Announced Care Inspection Report
24 June 2016

Oasis Dental Care – Omagh

Type of Service: Independent Hospital (IH) - Dental Treatment
Address: 27 Campsie Road, Omagh, BT79 0AE
Tel No: 028 8224 4811
Inspector: Emily Campbell

1.0 Summary

An announced inspection of Oasis Dental Care - Omagh took place on 24 June 2016 from 10:00 to 14:35.

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

Is care safe?

Observations made, review of documentation and discussion with Ms Burns, registered manager, and staff demonstrated that further development is needed to ensure that care provided to patients is safe and avoids and prevents harm. Areas reviewed included staffing, recruitment and selection, safeguarding, management of medical emergencies, infection prevention control and decontamination, radiology and the general environment. One requirement has been made in relation to infection prevention and control and seven recommendations have been made in relation to induction, appraisal, recruitment, infection prevention and control, health and safety, radiology and the legionella risk assessment.

Is care effective?

Observations made, review of documentation and discussion with Ms Burns and staff demonstrated that systems and processes were in place to ensure that care provided in the establishment was effective. Areas reviewed included clinical records, health promotion, audits and communication. Staff meetings have not been held on a regular basis, however, Ms Burns confirmed that she plans to re-introduce monthly staff meetings. No requirements or recommendations have been made.

Is care compassionate?

Observations made, review of documentation and discussion with Ms Burns and staff demonstrated that arrangements are in place to promote patients' dignity, respect and involvement in decision making. However, a review of the current arrangements for carrying out patient satisfaction surveys is needed. A recommendation was made in this regard.

Is the service well led?

Information gathered during the inspection identified that a number of issues need to be addressed to ensure that effective leadership and governance arrangements are in place and to 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 person's understanding of their role and responsibility in accordance with legislation. A recommendation was made for the second time to further develop the patient guide. As discussed above a number of issues were identified within the domain of is care safe which relate to quality assurance and good governance.

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	1	9

Details of the Quality Improvement Plan (QIP) within were discussed with Ms Linda Burns, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent care inspection

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

2.0 Service details

Registered organisation/registered provider: Oasis Dental Care Mr Andrew Relf	**Registered manager:** Ms Linda Burns
Person in charge of the service at the time of inspection: Ms Linda Burns	**Date manager registered:** 19 February 2016
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 Burns, registered manager, an associate dentist, a dental nurse and a trainee dental nurse. A tour of the premises was also undertaken.

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

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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspections dated 16 and 24 July 2015

The most recent inspections of the establishment were announced pre-registration care and estates inspections which were undertaken on 16 July and 24 July 2015 respectively. The completed QIPs were returned and approved by the care and estates inspectors. Following this, on receipt of outstanding information required in relation to estates issues, registration of the practice was approved on the 19 February 2016.

4.2 Review of requirements and recommendations from the last care inspection dated 16 July 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 18 (2) (a) **Stated:** First time	All staff should be provided with safeguarding children and vulnerable adults training. **Action taken as confirmed during the inspection**: Ms Burns confirmed that all staff had undertaken safeguarding children and vulnerable adults training. Review of training records evidenced this.	**Met**
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 1 **Stated:** First time	It is recommended that the patient guide should be further developed to include the arrangements for patient consultation as outlined in regulation 8 of The Independent Health Care Regulations (Northern Ireland) 2005. **Action taken as confirmed during the inspection**: The patient guide has been further developed to include a statement that the results from patient satisfaction surveys are available to patients at reception, however, it does not provide detail of the arrangements for carrying out patient satisfaction surveys. This recommendation has not been sufficiently addressed and has been stated for the second time.	**Not Met**
Recommendation 2 **Ref**: Standard 15.3 **Stated:** First time	It is recommended to establish either separate policies for the protection of children and vulnerable adults or implement one single joint policy. The types and indicators of abuse, reporting, recording and referral arrangements including local contact details should be contained in the policy/policies adopted. **Action taken as confirmed during the inspection**: A dedicated file has been established in relation to safeguarding which includes separate policies for the protection of children and vulnerable adults and additional relevant information. Staff have signed to confirm they have read and understood the policies.	**Met**

