Announced Care Inspection Report
21 February 2017

Ardent Dental Care

Type of service: Independent Hospital (IH) – Dental Treatment
Address: 14 Portaferry Road, Newtownards, BT23 8NN
Tel no: 028 9182 1348
Inspector: Norma Munn

1.0 Summary

An announced inspection of Ardent Dental Care took place on 21 February 2017 from 09:55 to 13:25.

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

Is care safe?

Observations made, review of documentation and discussion with Mr Simon Gay, registered person, and staff demonstrated that further development is needed to ensure that care provided to patients is safe and avoids and prevents harm. Areas reviewed included staffing, recruitment and selection, safeguarding, management of medical emergencies, infection prevention control and decontamination, radiology and the general environment. One requirement in relation to recruitment and selection of staff stated during the previous inspection has been stated for the second time. Four recommendations have been made in relation to implementing a formal annual appraisal process for staff, providing safeguarding training for staff, recording periodic tests accurately in keeping with Health Technical Memorandum (HTM) 01-05 Decontamination in primary care dental practices and recording water temperatures as recommended in the legionella risk assessment.

Is care effective?

Observations made, review of documentation and discussion with Mr Gay 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. No requirements or recommendations have been made.

Is care compassionate?

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

Is the service well led?

Information gathered during the inspection evidenced that there was effective leadership and governance arrangements in place which creates a culture focused on the needs of patients in order to deliver safe, effective and compassionate care. Areas reviewed included organisational and staff working arrangements, the arrangements for policy and risk assessment reviews, the arrangements for dealing with complaints, incidents and alerts, insurance arrangements and the registered provider's understanding of their role and responsibility in accordance with legislation. No requirements or recommendations have been made.

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	4

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mr Gay, registered person, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 02 November 2015.

2.0 Service details

Registered organisation/registered person: Mr Simon Gay	**Registered manager:** Mr Simon Gay
Person in charge of the practice at the time of inspection: Mr Simon Gay	**Date manager registered:** 6 March 2012
Categories of care: Independent Hospital (IH) – Dental Treatment	**Number of registered places:** 3

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 Mr Gay, registered person, a dental nurse and a receptionist. A tour of some of the premises was also undertaken.

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

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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 02 November 2015

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

4.2 Review of requirements and recommendations from the last care inspection dated 02 November 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 19 (2) Schedule 2 **Stated:** First time	The registered person must ensure that an enhanced AccessNI disclosure check is undertaken and received for any new staff including self-employed staff prior to them commencing work in the practice. An enhanced AccessNI check must be undertaken for the identified staff member. A record must be retained of the date the enhanced AccessNI checks are applied for and received, the unique identification number and the outcome of the check.	**Met**
	Action taken as confirmed during the inspection: A review of records evidenced that the enhanced AccessNI check had been undertaken for the identified staff member. A review of the personnel files for two of the most recently recruited staff members demonstrated that enhanced AccessNI checks had been undertaken and received prior to them commencing work. The AccessNI checks had been handled in keeping with the AccessNI code of practice and a log had been developed.	

Requirement 2 **Ref:** Regulation 19 (2) Schedule 2 **Stated:** First time	The registered person must ensure that staff personnel files for newly recruited staff, including self-employed staff contain all information as specified in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005.	
	Action taken as confirmed during the inspection: A review of the personnel files for two of the most recently recruited staff members demonstrated that not all the relevant information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 has been sought and retained. This is discussed further in section 4.3 of this report. This requirement has not been fully addressed and has been stated for a second time.	**Not Met**
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 13 **Stated:** Second time	The policy and procedure in place for the management and disposal of waste should be further developed to reflect the specific arrangements in the practice.	
	Action taken as confirmed during the inspection: The revised policy and procedure for the management and disposal of waste reflected the specific arrangements within the practice.	**Met**
Recommendation 2 **Ref:** Standard 13 **Stated:** Second time	Cabinetry should be sealed where it meets the flooring in the decontamination room	
	Action taken as confirmed during the inspection: Observation of the decontamination room confirmed that the cabinetry had been sealed where it meets the flooring.	**Met**

