Announced Care Inspection Report
14 February 2018

The White House Teeth Whitening Limited

Type of service: Independent Hospital (IH) - Dental Treatment
Address: 387 Lisburn Road, Belfast, BT9 7EW
Tel no: 028 9066 7330
Inspector: Elizabeth Colgan

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered dental practice with one registered place which provides teeth whitening treatments only.

3.0 Service details

Organisation/Registered Provider: The White House Teeth Whitening Limited **Responsible Individual:** Mr Fredrick Desmond	**Registered Manager:** Ms Hayley Purse
Person in charge at the time of inspection: Mr Fredrick Desmond	**Date manager registered:** 02 May 2017
Categories of care: Independent Hospital (IH) – Dental Treatment	**Number of registered places:** 1

4.0 Inspection summary

An announced inspection took place on 14 February 2018 from 10.00 to 12.00.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Independent Health Care Regulations (Northern Ireland) 2005, The Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011 and the Department of Health, Social Services and Public Safety (DHSSPS) Minimum Standards for Dental Care and Treatment (2011).

The inspection assessed progress with any areas for improvement identified during and since the previous inspection and to determine if the practice was delivering safe, effective and compassionate care and if the service was well led.

Examples of good practice were evidenced in all four domains. These related to patient safety in respect of staff induction and development and the environment. Other examples included engagement to enhance the patients' experience.

Three areas requiring improvement were identified against the regulations in respect of staff recruitment, relevant information regarding the automated external defibrillator (AED) in the management of medical emergency protocols and ensuring the registered person undertakes six monthly unannounced monitoring visits, and reports on the findings.

Four areas requiring improvement were identified against the standards, three areas related to the further development of the safeguarding adults at risk of harm policy, health and safety policies and procedures, and the Infection Prevention and Control Policy as outlined. The fourth area identified that staff training records should be retained in the practice and available for inspection.

Patients who submitted questionnaire response indicated that they very satisfied or satisfied with care and services provided. Comments provided include the following:

- "Very good, impressed."

- "Very professional."

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

While we assess the quality of services provided against regulations and associated DHSSPS care standards.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	3	4

Details of the Quality Improvement Plan (QIP) were discussed with Mr Fredrick Desmond, 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.

4.2 Action/enforcement taken following the most recent care inspection dated 14 October 2016

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 14 October 2016.

5.0 How we inspect

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

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

Questionnaires were provided to patients and staff prior to the inspection by the practice on behalf of RQIA. Returned completed patient questionnaires were also analysed prior to the inspection. No staff questionnaires were received by RQIA.

A poster informing staff to complete a questionnaire by web portal was provided and displayed.

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

During the inspection the inspector met with Mr Desmond, registered person, Ms Hayley Purse, registered manager and a receptionist. A tour of the premises was also undertaken.

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

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

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

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

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 14 October 2016

The most recent inspections of the establishment were announced pre-registration care and estates inspections which were undertaken on 14 October 2016. The completed QIPs were returned and approved by the care and estates inspectors. Following this, on receipt of outstanding information required, registration of the practice was approved on the 02 may 2017.

6.2 Review of areas for improvement from the last care inspection dated 14 October 2016

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

Ref: Regulation 15 (1) (b) and (c)

Stated: First time</td><td>The registered person must ensure that the arrangement for timely accessibility to an AED is documented within the management of medical emergency protocols and the following emergency equipment is provided;
pocket mask with oxygen port
oropharyngeal airways in sizes 0,1,2,3 and 4
self-inflating bag with reservoir (adult)
clear face masks and tubing
Relevant staff must have received training in the use of the AED.</td><td rowspan="2">Partially met</td></tr>
<tr><td></td><td>Action taken as confirmed during the inspection:
Review of documentation and observation confirmed that the following emergency equipment was provided:
pocket mask with oxygen port
oropharyngeal airways in sizes 0,1,2,3 and 4
self-inflating bag with reservoir (adult)
clear face masks and tubing
Arrangement for timely accessibility to an AED has not been documented within the management of medical emergency protocols.