	Ms Burns was advised that the 'Child Protection Policy Statement' in the safeguarding file pertaining to CRB checks should be amended to reflect that the arrangements in Northern Ireland are to carry out enhanced AccessNI checks. Ms Burns was aware of the need to revise the safeguarding vulnerable adults policy in keeping with the new regional guidance Adult Safeguarding Prevention and Protection in Partnership (July 2015) which was available and had been shared with staff.	
Recommendation 3 **Ref**: Standard 10 **Stated:** First time	It is recommended that registration with the Information Commissioner's Office (Northern Ireland) should be attained. **Action taken as confirmed during the inspection**: A valid Information Commissioner's Office certificate was in place.	**Met**
Recommendation 4 **Ref**: Standard 9.4 **Stated:** First time	It is recommended that a system is established to ensure that patient satisfaction surveys are completed at least on an annual basis. The findings of the survey should be collated to provide a summary report which should be made available to patients and for inspection. **Action taken as confirmed during the inspection**: A system has been established within the Oasis Dental Care group that all patients are provided with a patient satisfaction questionnaire on completion of their course of treatment. The results of these are then collated on a monthly basis and the results of the most recent survey was on display in the waiting area. This recommendation has been addressed; however, the meaningfulness of the current process is discussed further in section 4.5 of the report and a recommendation was made during this inspection for it to be reviewed.	**Met**

Recommendation 5 **Ref**: Standard 13 **Stated:** First time	It is recommended that : • The decontamination and infection prevention and control policy should be further developed to reflect the Northern Ireland amendments of HTM 01-05 and the environmental cleaning section should reflect the local arrangements and specifically the contracted cleaning arrangements and colour coding of cleaning equipment • The Infection Prevention Society (IPS) HTM 01-05 audit tool should be completed and an action plan for compliance generated. This should be re-audited ion a six monthly basis	**Partially Met**
	Action taken as confirmed during the inspection: There has been some development in relation to the decontamination and infection prevention and control policy; however, some aspects still do not reflect the Northern Ireland (NI) amendments. For example endodontic reamers and files are identified as instruments for single patient use; the NI amendment states they should be single use. There was no environmental cleaning or clinical area cleaning policy available. However, cleaning schedules were available for both the cleaning service and for dental nurses which included the colour coding of cleaning equipment. IPS HTM 01-05 audits were observed to have been completed in September 2015 and May 2016. This recommendation has been partially addressed and the unaddressed aspect is stated for the second time.	

Recommendation 6 **Ref**: Standard 13 **Stated:** First time	It is recommended that: • The non-vacuum steriliser which is rusted should be re-skinned or replaced • Staff should be made aware that instruments should be inspected after cleaning and prior to sterilisation in keeping with good practice • The tears in the dental chairs in surgeries one and three should be repaired • Fabric covered chairs in surgeries should be removed. **Action taken as confirmed during the inspection**: Observations made and discussion with staff confirmed that this recommendation has been addressed.	**Met**
Recommendation 7 **Ref**: Standard 12.4 **Stated:** First time	It is recommended that oropharyngeal airways in sizes 1-4 are replaced, and included in the monthly checking procedure. **Action taken as confirmed during the inspection**: Oropharyngeal airways in sizes 1-4 were available and included in the monthly checking procedure.	**Met**
Recommendation 8 **Ref**: Standard 8.3 **Stated:** First time	It is recommended in relation to radiology and radiation protection that: • The local rules should identify Oasis Dental Care as the legal person, not Smiles Dental Care • Six monthly audits of x-ray grading and annual justification and clinical evaluation recording should be implemented. • Dental nursing staff should sign to confirm they had read and understood the local rules. **Action taken as confirmed during the inspection**: Review of the radiation protection file confirmed that the local rules had been amended and staff had signed them. An x-ray quality grading audit had been undertaken and was scheduled again for July 2016 along with the justification and clinical evaluation recording audit. Ms Burns confirmed that audits would be carried out six monthly and annually as recommended.	**Met**