Recommendation 3 **Ref:** Standard 12.1 **Stated:** First time	It is recommended that a policy for the management of medical emergencies is developed in line with legislative and best practice.	**Met**
	Action taken as confirmed during the inspection: Discussion with Mr Gay confirmed that information had been made available for staff of the action to take in the event of a medical emergency. However, an overarching policy for the management of medical emergencies had not been developed. Mr Gay agreed to action this following the inspection. RQIA received a copy of the medical emergency policy by email on 24 February 2017. The policy had been developed in line with legislative and best practice.	
Recommendation 4 **Ref:** Standard 11.1 **Stated:** First time	It is recommended that a recruitment policy is developed in line with legislative and best practice guidance.	**Met**
	Action taken as confirmed during the inspection: Mr Gay confirmed that the recruitment policy had been developed since the previous inspection. However, the policy reviewed needed further development in line with legislative and best practice guidance. Mr Gay agreed to action this following the inspection. RQIA received a copy of the amended recruitment policy by email on 24 February 2017. The policy had been developed in line with legislative and best practice.	
Recommendation 5 **Ref:** Standard 11.3 **Stated:** First time	It is recommended that a record of induction is retained in staff personnel files.	**Met**
	Action taken as confirmed during the inspection: Discussion with Mr Gay and a review of the personnel files for two of the most recently recruited staff members confirmed that inductions had been completed and records retained.	

Recommendation 6 **Ref:** Standard 11.1 **Stated:** First time	It is recommended that all staff who work in the practice, including self-employed staff should be provided with a contract/agreement. Records of contracts/agreements should be retained in the personnel files of any new staff recruited.	**Met**
	Action taken as confirmed during the inspection: Discussion with Mr Gay and a review of two personnel files confirmed that all staff have a contract of employment/agreement in place.	

4.3 Is care safe?

Staffing

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

Induction programme templates were in place relevant to specific roles and responsibilities. A review of the personnel files of two recently recruited staff evidenced that induction programmes had been completed when new staff joined the practice.

Mr Gay and staff confirmed that no formal arrangements are in place for appraising staff performance. A recommendation has been made that a system should be implemented for appraising staff performance at least on an annual basis.

Staff confirmed that there was a system in place to ensure that all staff receive appropriate training to fulfil the duties of their role.

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 Gay confirmed that two staff have been recruited since the previous inspection. As previously discussed 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 following was noted in the personnel files reviewed:

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

One file did not contain a full employment history, including an explanation of any gaps in employment. None of the files contained a criminal conviction declaration or confirmation that the person was physically and mentally fit to fulfil their duties. Mr Gay was advised that staff personnel files must contain all information as specified in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005. The requirement in relation to recruitment and selection of staff stated following the previous inspection has not been addressed and has been stated for the second time.

There was a recruitment policy and procedure available. As previously discussed, an amendment was made to the policy following the inspection. The revised policy was comprehensive and reflected best practice guidance.

Safeguarding

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

Review of records demonstrated that not all staff had received training in safeguarding children and adults as outlined in the Minimum Standards for Dental Care and Treatment 2011. This was discussed with Mr Gay and a recommendation has been made.

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

Mr Gay has agreed to make available the new regional guidance ‘Adult Safeguarding Prevention and Protection in Partnership’ (July 2015) and ‘Co-operating to safeguard children and young people in Northern Ireland’ (March 2016) for staff reference. Mr Gay has also agreed to review the safeguarding children and adults policies to reflect the new regional guidance.

Management of medical emergencies

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

Review of training records and discussion with staff confirmed that the management of medical emergencies is included in the induction programme and training is updated on an annual basis in keeping with best practice guidance.

Discussion with staff demonstrated that they have a good understanding of the actions to be taken in the event of a medical emergency and the location of medical emergency medicines and equipment.

As previously discussed, a policy for the management of medical emergencies had not been developed. Mr Gay agreed to action this immediately following the inspection. RQIA received a copy of the policy by electronic mail on 24 February 2017. The policy had been developed in line with legislative and best practice.

Protocols were available for staff reference outlining the local procedure for dealing with the various medical emergencies.

Infection prevention control and decontamination procedures

Clinical and decontamination areas were tidy and uncluttered and work surfaces were intact and easy to clean. Fixtures, fittings, dental chairs and equipment were free from damage, dust and visible dirt. Staff were aware of best practice in terms of the uniform and hand hygiene policies.

Discussion with staff demonstrated that they had an understanding of infection prevention and control policies and procedures and were aware of their roles and responsibilities. Staff confirmed that they have received training in infection prevention and control and decontamination in keeping with best practice.