This part of this area for improvement has been stated for the second time.</td></tr>
</table>

Action required to ensure compliance with The Minimum Standards for Dental Care and Treatment (2011)		Validation of compliance
Recommendation 1 **Ref**: Standard 9 **Stated:** First time	The complaints procedure should be further developed to; • outline the recording process for complaints management • state that complaints would be investigated and a written response issued within the recommended 28 day timeframe • direct complainants to the General Dental Council (GDC), Complaints Service, if they were dissatisfied with local resolution to their complaint	**Met**
	Action taken as confirmed during the inspection: Review of documentation confirmed that the complaints procedure had been further developed to include: • the recording process for complaints management • The timescale that complaints would be investigated and a written response issued within the recommended 28 day timeframe • Complainants were directed to the General Dental Council (GDC), Complaints Service, if they were dissatisfied with local resolution to their complaint	
Recommendation 2 **Ref**: Standard 15 **Stated:** First time	The Safeguarding Adults at Risk of Harm policy should be further developed to fully reflect the new regional guidance issued in July 2015 entitled 'Adult Safeguarding Prevention and Protection in Partnership'.	**Not met**
	Action taken as confirmed during the inspection: Review of documentation confirmed that the Safeguarding Adults at Risk of Harm policy had not been further developed to fully reflect the new regional guidance issued in July 2015 entitled 'Adult Safeguarding Prevention and Protection in Partnership'. This area for improvement has been stated for the second time.	

Recommendation 3 **Ref**: Standard 14 **Stated:** First time	Health and safety policies and procedures relevant to the establishment should be developed for example; Control of Substances Hazardous to Health (COSHH).	**Not met**
	Action taken as confirmed during the inspection: Review of documentation confirmed that Health and safety policies and procedures relevant to the establishment had not been developed for example; Control of Substances Hazardous to Health (COSHH). This area for improvement has been stated for the second time.	
Recommendation 4 **Ref**: Standard 13 **Stated:** First time	The Policy on Infection Prevention and Control should be further developed to include the following; • eye protection- the procedure should state the actual disinfectant product to be used between use • decontamination procedure of the light-emitting diode (LED) lamp between use • environmental cleaning and cleaning schedules	**Partially met**
	Action taken as confirmed during the inspection: Review of documentation confirmed that the Policy on Infection Prevention and Control had been further developed to include the following; • eye protection- the procedure should state the actual disinfectant product to be used between use • decontamination procedure of the light-emitting diode (LED) lamp between use Environmental cleaning and cleaning schedules had not been included. This part of this area for improvement has been stated for the second time	

Recommendation 5 **Ref**: Standard 12 **Stated:** First time	A medical emergency policy should be provided and include the following information: • arrangements for staff training • list of emergency medicines and equipment available • the checking procedures for emergency medicines and equipment • how to summons help in an emergency • the procedure for documenting medical emergencies • and the procedure to be followed in regards to staff debriefing following a medical emergency	**Met**
	Action taken as confirmed during the inspection: Review of documentation confirmed that a medical emergency policy had been provided and included the following information: • arrangements for staff training • list of emergency medicines and equipment available • the checking procedures for emergency medicines and equipment • how to summons help in an emergency • the procedure for documenting medical emergencies • and the procedure to be followed in regards to staff debriefing following a medical emergency	
Recommendation 6 **Ref**: Standard 11.4 **Stated:** First time	Staff training records should be retained in the practice and available for inspection.	**Partially met**
	Action taken as confirmed during the inspection: Review of documentation and discussion confirmed that not all training records were available for inspection. This area for improvement has been stated for the second time.	

6.3 Inspection findings

6.4 Is care safe?

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

Staffing

One dental surgery is 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 programme templates were in place relevant to specific roles and responsibilities. A sample of two staff files evidenced that induction programmes had been completed when new staff joined the practice.

Mr Desmond confirmed that there are procedures 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. The system in place to ensure that all staff receive appropriate training to fulfil the duties of their role needs further development. The area for improvement made at the previous pre-registration inspection has been stated for a second time to ensure that all records of staff training are retained in the practice and available for inspection.

