The Regulation and Quality Improvement Authority

Inspection Report

20 March 2026

Gransha Dental

Type of service: Independent Hospital (IH) – Dental Treatment
Address: 89A-89B Glen Road, Belfast, BT11 8BD
Telephone number: 028 9061 2312

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/, The Independent Health Care Regulations (Northern Ireland) 2005 and the Minimum Standards for Dental Care and Treatment (March 2011)

1.0 Service information

Organisation/Registered Provider: Gransha Dental Limited **Responsible Individual:** Mrs Louise McGuigan	**Registered Manager:** Ms Debbie McVeigh **Date registered:** 1 March 2021
Person in charge at the time of inspection: Ms Debbie McVeigh	**Number of registered places:** Three
Categories of care: Independent Hospital (IH) – Dental Treatment	
Brief description of how the service operates: Gransha Dental is registered with the Regulation and Quality Improvement Authority (RQIA) as an independent hospital (IH) with a dental treatment category of care. The practice has three registered dental surgeries and provides general dental services, private and health service treatment and does not offer conscious sedation. Gransha Dental Limited is the registered provider for two dental practices registered with RQIA. Mrs Louise McGuigan is the responsible individual for Gransha Dental Limited.	

2.0 Inspection summary

This was an announced inspection, undertaken by a care inspector on 20 March 2026 from 9.15 am to 1.00 pm.

The inspection focused on the themes for the 2025/26 inspection year and assessed progress against the five areas for improvement identified at the last care inspection. Four of these areas for improvement were assessed as met. One area for improvement, in relation to the management of complaints, was assessed as not met and has therefore been stated for a second time.

There was evidence of good practice in relation to staff training; management of medical emergencies; infection prevention and control (IPC) and decontamination of reusable dental instruments.

No immediate concerns were identified regarding the delivery of front line patient care.

3.0 How we inspect

RQIA is required to inspect registered services in accordance with legislation. To do this, we gather and review the information we hold about the service, examine a variety of relevant records, meet and talk with staff and management and observe practices on the day of the inspection.

The information obtained is then considered before a determination is made on whether the practice is operating in accordance with the relevant legislation and minimum standards.

Examples of good practice are acknowledged and any areas for improvement are discussed with the person in charge and detailed in the quality improvement plan (QIP).

4.0 What people told us about the care and treatment?

We issued posters to the registered provider prior to the inspection inviting patients and members of the dental team to complete an electronic questionnaire.

One patient submitted a response. The patient response indicated that they felt their care was safe and effective, that they were treated with compassion and that the service was well led. The patient indicated that they were very satisfied with each of these areas of care.

Three staff submitted questionnaire responses. Staff responses indicated that they felt patient care was safe, effective, that patients were treated with compassion and that the service was well led. All staff indicated that they were either satisfied or very satisfied with each of these areas of patient care.

5.0 The inspection

5.1 What action has been taken to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 23 June 2025		
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 19 (2) Schedule 2	The responsible individual shall ensure that recruitment records are sought, reviewed and retained in keeping with Schedule 2, as amended for all new staff.	**Met**

Stated: First time	**Action taken as confirmed during the inspection**: This area for improvement was assessed as met and further details can be found in section 5.2.1.	
Area for improvement 2 **Ref:** Regulation 15 (7) **Stated:** First time	The responsible individual shall ensure a risk assessment is completed when a safer sharp is not deemed practical, this should be signed by the treating clinician.	**Met**
	Action taken as confirmed during the inspection: This area for improvement was assessed as met and further details can be found in section 5.2.5.	
Action required to ensure compliance with The Minimum Standards for Dental Care and Treatment (2011)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 11.4 **Stated:** First time	The responsible individual shall ensure that mandatory staff training is undertaken and recorded, in line with any professional requirements, and the training guidance provided by RQIA.	**Met**
	Action taken as confirmed during the inspection: This area for improvement was assessed as met and further details can be found in section 5.2.2.	
Area for improvement 2 **Ref:** Standard 14.4 **Stated:** First time	The responsible individual must ensure the arrangements to revalidate all decontamination equipment is embedded into practice.	**Met**
	Action taken as confirmed during the inspection: This area for improvement was assessed as met and further details can be found in section 5.2.6.	
Area for improvement 3 **Ref:** Standard 9.3 **Stated:** First time	The responsible individual must ensure complaints are managed effectively in accordance with legislation and best practice guidance.	**Not met**
	Action taken as confirmed during the inspection: This area for improvement was assessed as not met and has been stated for a second	

	time. Further details can be found in section 5.2.8.	