Recommendation 9 **Ref**: Standard 11.2 **Stated:** First time	It is recommended that a robust system is 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: Review of documentation and discussion with Ms Burns confirmed that a robust system has been introduced to review the professional indemnity status of staff.	
Recommendation 10 **Ref**: Standard 11.1 **Stated:** First time	It is recommended that a staff register is established containing staff details including, name, date of birth, position; dates of employment; and details of professional qualification and professional registration with the GDC, where applicable.	**Met**
	Action taken as confirmed during the inspection: The staff register was available and was observed to be up to date.	

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.

Staff confirmed that new staff are provided with induction on commencement of employment, however, review of one written induction programme evidenced that it only pertained to the first day of employment which focused mainly on corporate arrangements. A recommendation was made that formal written induction programmes should be developed for staff relevant to their roles. Copies of completed induction records should be retained.

Procedures were in place for appraising staff performance. Ms Burns confirmed that appraisals have not been undertaken in over one year, however, she is currently making arrangements to carry out appraisals. A recommendation was made in this regard.

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.

Ms Burns advised that she is currently in the process of completing continuing professional development (CPD) training records in respect of all staff which has recently been introduced by the Oasis Dental Care group. This will provide an overview of training and identify any gaps in training. This is good practice.

Recruitment and selection

A review of the submitted staffing information and discussion with Ms Burns confirmed that two new staff have been recruited since the previous inspection. A review of the personnel file in respect of one staff member identified that the following relevant information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 was not available:

- a criminal conviction declaration
- two written references, one of which should be from the current/previous employer
- reasons for leaving employment and an explanation of any gaps in employment

A recommendation was made in this regard.

Safeguarding

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

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

As discussed in section 4.2, a dedicated file has been established in relation to safeguarding which includes separate policies for the protection of children and vulnerable adults and additional relevant information. Staff have signed to confirm they have read and understood the policies. Ms Burns was advised that the 'Child Protection Policy Statement' in the safeguarding file pertaining to CRB checks should be amended to reflect that the arrangements in Northern Ireland are to carry out enhanced AccessNI checks. Ms Burns was aware of the need to revise the safeguarding vulnerable adults policy in keeping with the new regional guidance Adult Safeguarding Prevention and Protection in Partnership (July 2015) which was available and had been shared with staff.

Management of medical emergencies

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

Review of training records and discussion with staff confirmed that the management of medical emergencies is included in the induction programme and training is updated on an annual basis in keeping with best practice guidance. As discussed previously, formal written induction programmes need be developed; these should include the management of medical emergencies as a topic covered.

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. Templates are available to provide relevant information to medical staff in the event that a patient requires transfer to hospital due to a medical emergency.

Infection prevention control and decontamination procedures

Clinical and decontamination areas were tidy and uncluttered and work surfaces were generally intact and easy to clean. Fixtures, fittings, dental chairs and equipment were in general free from damage, dust and visible dirt. The following issues were identified:

- black bag waste bins in surgeries were not pedal operated
- a tear was observed on the dental nurse's chair in surgery 1
- the horizontal blinds on one window in surgery 1 were dusty and the vertical blinds in the other surgeries appeared grubby. Consideration should be given to the removal of blinds in surgeries
- in surgery 1 there were three cupboards which did not have doors and there was a hole in one of the worktops
- the Durr suction unit in surgery 4 was housed under a worktop which was not closed in and staff reported it was very noisy when in use
- a cobweb was observed at the top of a window surgery 3
- there was no soap dispenser in the staff toilet facility; this should be wall mounted
- colour coded mops had been left steeping in a bleach solution in mop buckets
- wrapped sterilised dental instruments are stored in the OPG room and the dental surgeries. Instruments should not be stored in surgeries

A requirement was made that these matters should be addressed.