A review of records confirmed that a robust system was in place to review the General Dental Council (GDC) registration status and professional indemnity of all clinical staff.

Recruitment and selection

A review of the submitted staffing information and discussion with Mr Desmond confirmed that two staff have been recruited since the previous inspection. A review of the personnel files for these staff 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 files reviewed did not include a criminal conviction declaration, or a physical and mental health assessment. In one of the files reviewed the AccessNI enhanced disclosure check had been received after the date employment had commenced. Mr Desmond stated that he had already discussed this issue with RQIA. In the second file reviewed the AccessNI enhanced disclosure check had not been requested. Mr Desmond stated he was unaware that this check was needed for reception staff. An area for improvement has been made against the regulations to ensure that staff are recruited in accordance with legislative requirements.

There was a recruitment policy and procedure available. The policy was comprehensive and reflected best practice guidance.

Safeguarding

Staff 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. It was confirmed by electronic mail to RQIA on 21 February 2018 that the safeguarding lead has arranged formal training in March 2018 in safeguarding adults in keeping with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016). It was also confirmed by electronic mail to RQIA on 21 February 2018 that the safeguarding training has been organised for all other staff members.

Mr Desmond confirmed that persons under the age of 18years are not provided teeth whitening treatment in the establishment. One overarching policy was in place for the safeguarding and protection of adults and children at risk of harm. The policy did not fully include the types and indicators of abuse and distinct referral pathways in the event of a safeguarding issue arising with an adult or child. The area for improvement made at the pre-registration inspection has been stated for a second time. The relevant contact details for onward referral to the local Health and Social Care Trust should a safeguarding issue arise were included.

Mr Desmond confirmed that copies of the regional policy entitled 'Co-operating to Safeguard Children and Young People in Northern Ireland' (March 2016) and the regional guidance document entitled 'Adult Safeguarding Prevention and Protection in Partnership' (July 2015) were both available on computer for staff reference.

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. It was confirmed by electronic mail to RQIA on 21 February 2018 that a robust system was now 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.

Mr Desmond also confirmed that an AED was available in a supermarket within close proximity to the establishment. Formal arrangement for timely accessibility to the AED has not been documented within the management of medical emergency protocols. This section of an area for improvement identified at the pre-registration inspection has been stated for the second time.

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

The clinical area was tidy and uncluttered and work surfaces were intact and easy to clean. Fixtures, fittings, treatment chair and equipment were free from damage, dust and visible dirt. Staff were observed to be adhering to best practice in terms of the uniform policies.

Staff confirmed that only single use instruments and mouth guards are used during the teeth whitening procedure. As no reusable dental instruments are used in the practice therefore a separate decontamination room is not required. It was confirmed that the single use mouth guards and tissues are disposed in in keeping with best practice guidance as outlined in HTM 07-01, Safe management of healthcare waste.

Policies and procedures in regards to infection prevention and control had been further developed and now included relevant details on eye protection, and the disinfectant product to be used for decontamination between use. The policy also included the decontamination procedure of the light-emitting diode (LED) lamp between use. However the policy did not include environmental cleaning and cleaning schedules. This section of an area for improvement identified at the pre-registration inspection has been stated for the second time.

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 in keeping with best practice. There was a nominated lead with responsibility for infection control and decontamination.

Radiography

Mr Desmond confirmed that The White House does not have any x-ray equipment in the premises.

Environment

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

As previously stated in the report detailed cleaning schedules were not in place. A colour coded cleaning system was in place.

Mr Desmond confirmed that arrangements are in place for maintaining the environment.

A fire risk assessment had been undertaken and Mr Desmond confirmed that staff fire training and fire drills have been arranged. Staff demonstrated that they were aware of the action to take in the event of a fire.

Health and safety policies and procedures relevant to the establishment have not been developed for example; Control of Substances Hazardous to Health (COSHH). This area for improvement identified at the pre-registration inspection has been stated for the second time.

It was confirmed that prescription pads/forms are not used in the establishment.

