained to a good standard of maintenance and décor. Detailed cleaning schedules were in place and a colour coded cleaning system was in place.

A fire risk assessment had been undertaken in March 2013; however, there was no evidence that this had been reviewed on an annual basis. There was no evidence to confirm that the only fire extinguisher provided had been serviced or fire safety checks were being carried out. Although Ms Browne confirmed that the staff were aware of the action to take in the event of a fire, fire safety training and fire drills had not been undertaken in some time. A requirement has been made that the fire risk assessment is reviewed by a competent person and any issues identified are addressed within timescales acceptable to the risk assessor. Following the inspection RQIA received confirmation that the fire risk assessment is to be reviewed on 5 April 2017.

A legionella risk assessment was last undertaken during July 2015 by an external organisation; however there was no evidence that this had been reviewed on an annual basis. Following the inspection RQIA received confirmation that the legionella risk assessment has been reviewed and any recommendations actioned.

Patient and staff views

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

Comments provided included the following:

- "Every option is always given and also the pros and cons. Very hygienic and staff are very friendly and professional."
- "Staff very helpful and discuss everything to you."

One staff member submitted a questionnaire response. The member of staff indicated that they felt that patients are safe and protected from harm. Staff spoken with during the inspection concurred with this. No comments were included in the submitted questionnaire response.

Areas for improvement

All information outlined in Schedule 2 of the Independent Health Care Regulations (Northern Ireland) 2005 should be retained within staff personnel files for all newly recruited staff.

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).

All equipment used in the decontamination process must be validated in keeping with HTM 01-05. On completion a copy of the validation certificates should be submitted to RQIA with the returned QIP.

The radiation protection file must be reviewed to include: a copy of the most recent RPA report(s) and confirmation that any recommendations made within the report(s) have been addressed, the local rules signed by all appropriate staff to confirm they have read and understood them, a record of staff entitlements, audits of x-ray quality grading, audits of justification and clinical evaluation recording and records pertaining to the servicing and maintenance of radiology equipment.

All x-ray equipment should be serviced and maintained in keeping with manufacturer's instructions.

The fire risk assessment must be reviewed by a competent person and any issues identified addressed within timescales acceptable to the risk assessor.

Number of requirements	4	Number of recommendations	3

4.4 Is care effective?

Clinical records

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

Routine dental examinations include a review of medical history, a check for gum disease and oral cancers and it was confirmed that treatment plans are developed in consultation with patients. It was confirmed that patients are informed about the cost of treatments, choices and options.

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

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

A Freedom of Information Publication Scheme has been established, however, Ms Browne confirmed that the practice was not registered with the Information Commissioner's Office (ICO) on the day of the inspection. Following the inspection RQIA received confirmation that the practice has since registered with the ICO.

Health promotion

The practice has a strategy for the promotion of oral health and hygiene. Oral health is actively promoted on an individual level with patients during their consultations. A range of health promotion information leaflets are displayed throughout the practice.

The practice has a health promotion outreach programme that includes a recent visit to the local nursery school to help educate children on the importance of good oral health and hygiene.

Audits

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

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

As previously stated it was advised that the IPS audit should be completed every six months and all x-ray audits once completed should be retained in the radiation protection file.

Communication

Ms Browne confirmed that arrangements are in place for onward referral in respect of specialist treatments. A policy and procedure and template referral letters have been established.

Staff meetings are held on a monthly basis to discuss clinical and practice management issues. Staff confirmed that minutes of staff meetings are retained. Staff spoken with confirmed that meetings also facilitated informal in house training sessions.

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

Patient and staff views

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

Comments provided included the following:

- "Care very effective and they tell what is best for you."
- "Yes the girls do their best to fit you in at the best time although sometimes waiting for an appointment can take a few weeks."
- "I am always given an option and always told possible outcomes. Great in an emergency."

The submitted staff questionnaire response 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 the submitted questionnaire response.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.5 Is care compassionate?

Dignity, respect and involvement in decision making

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

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

It was confirmed that treatment options, including the risks and benefits, were discussed with each patient. This ensured that 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. Review of the most recent patient satisfaction report demonstrated that the practice pro-actively seeks the views of patients about the quality of treatment and other services provided. Patient feedback whether constructive or critical, is used by the practice to improve, as appropriate.

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

Patient and staff views

All of the seven patients who submitted questionnaire responses indicated that they are treated with dignity and respect and are involved in decision making affecting their care.

Comments provided included the following:

- "All staff are very friendly and professional. I feel my details are kept confidential and again I am always given options and I am able to make choices on what treatment I am given."
- "Everything is always explained in great detail."
- "Your care is treated with dignity and respect, they are very supportive and everything is explained to you."

The submitted staff questionnaire response indicated that they felt that patients are treated with dignity and respect and are involved in decision making affecting their care. Staff spoken with during the inspection concurred with this.

One comment provided included the following:

- "Recent patient survey completed 2017."

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Management and governance arrangements

There was a clear organisational structure within the practice and staff were able to describe their roles and responsibilities and were aware of who to speak to if they had a concern. Staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Ms Browne 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 systematically reviewed on a three yearly basis. Staff spoken with were aware of the policies and how to access them. Ms Browne was advised to centrally index the policies for easier accessibility.