5.2 Inspection findings

5.2.1 Do recruitment and selection procedures comply with all relevant legislation?

There were recruitment and selection policies and procedures in place that adhered to legislation and best practice guidance.

Mrs McGuigan oversees the recruitment and selection of the dental team and approves all staff appointments with the support of Ms McVeigh. Discussion with Ms McVeigh confirmed that she had an understanding of the legislation and best practice guidance.

A review of the staff register evidenced that it needed to be updated. Advice and guidance was provided regarding this and following the inspection, RQIA received confirmation that the staff register had been reviewed and updated accordingly.

Review of recruitment records identified some missing information. This was discussed, and following the inspection RQIA received confirmation that this information was now in place. Therefore, it was determined that the previous area for improvement one, made against the regulations, as outlined in section 5.1 has been met.

There was evidence of job descriptions and induction checklists for the different staff roles. A review of records confirmed that if a professional qualification is a requirement of the post, a registration check is made with the appropriate professional regulatory body.

As a result of action taken following inspection, it is determined that the recruitment of the dental team complies with the legislation and best practice guidance to ensure suitably skilled and qualified staff work in the practice.

5.2.2 Is the dental team appropriately trained to fulfil the duties of their role?

The dental team takes part in ongoing training to update their knowledge and skills, relevant to their role. Policies and procedures are in place that outline mandatory training to be undertaken, in line with any professional requirements, and the training guidance provided by RQIA.

A record is kept of all training (including induction) and professional development activities undertaken by staff, which is overseen by Ms McVeigh, to ensure that the dental team is suitably skilled and qualified. Therefore, it was determined that the previous area for improvement one, made against the standards, as outlined in section 5.1 has been met.

The care and treatment of patients is being provided by a dental team that is appropriately trained to carry out their duties.

5.2.3 Is the practice fully equipped and is the dental team trained to manage medical emergencies?

The British National Formulary (BNF) and the Resuscitation Council (UK) specify the emergency medicines and medical emergency equipment that must be available to safely and effectively manage a medical emergency. Systems were in place to ensure that emergency medicines and equipment are immediately available as specified and do not exceed their expiry dates.

There was a medical emergency policy and procedure in place and a review of this evidenced that it reflected legislation and best practice guidance. Protocols were available to guide the dental team on how to manage recognised medical emergencies.

Managing medical emergencies is included in the induction programme and refresher training is undertaken annually.

Members of the dental team were able to describe the actions they would take, in the event of a medical emergency, and were familiar with the location of medical emergency medicines and equipment.

Sufficient emergency medicines and equipment were in place and the dental team is trained to manage a medical emergency as specified in the legislation, professional standards and guidelines.

5.2.4 Does the dental team provide dental care and treatment using conscious sedation in line with the legislation and guidance?

Conscious sedation helps reduce anxiety, discomfort and pain during certain procedures. This is accomplished with medications or medical gases to relax the patient. Ms McVeigh confirmed that conscious sedation is not offered in Gransha Dental.

5.2.5 Does the dental team adhere to infection prevention and control (IPC) best practice guidance?

The IPC arrangements were reviewed throughout the practice to evidence that the risk of infection transmission to patients, visitors and staff was minimised.

The infection prevention and control measures to prevent transmission of respiratory illnesses in the practice was discussed with Ms McVeigh. It was confirmed that arrangements are in place in keeping with the Health and Social Care Public Health Agency guidance Infection Prevention and Control Measures for Respiratory illnesses March 2023 and the Infection Prevention and Control Manual for Northern Ireland. Ms McVeigh confirmed arrangements are in place to check the Department of Health (DoH) websites for further advisory information, guidance and alerts in this regard.

There was an overarching IPC policy and associated procedures in place. Review of these documents demonstrated that they reflected legislation and best practice guidance. Ms McVeigh confirmed there was a nominated lead dental nurse who had responsibility for IPC and decontamination in the practice. The lead dental nurse had undertaken IPC and decontamination training in line with their continuing professional development and had retained the necessary training certificates as evidence.

During a tour of some areas of the practice, it was observed that clinical and decontamination areas were clean, tidy and uncluttered. All areas of the practice observed were equipped to meet the needs of patients. A discussion took place with Ms McVeigh around the condition of the flooring in surgery three and Ms McVeigh provided RQIA with assurance that this would be appropriately repaired.