Patient and staff views

Fourteen patients submitted questionnaire responses to RQIA, two of these questionnaires had not been completed . All completed questionnaires indicated that they felt safe and protected from harm. Eleven patients indicated that they were very satisfied with this aspect of care and one indicated that they were satisfied.

No staff submitted questionnaire responses.

Areas of good practice

There were examples of good practice found in relation to, induction, appraisal and the environment.

Areas for improvement

Records of all staff training should be retained in the practice and available for inspection.

Staff should be recruited in as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 ensuring that AccessNI enhanced disclosure checks are received before staff employment has commenced.

The safeguarding adults at risk of harm policy should be further developed to fully reflect the new regional guidance issued in July 2015 entitled 'Adult Safeguarding Prevention and Protection in Partnership'.

Formal arrangement for timely accessibility to the AED should be documented within the management of medical emergency protocols.

Infection prevention and control policies should include environmental cleaning and cleaning schedules.

Health and safety policies and procedures relevant to the establishment should be developed

	Regulations	Standards
Total number of areas for improvement	2	4

6.5 Is care effective?

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

Clinical records

Staff confirmed that clinical records are updated contemporaneously during each patient's treatment session in accordance with best practice. It was confirmed that patients are informed about the cost of treatments, choices and options.

A computer system was in place for record management and some other relevant documents were held in hard copy. Electronic records have different levels of access afforded to staff dependent on their role and responsibilities. Discussion with staff and observations made during the inspection demonstrated that appropriate systems and processes were in place for the management of electronic and manual records and maintaining patient confidentiality.

Policies were available in relation to records management, data protection and confidentiality and consent. The records management policy includes the arrangements in regards to the creation, storage, recording, retention and disposal of records and data protection. The policy is in keeping with legislation and best practice guidance.

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

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:

- patient satisfaction

Communication

Staff meetings are held on a regular basis to discuss clinical and practice issues. 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

Fourteen patients submitted questionnaire responses to RQIA, two of these questionnaires had not been completed. All completed questionnaires indicated that they get the right care, at the right time and with the best outcome for them. Eleven patients indicated that they were very satisfied with this aspect of care and one indicated that they were satisfied.

No staff submitted questionnaire responses.

Areas of good practice

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

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

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

Dignity, respect and involvement in decision making

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

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

It was confirmed that treatment options, including the risks and benefits, were discussed with each patient. This ensured patients understood what treatment is available to them and can make an informed choice. Staff demonstrated how consent would be obtained.

The practice undertakes patient satisfaction surveys on an annual basis. Review of the most recent patient satisfaction report demonstrated that the practice pro-actively seeks the views of patients about the quality of treatment and other services provided. Patient feedback whether constructive or critical, is used by the practice to improve, as appropriate.

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

Patient and staff views

Fourteen patients submitted questionnaire responses; two of these questionnaires had not been completed. All completed questionnaires indicated that they are treated with dignity and respect and are involved in decision making affecting their care. Eleven patients indicated that they were very satisfied with this aspect of care and one indicated that they were satisfied.

No submitted staff questionnaire responses were received.

Areas of good practice

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

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

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

Management and governance arrangements

There was a clear organisational structure within the practice and staff were able to describe their roles and responsibilities and were aware of 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 Hayley Purse, register manager, is the nominated individual with overall responsibility for the day to day management of the practice. Mr Desmond, registered person, does not monitor the quality of services in accordance with legislation. He undertakes visits to the premises every two weeks. Reports of six monthly unannounced monitoring visits were not available for inspection. An area for improvement has been made against the regulations.

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.

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 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.

Mr Desmond 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.

Mr Desmond demonstrated a clear understanding of his role and responsibility in accordance with legislation. Information requested by RQIA has been submitted within specified timeframes. 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 up to date and displayed appropriately.

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

Patient and staff views

Fourteen patients submitted questionnaire responses; two of these questionnaires had not been completed. Eleven patients who submitted questionnaire responses indicated that they felt that the service is well led; one patient was undecided. Ten patients indicated that they were very satisfied with this aspect of the service and two indicated that they were satisfied.