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

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. Training records were available for inspection.

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

A decontamination room, separate from patient treatment areas and dedicated to the decontamination process, was available. Appropriate equipment, including a washer disinfector and three steam sterilisers have been provided to meet the practice requirements. A review of documentation evidenced that equipment used in the decontamination process has been appropriately validated. 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 decontamination room was hot and uncomfortable to work in. A recommendation was made, in the interest of health and safety of staff, that the ventilation system in the decontamination room should be reviewed to provide a more comfortable environment for staff to work in.

Records evidenced that the practice continues to audit compliance with HTM 01-05 using the IPS audit tool on a six monthly basis. The most recent IPS audit was completed in May 2016. Hand hygiene audits are carried out annually; the most recent one having been completed in June 2016.

As discussed in section 4.2, there has been some development in relation to the decontamination and infection prevention and control policy; however, some aspects still do not reflect the Northern Ireland (NI) amendments. For example endodontic reamers and files are identified as instruments for single patient use, however, the NI amendment states they should be single use. There was no environmental cleaning or clinical area cleaning policy available. Cleaning schedules however, were available for both the cleaning service and for dental nurses which included the colour coding of cleaning equipment. A recommendation was made for the second time in this regard.

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. The OPG is not in use.

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

A review of the file confirmed that staff have not been authorised by the radiation protection supervisor (RPS) for their relevant duties. It was evidenced that some measures are taken to optimise dose exposure which included the use of rectangular collimation and x-ray quality grading audits. Ms Burns confirmed that x-ray justification and clinical evaluation recording audits will be carried out in July 2016.

A copy of the local rules was on display near each x-ray machine and appropriate staff had signed to confirm that they had read and understood these. Staff spoken with demonstrated sound knowledge of the local rules and associated practice.

Engineer reports were available in respect of three of the x-ray units which were carried out in September 2015 and for a newly installed x-ray unit in February 2016 as part of the three yearly critical examinations. However, there was no evidence that the appointed radiation protection advisor (RPA) had completed a quality assurance check.

The Oasis Dental Care Clinical Governance Manual refers to the Ionising Radiation Regulations (IRR) and Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) in Great Britain. The manual should be further developed to include reference to the IRR 2000 and IR(ME)R 2000 (Northern Ireland) legislation.

A recommendation was made that:

- a radiation protection advisor (RPA) report is obtained and any recommendations made by the RPA are addressed
- all relevant staff should be authorised by the radiation protection supervisor (RPS) for their relevant duties
- the Oasis Dental Care Clinical Governance Manual should be further developed to include reference to the IRR 2000 and IR(ME)R 2000 (Northern Ireland) legislation

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

Quality assurance systems and processes were in place to ensure that all matters relating to x-rays reflect legislative and best practice guidance.

Environment

The environment was maintained to a good standard of maintenance and décor.

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. Records reviewed included the servicing/testing of the air conditioning unit, emergency lighting, fire extinguishers, portable appliance and fixed electrical wiring and the relative anaesthesia (RA) unit. In addition, a variety of risk assessments were in place.

A legionella risk assessment was undertaken on 9 June 2016 and review of the report identified that a number of recommendations were made to minimise risk. Ms Burns advised that the report has been passed to the estates department at Oasis head office for action. A recommendation was made to ensure that recommendations made in the legionella risk assessment are addressed.

A fire risk assessment had been undertaken in January 2016 and records confirmed that fire training and fire drills had been completed. The evacuation procedure was on display in each room. Staff demonstrated that they were aware of the action to take in the event of a fire.

A written scheme of examination of pressure vessels was in place and pressure vessels had been inspected in keeping with the scheme.