The arrangements for personal protective equipment (PPE) were discussed and Ms McVeigh advised that appropriate PPE was readily available for the dental team in accordance with the treatments provided.

Using the Infection Prevention Society (IPS) audit tool, IPC audits are routinely undertaken by members of the dental team to self-assess compliance with best practice guidance. The purpose of these audits is to assess compliance with key elements of IPC, relevant to dentistry, including the arrangements for environmental cleaning; the use of PPE; hand hygiene practice; and waste and sharps management. This audit also includes the decontamination of reusable dental instruments which is discussed further in the following section of this report. A review of these audits evidenced that they were completed on a six monthly basis and, where applicable, an action plan was generated to address any improvements required.

The management of sharps was reviewed and it was confirmed that a risk assessment had been completed when a safer sharp is not deemed practical, and this had been signed by the treating clinician. Therefore, it was determined that the previous area for improvement two, made against the regulations, as outlined in section 5.1 has been met.

Hepatitis B vaccination is recommended for clinical members of the dental team as it protects them if exposed to this virus. A system was in place to ensure that relevant members of the dental team have received this vaccination. Ms McVeigh confirmed that vaccination history is checked during the recruitment process and vaccination records are retained in personnel files.

Ms McVeigh confirmed that members of the dental team had received IPC training relevant to their roles and responsibilities and they demonstrated good knowledge and understanding of these procedures. Review of training records evidenced that the dental team had completed relevant IPC training and had received regular updates.

As a result of the assurances provided by Ms McVeigh following the inspection, it was confirmed that the IPC arrangements in place minimise the risk of infection transmission to patients, visitors and staff.

5.2.6 Does the dental team meet current best practice guidance for the decontamination of reusable dental instruments?

Robust procedures and a dedicated decontamination room must be in place to minimise the risk of infection transmission to patients, visitors and staff in line with Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the DoH.

There was a range of policies and procedures in place for the decontamination of reusable dental instruments that were comprehensive and reflected legislation, minimum standards and best practice guidance.

There was a designated decontamination room separate from patient treatment areas and dedicated to the decontamination process. The design and layout of this room complied with best practice guidance and the equipment was sufficient to meet the requirements of the practice. Records evidencing that the equipment for cleaning and sterilising instruments was inspected, validated, maintained and used in line with the manufacturers' guidance were reviewed. Therefore, it was determined that the previous area for improvement two, made against the standards, as outlined in section 5.1 has been met.

Review of equipment logbooks demonstrated that all required tests to check the efficiency of the machines had been undertaken.

Discussion with members of the dental team confirmed that they had received training on the decontamination of reusable dental instruments in keeping with their role and responsibilities. They demonstrated good knowledge and understanding of the decontamination process and were able to describe the equipment treated as single use and the equipment suitable for decontamination.

Decontamination arrangements demonstrated that the dental team are adhering to current best practice guidance on the decontamination of dental instruments.

5.2.7 How does the dental team ensure that appropriate radiographs (x-rays) are taken safely?

The arrangements regarding radiology and radiation safety were reviewed to ensure that appropriate safeguards were in place to protect patients, visitors and staff from the ionising radiation produced by taking an x-ray.

Dental practices are required to notify and register any equipment producing ionising radiation with the Health and Safety Executive Northern Ireland (HSENI). A review of records evidenced the practice had registered with the HSENI.

The practice has three registered surgeries, two of which have intra-oral x-ray machines and an orthopan tomogram (OPG) machine, which is located in a separate room as reflected in the equipment inventory. An additional intra-oral x-ray machine was not in use and this was documented within the most recent radiation protection advisor (RPA) report and clearly identified as "out of use". Documentation confirmed that the x-ray equipment in use had been serviced and maintained in line with the manufacturer's instructions.

A radiation protection advisor (RPA), medical physics expert (MPE) and radiation protection supervisor (RPS) have been appointed in line with legislation.

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 the Employer had entitled all but one member of the dental team to undertake specific roles and responsibilities associated with radiology and had ensured that these staff had completed appropriate training. It was also noted that the RPS had not completed the required annual review of the radiation protection file. Advice was provided, and following the inspection confirmation was received that these matters had been addressed.

The appointed RPA must undertake a critical examination and acceptance test of all new x-ray equipment; thereafter the RPA must complete a quality assurance test every three years as specified within the legislation. Ms McVeigh confirmed that no new radiology equipment had been installed since the previous RQIA inspection.