No submitted staff questionnaire responses were received.

Areas of good practice

There were examples of good practice found in relation, management of complaints and incidents, quality improvement and maintaining good working relationships.

Areas for improvement

Six monthly unannounced monitoring visits should be undertaken and reports available for inspection.

	Regulations	Standards
Total number of areas for improvement	1	0

7.0 Quality improvement plan

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

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

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

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and The Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011 and the Department of Health, Social Services and Public Safety (DHSSPS) Minimum Standards for Dental Care and Treatment (2011).

7.2 Actions to be taken by the service

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

Quality Improvement Plan	
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 19 Schedule (2) as amended **Stated:** First time **To be completed by:** 14 March 2018	The registered person shall ensure that staff personnel files for newly recruited staff includes all relevant documentation as specified in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005. As specified the AccessNI enhanced disclosure check must be received prior to commencement of employment. Ref: 6.4
	Response by registered person detailing the actions taken: This is completed for all staff. AccessNI enhanced disclosure check will be received prior to the commencement of employment for any new staff.
Area for improvement 2 **Ref:** Regulation 15 (1) (b) and (c) **Stated:** Second time **To be completed by:** 14 March 2018	The registered person must ensure that the arrangement for timely accessibility to an AED is documented within the management of medical emergency protocols, Ref: 6.4
	Response by registered person detailing the actions taken: This is completed and now included in our Policies and Procedures document.

Area for improvement 3 **Ref:** Regulation 26 **Stated:** First time **To be completed by** 14 March 2018	The registered person or a person nominated by them should undertake unannounced visits to the practice at least on a six monthly basis and generate a report detailing the main findings of their quality monitoring visit. The report should include the matters identified in Regulation 26 (4) of The Independent Health Care Regulations (Northern Ireland) 2005. An action plan to address any issues identified should be generated. The report should be shared with the registered manager and be available for inspection. Ref: 6.7
	Response by registered person detailing the actions taken: New report form created in accordance with regulation 26 (4) as per guidance of the Independent Health Care Regulations. First unannounced clinic inspection has been completed and action plan included in the report which is available for inspection
Action required to ensure compliance with The Minimum Standards for Dental Care and Treatment (2011)	
Area for improvement 1 **Ref**: Standard 11.4 **Stated:** First time **To be completed by:** 14 March 2018	The registered person shall ensure that staff training records are retained in the practice and available for inspection. Ref: 6.4
	Response by registered person detailing the actions taken: All training records are retained in the practice and available for inspection. These are kept digitally timespamped on our servers and available printed on request.
Area for improvement 2 **Ref**: Standard 15 **Stated:** Second time **To be completed by:** 14 March 2018	The registered person shall ensure that the Safeguarding Adults at Risk of Harm policy is further developed to fully reflect the new regional guidance issued in July 2015 entitled 'Adult Safeguarding Prevention and Protection in Partnership'. Ref: 6.4
	Response by registered person detailing the actions taken: This is completed and included in our policies and procedures documentation and available for inspection.
Area for improvement 3 **Ref**: Standard 14 **Stated:** Second time **To be completed by:** 14 March 2018	The registered person shall ensure that health and safety policies and procedures relevant to the establishment are developed for example; Control of Substances Hazardous to Health (COSHH). Ref: 6.4

	Response by registered person detailing the actions taken: A Health and safety risk assessment has been completed to identify any risks, a new section has been added to the policies and procedures documentation for health and safety and includes control of hazardous substance and will be developed to encompass any other health hazards identified in order to minimise risk and will be inspected and updated regularly.
Area for improvement 4 **Ref**: Standard 13 **Stated:** Second time **To be completed by:** 14 March 2018	The registered person shall ensure that the Policy on Infection Prevention and Control includes the following; • environmental cleaning and cleaning schedules Ref: 6.4
	Response by registered person detailing the actions taken: Envorinmental cleaning and cleaning schedules have been completed and included in our internal documentation and will be followed.

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

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