Patient and staff views

Five patients submitted questionnaire responses to RQIA. Four patients indicated that they felt safe and protected from harm; one patient did not. Comments provided included the following:

- "Everything well explained."
- "*Xxx* and *xxx* on occasions were my dentists for many years, bur since *xxx's* retirement I have only had one appointment with *xxx*. I am confident that the good service I've always experienced will continue. My daughter and her 3 children are now in his care as well. All reports are good."
- "Some staff could be more friendly."

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

Areas for improvement

Formal written induction programmes should be developed for staff relevant to their roles. Copies of completed induction records should be retained.

A system should be established to ensure that staff appraisals are carried out on an annual basis. Appraisal records should be retained.

Recruitment and selection procedures should be further developed.

Infection prevention and control arrangements must be reviewed and addressed as identified.

In the interest of health and safety of staff, the ventilation system in the decontamination room should be reviewed to provide a more comfortable environment for staff to work in.

The decontamination and infection prevention and control policy should be further developed to reflect the Northern Ireland amendments of HTM 01-05 and the environmental cleaning section should reflect the local arrangements and specifically the contracted cleaning arrangements and colour coding of cleaning equipment.

An RPA report should be obtained and all relevant staff should be authorised by the RPS for their relevant duties. The Oasis Dental Care Clinical Governance Manual should include reference to the Northern Ireland IRR and IR(ME)R legislation.

The recommendations made in the legionella risk assessment should be addressed.

Number of requirements	**1**	**Number of recommendations**:	**7**

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 that treatment plans are developed in consultation with patients. It was confirmed that patients are informed about the cost of treatments, choices and options. Patients are provided with written treatment plans including approximate costs and information pertaining to after care following treatment is available in a range of languages.

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.

The practice is registered with the Information Commissioner's Office (ICO).

Health promotion

The practice has a strategy for the promotion of oral health and hygiene. There were information leaflets available in the waiting room and on display promoting oral health. Ms Burns advised that the practice plans to provide oral health presentations at local schools in the future as part of the practice's oral health promotion strategy.

Staff confirmed that oral health is actively promoted on an individual level with patients during their consultations.

Audits

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

- x-ray quality grading
- IPS HTM 01-05 compliance
- hand hygiene
- clinical records
- review of complaints/accidents/incidents
- review of risk assessments

Communication

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

Ms Burns advised that a staff meeting was held in May 2016, however, it was the start of the year since the previous one had been held. Ms Burns confirmed that she plans to re-introduce staff meetings on a monthly basis. Review of documentation demonstrated that minutes of staff meetings are retained. Ms Burns and staff 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

Four of the five patients who submitted questionnaire responses indicated that they get the right care, at the right time and with the best outcome for them, one did not. Comments provided included the following:

- "Always provide follow-up care, floss, soft brushes etc."
- "Long waiting list/time."

All submitted staff questionnaire responses indicated that they felt that patients get the right care, at the right time and with the best outcome for them. Staff spoken with during the inspection concurred with this.

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

The practice can accommodate patients with a disability and an interpreter service is available for patients who require this assistance. Written treatment plans including estimated costs are provided to patients and information pertaining to after care following treatment is available in a variety of languages.

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.

As discussed in section 4.2, a system has been established within the Oasis Dental Care group that all patients are provided with a patient satisfaction questionnaire on completion of their course of treatment. The results of these are then collated on a monthly basis and the results of the most recent survey were on display in the waiting area.
However, the results of the surveys do not indicate the period they relate to or how many patients took part in the survey. Further review of this information identified that during some months only one or two patients completed questionnaires. The production of a survey consisting of one or two patients' views could be misleading for patients. In order to make this process more meaningful, it was recommended that patient satisfaction questionnaires are collated during a longer period of time, for example three, six or twelve months. The summary report should reflect the period of the consultation period and the number of participants.

Patient and staff views

Four of the five patients who submitted questionnaire responses indicated that they are treated with dignity and respect and are involved in decision making affecting their care, one did not.