The most recent report generated by the RPA during March 2026 evidenced that the x-ray equipment had been examined. Advice and guidance was provided to Ms McVeigh in relation to the RPS signing and dating the RPA report to confirm that any recommendations made had been actioned. Ms McVeigh was receptive to this advice and following the inspection, RQIA received confirmation that this matter had been addressed.

A copy of the local rules was on display near each x-ray machine observed and appropriate staff had signed to confirm that they had read and understood these.

Quality assurance systems and processes were in place to ensure that all matters relating to x-rays reflect legislation and best practice guidance. It was evidenced that all measures are taken to optimise radiation dose exposure. This included the use of rectangular collimation, x-ray audits and digital x-ray processing.

As a result of the actions taken following the inspection, it is determined that procedures are in place to ensure that appropriate x-rays are taken safely.

5.2.8 Are complaints and incidents being effectively managed?

The arrangements for the management of complaints and incidents were reviewed to ensure that they were being managed in keeping with legislation and best practice guidance.

The complaints policy and procedure in place provided instructions for patients and staff to follow. Patients and/or their representatives were made aware of how to make a complaint by way of the patient's guide and information on display in the practice.

A complaints register was in place, however this needs further developed to ensure it includes all relevant records, including details of any investigation undertaken, all communication with complainants, the outcome of the complaint and the complainant's level of satisfaction.

A review of records concerning complaints evidenced that complaints had not been recorded and managed in line with best practice guidance.

Therefore, it was determined that the previous area for improvement three, made against the standards, as outlined in section 5.1 has not been met and has been stated for a second time.

Ms McVeigh confirmed that an incident policy and procedure was in place, including the reporting arrangements to RQIA. Ms McVeigh confirmed that incidents are appropriately documented and investigated in line with legislation. However, it was noted that a notifiable incident had not been reported to RQIA. Advice and guidance was provided and following the inspection this notification was subsequently reported retrospectively. Arrangements are in place to audit adverse incidents to identify trends and improve service provided.

Addressing the area for improvement will ensure that complaints are being managed effectively in accordance with legislation and best practice guidance.

5.2.9 How does a registered provider who is not in day to day management of the practice assure themselves of the quality of the services provided?

Where the business entity operating a dental practice is a corporate body or partnership or an individual owner who is not in day to day management of the practice, unannounced quality monitoring visits by the registered provider must be undertaken and documented every six months; as required by Regulation 26 of The Independent Health Care Regulations (Northern Ireland) 2005.

Ms McVeigh is the nominated individual with overall responsibility for the day to day management of the practice and is responsible for reporting to the registered provider. During the inspection, it was identified that the unannounced quality monitoring visits by the registered provider were not taking place. Advice and guidance was provided on this matter and following the inspection correspondence was received to confirm that that the unannounced quality monitoring visits by the registered provider would take place on a six monthly basis.

5.3 Does the dental team have suitable arrangements in place to record equality data?

The arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients was discussed with Ms McVeigh.

6.0 Quality Improvement Plan/Areas for Improvement

An area for improvement has been identified where action is required to ensure compliance with the Minimum Standards for Dental Care and Treatment (March 2011)

	Regulations	Standards
Total number of Areas for Improvement	0	1*

the total number of areas for improvement includes one that has been stated for a second time.

Areas for improvement and details of the QIP were discussed with Ms McVeigh, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with the Minimum Standards for Dental Care and Treatment (March 2011)	
Area for improvement 1 **Ref:** Standard 9.3 **Stated:** Second time **To be completed by:** 20 March 2026	The responsible individual must ensure complaints are managed effectively in accordance with legislation and best practice guidance. Ref: 5.1 and 5.2.8
	Response by registered person detailing the actions taken: We will update its complaints policy in line with Health and Social Care Complaints Procedure (Northern Ireland) Regulations 2009 and the principles of Northern Ireland Public Services Ombudsman guidance. This includes being customer focused, open and accountable, acting fairly and proportionately, putting things right, and seeking continuous improvement, to ensure a clear and consistent approach to complaint handling. A central complaints log and standard investigation template has been implemented to improve recording, investigation, and documentation of outcomes. All complaints will be acknowledged within 2 working days and responded to within 10 working days, with clear communication and apologies where appropriate. The Responsible Individual and Registered Manager will undertake monthly oversight of complaints to monitor compliance and identify themes, with learning shared at team meetings to support continuous improvement. Staff will receive training on complaints handling and NIPSO guidance to support effective implementation. Compliance will be monitored through regular audit and governance processes to ensure complaints are managed in line with legislation and best practice.

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