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

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

Ms Browne confirmed that arrangements were in place to monitor, audit and review the effectiveness and quality of care delivered to patients at appropriate intervals. If required an action plan is developed and embedded into practice to address any shortfalls identified during the audit process.

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

Ms Browne, as registered person and registered manager, demonstrated a clear understanding of her role and responsibility in accordance with legislation. It was confirmed that the Statement of Purpose and Patient's Guide are kept under review, revised and updated when necessary and available on request.

The RQIA certificate of registration was not available for inspection. Ms Browne confirmed that the certificate had been removed during redecoration. Ms Browne was advised that the registration certificate should be displayed appropriately. RQIA agreed to send out a replacement certificate. On 7 April, RQIA received confirmation that the certificate has been received by the practice and is now displayed.

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

Evidence gathered during the inspection has identified a number of issues which could affect the delivery of safe care, all of which have an impact on quality assurance and good governance. Four requirements and three recommendations have been made in order to progress improvement in identified areas. There has been a lack of governance arrangements within the practice and the requirements and recommendations made during this inspection must be actioned to ensure improvements are made. It is important these are kept under review to ensure improvements are sustained. Therefore, an additional recommendation has made to review current monitoring systems to ensure effective quality assurance and governance arrangements are in operation.

Patient and staff views

All of the seven patients who submitted questionnaire responses indicated that they felt that the service is well managed.

Comments provided included the following:

- "Staff are really friendly and very nice to talk to. They get you seen if needs be if you have a problem."
- "The staff within the practice are all very professional yet compassionate and understanding."
- "I am very confident that the dentists in this surgery are more than capable to do what they do correctly and are very professional. They know what they are doing."

The submitted staff questionnaire response indicated that they felt that the service is well led. Staff spoken with during the inspection concurred with this. No comments were included in the submitted questionnaire response.

Areas for improvement

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

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

5.0 Quality improvement plan

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

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

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

5.1 Statutory requirements

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

5.2 Recommendations

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

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP 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 19 (2) (d) Schedule 2, as amended **Stated:** Second time **To be completed by:** 27 March 2017	The registered persons must ensure that all information outlined in Schedule 2 of the Independent Health Care Regulations (Northern Ireland) 2005 is retained within staff personnel files for all newly recruited staff.
	Response by registered provider detailing the actions taken: Recruitment policy and employment file updated to record full CV, explanation of employment gaps, 2 written references (current and most relevant),Access NI cert number, statement of criminal convictions, health declaration form, and certificates including qualifications, GDC, Indemnity
Requirement 2 **Ref:** Regulation 15(2) **Stated:** First time **To be completed by:** 22 May 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 should be submitted to RQIA with the returned Quality Improvement Plan(QIP).
	Response by registered provider detailing the actions taken: Validation was completed in April and certs forwarded as requested. A calender reminder was set for next years validation due date
Requirement 3 **Ref:** Regulation 15 (1) (b) **Stated:** First time **To be completed by:** 27 May 2017	The registered person must ensure that the radiation protection file is reviewed. The radiation protection file should include: • a copy of the most recent RPA report(s) and confirmation that any recommendations made within the report(s) have been addressed • the local rules signed by all appropriate staff to confirm they have read and understood them • 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) • records pertaining to the servicing and maintenance of radiology equipment
	Response by registered provider detailing the actions taken: All actions listed above were carried out and the Radiation Protection Superviser has been changed to Anne McIlhagger

Requirement 4 **Ref:** Regulation 25 (4) (d) (e) (f) **Stated:** First time **To be completed by:** 27 April 2017	The registered persons must ensure that the fire risk assessment is reviewed by a competent person and any issues identified addressed within timescales acceptable to the risk assessor. This should include the following: • the procedure to be taken in the event of a fire • the provision and servicing of fire-fighting equipment • the provision of fire awareness training for all staff annually • the frequency of fire drills
	Response by registered provider detailing the actions taken: Risk assessment was carried out by Fire Risk Assessment NI and their recommendations are being put in place
Recommendations	
Recommendation 1 **Ref:** Standard 11.4 **Stated:** First time **To be completed by:** 27 April 2017	Records of staff training are to be retained and available for inspection.
	Response by registered provider detailing the actions taken: CPD file complied on XL spreadsheet and available for staff to update as required.
Recommendation 2 **Ref:** Standard 15.3 **Stated:** First time **To be completed by:** 27 May 2017	Ensure that all staff receive safeguarding adults at risk of harm and safeguarding children training 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) should be included.
	Response by registered provider detailing the actions taken: Regional guidance is available to staff as requested staff have completed online child protection training and will have completed online adult safeguarding by 27th May
Recommendation 3 **Ref:** Standard 8.3 **Stated:** First time **To be completed by:** 27 May 2017	Ensure that all x-ray equipment is serviced and maintained in keeping with manufacturer's instructions.
	Response by registered provider detailing the actions taken: All x-ray machined serviced and no faults recorded. service reports available on request

Recommendation 4 **Ref:** Standard 8 **Stated:** First time **To be completed by:** 27 May 2017	Review the current monitoring systems to ensure effective quality assurance and governance arrangements are in operation.
	Response by registered provider detailing the actions taken: An outlook calendar has been set up to provide reminders to staff for revalidation, CPD and other required arrangements that need to be met.

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

The Regulation and Quality Improvement Authority

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