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

Areas for improvement

The patient consultation process should be reviewed to make it more meaningful.

Number of requirements	0	Number of recommendations:	1

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. The practice initially registered as Slevin and Turbitt Dental Practice was taken over by Smiles Dental, Omagh and within a short period of time was bought over by Oasis Dental Care. As a result staff have experienced a lot of change associated with any change in ownership. However, staff spoken with indicated that they were settling in well with the current arrangements and confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. Ms Burns 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 Ms Burns confirmed these would be reviewed on a yearly basis. Staff spoken with were aware of the policies and how to access them. As discussed previously, a recommendation was made for the second time that the decontamination and infection prevention and control policy should be further developed.

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 evidence provided in the returned questionnaire and review of documentation indicated that complaints have been managed in accordance with best practice.

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

Ms Burns confirmed that arrangements were in place to monitor, audit and review the effectiveness and quality of care delivered to patients at appropriate intervals. However as discussed previously, a number of issues were identified which indicate that more robust arrangements need to be put in place to progress improvement. Ms Burns advised that she has recently completed a corporate annual pre-audit which covers five key areas/topics of care – safe, effective, caring, responsive and well led. The Oasis Dental Care compliance manager will then carry out an audit and identify actions to be taken as a result. Ms Burns will have 12 weeks to implement the action plan and complete a post-audit. It is anticipated that this process will assist in progressing improvement in the areas identified during this inspection.

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 Burns demonstrated a clear understanding of her role and responsibility in accordance with legislation. Information requested by RQIA has been submitted within specified timeframes. However, there was a long delay with the Oasis Dental Care group addressing the requirements and recommendations made by the estates inspector during the pre-registration inspection on 24 July 2015, before registration of the practice could be approved on 19 February 2016. The Oasis Dental Care should be mindful of the need to action any requirements or recommendations made by RQIA within the specified timescales.

The statement of purpose and patient guide are kept under review, revised and updated when necessary and available on request. As discussed in section 4.2, a recommendation was made for the second time that the patient guide should be further developed to include the arrangements for patient consultation as outlined in regulation 8 of The Independent Health Care Regulations (Northern Ireland) 2005.

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

Three of the five patients who submitted questionnaire responses indicated that they feel that the service is well managed; two patients did not respond. The following comment was provided:

- “All staff are very friendly. Contacted if any changes to appointment. When was looking for emergency appointment – very helpful.”

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

Areas for improvement
No areas for improvement were identified during the inspection.

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 this QIP were discussed with Ms Linda Burns, registered manager, 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 Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider may enhance service, quality and delivery.

5.3 Actions taken by the Registered Provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return completed QIP to iIndependent.Healthcare@rqia.org.uk for review 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 15 (7) **Stated:** First time **To be completed by:** 24 September 2016	The registered provider must ensure that the following issues pertaining to infection prevention and control are addressed: • black bag waste bins in surgeries were not pedal operated • a tear was observed on the dental nurse's chair in surgery 1 • the horizontal blinds on one window in surgery 1 were dusty and the vertical blinds in the other surgeries appeared grubby. Consideration should be given to the removal of blinds in surgeries. • in surgery 1 there were three cupboards which did not have doors and there was a hole in one of the worktops • the Durr suction unit in surgery 4 was housed under a worktop which was not closed in and staff reported it was very noisy when in use • there was no soap dispenser in the staff toilet facility; this should be wall mounted • a cobweb was observed at the top of a window surgery 3 • colour coded mops had been left steeping in a bleach solution in mop buckets • wrapped sterilised dental instruments are stored in the OPG room and the dental surgeries. Instruments should not be stored in surgeries
	Response by registered provider detailing the actions taken: All general waste bins have been removed from the surgeries. Nurses chair in surgery 1 to be re-covered within time frame, Blinds are being removed from all surgeries and replaced, Estates team have been to measure up for replacement of cupboard doors and work tops and are working on providing a central store for instruments in the practice. Mops are now hung up to dry and removed from buckets over night.
Recommendations	
Recommendation 1 **Ref**: Standard 11.3 **Stated:** First time **To be completed by:** 24 July 2016	Formal written induction programmes should be developed for staff relevant to their roles. Copies of completed induction records should be retained.
	Response by registered provider detailing the actions taken: New induction policies are being implemented in accordance with their roles.
Recommendation 2 **Ref**: Standard 11 **Stated:** First time **To be completed by:** 24 September 2016	A system should be established to ensure that staff appraisals are carried out on an annual basis. Appraisal records should be retained.
	Response by registered provider detailing the actions taken: Final part of apprasials for the year have since been carried out.

Recommendation 3 **Ref**: Standard 11.1 **Stated:** First time **To be completed by:** 24 June 2016	Recruitment and selection procedures should be further developed to ensure that all relevant information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 is sought and retained in respect of any new staff recruited to include: • a criminal conviction declaration • two written references, one of which should be from the current/previous employer • reasons for leaving employment and an explanation of any gaps in employment
	Response by registered provider detailing the actions taken: All references have now been obtained, criminal convictions declaration is now included and gaps between employment are accounted for.
Recommendation 4 **Ref**: Standard 14.2 **Stated:** First time **To be completed by:** 24 September 2016	In the interest of health and safety of staff, that the ventilation system in the decontamination room should be reviewed to provide a more comfortable environment for staff to work in.
	Response by registered provider detailing the actions taken: Estates team have visited and are in the process of fizing this issue.
Recommendation 5 **Ref**: Standard 13 **Stated:** Second time **To be completed** 24 September 2016	It is recommended that: • the decontamination and infection prevention and control policy should be further developed to reflect the Northern Ireland amendments of HTM 01-05 and the environmental cleaning section should reflect the local arrangements and specifically the contracted cleaning arrangements and colour coding of cleaning equipment
	Response by registered provider detailing the actions taken: A company policy in line with the HTM01-05 is currently being drafted.
Recommendation 6 **Ref**: Standard 8.3 **Stated:** First time **To be completed by:** 24 August 2016	A radiation protection advisor (RPA) report should be obtained and any recommendations made by the RPA should be addressed All relevant staff should be authorised by the radiation protection supervisor (RPS) for their relevant duties. The Oasis Dental Care Clinical Governance Manual should be further developed to include reference to the Ionising Radiation Regulations (IRR) (Northern Ireland) 2000 and the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) (Northern Ireland) 2000 legislation.
	Response by registered provider detailing the actions taken: Oasis are currently revising their RPA for Northern Ireland, All staff have since been authorised by the RPS for their relevant duties, Oasis manual is being updated to include N. I regulations.

Recommendation 7 **Ref**: Standard 14.2 **Stated:** First time **To be completed by:** 24 September 2016	The recommendations made in the legionella risk assessment should be addressed.
	Response by registered provider detailing the actions taken: Coral Environmental are booked in the complete remedial work from the most recent Legionella risk assessment.
Recommendation 8 **Ref**: Standard 9.4 **Stated:** First time **To be completed by:** 24 September 2016	In order to make the patient consultation process more meaningful, patient satisfaction questionnaires should be collated over a longer period of time, for example three, six or twelve months. The summary report should reflect the period of the consultation and the number of participants and should be made available to patients and for inspection.
	Response by registered provider detailing the actions taken: Patient feedback now states a time frame for collection on the patient information board.
Recommendation 9 **Ref**: Standard 1 **Stated:** Second time **To be completed by:** 24 August 2016	It is recommended that the patient guide should be further developed to include the arrangements for patient consultation as outlined in regulation 8 of The Independent Health Care Regulations (Northern Ireland) 2005.
	Response by registered provider detailing the actions taken: Patient guide will be adapted to include N.I regulations within time frame.

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

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