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

A decontamination room, separate from patient treatment areas and dedicated to the decontamination process, was available. Appropriate equipment, including a washer disinfector**,** a DAC Universal and a steam steriliser 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. However, the results of the automated control tests (ACT) had been recorded prior to the tests actually being carried out for the three days following the inspection. The practice of recording periodic tests results before the tests have actually been carried out was discussed with the dental nurse and Mr Gay. This is not in keeping with Health Technical Memorandum (HTM) 01-05 Decontamination in primary care dental practices and a recommendation has been made.

It was confirmed that the practice continues to audit compliance with HTM 01-05 using the Infection Prevention Society (IPS) audit tool. The most recent IPS audit was completed during February 2017.

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

Radiography

The practice has three surgeries, each of which has an intra-oral x-ray machine.

A dedicated radiation protection file containing the relevant local rules, employer's procedures and other additional information was retained. A review of the file confirmed that staff have been authorised by the radiation protection supervisor (RPS) for their relevant duties and have received local training in relation to these duties. It was evidenced that all measures are taken to optimise dose exposure. This included the use of rectangular collimation and x-ray audits.

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.

The radiation protection advisor (RPA) completes a quality assurance check every three years. Review of the report of the most recent visit by the RPA demonstrated that the recommendations made have been addressed.

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. However, an area of the carpet at the entrance to the practice was extensively damaged. Mr Gay confirmed that this was as a result of a recent flood and he has arranged for the carpet to be replaced.

Detailed cleaning schedules and a colour coded cleaning system was in place.

Arrangements are in place for maintaining the environment. This included servicing of the fire detection system and firefighting equipment.

A legionella risk assessment has been undertaken. Records evidenced that hot and cold sentinel water temperatures had not been recorded since September 2015. This was discussed with Mr Gay and a recommendation has been made.

A fire risk assessment had been undertaken and staff demonstrated that they were aware of the action to take in the event of a fire.

Review of records confirmed the pressure vessels in the practice had been inspected in keeping with the written scheme of examination.

Patient and staff views

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

One comment provided included the following:

- "100%."

Five 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.

One comment provided included the following:

- "We are experienced staff for our patients."

Areas for improvement

A system should be implemented for appraising staff performance at least on an annual basis.

All staff personnel files for newly recruited staff, including self-employed staff must contain all information as specified in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005.

Staff training should be provided in safeguarding children and adults as outlined in the Minimum Standards for Dental Care and Treatment 2011.

All records in relation to decontamination should be recorded accurately in keeping with HTM 01-05 Decontamination in primary care dental practices.

Implement monthly monitoring of the sentinel water temperatures, and retain records for inspection.

Number of requirements	1	Number of recommendations	4

4.4 Is care effective?

Clinical records

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

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

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

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

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

Health promotion

The practice has a strategy for the promotion of oral health and hygiene. Oral health is actively promoted on an individual level with patients during their consultations. A dental hygienist service is available within the practice for patients to attend if required. A range of health promotion information leaflets are displayed throughout the practice.

Audits

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

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

Communication

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

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

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

A breaking bad news policy in respect of dentistry was in place.

Patient and staff views

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

One comment provided included the following:

- "xxx is always sure to talk through the treatment procedure. You are aware of any possible alternatives etc. Advised not to hesitate to contact the practice if any concerns/ questions after treatment, for example."

All of the 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. No comments were included in submitted questionnaire responses.

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 discussed how they 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 ensures that patients understand what treatment is available to them and can make an informed choice. Staff demonstrated how consent would be obtained.

The practice undertakes patient satisfaction surveys on a six monthly 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

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

One comment provided included the following:

- "All staff are extremely supportive and caring."

All of the 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. No comments were included in submitted questionnaire responses.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.6 Is the service well led?

Management and governance arrangements

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

Mr Gay has overall responsibility for the day to day management of the practice.

Policies and procedures were available for staff reference. Observations made confirmed that policies and procedures were indexed, dated and systematically reviewed on a 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 Gay 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 Gay 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

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

Comments provided included the following:

- "Always very helpful."
- "The service in my opinion is run very efficiently."

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

Areas for improvement

No areas for improvement were identified during the inspection.

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

5.0 Quality improvement plan

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

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

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

5.1 Statutory requirements

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

5.2 Recommendations

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

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP via web portal for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref:** Regulation 19 (2) Schedule 2 **Stated:** Second time **To be completed by:** 21 February 2017	The registered person must ensure that staff personnel files for newly recruited staff, including self-employed staff contain all information as specified in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005.
	Response by registered provider detailing the actions taken: Personnel Files now contain all information as specified in Schedule 2
Recommendations	
Recommendation 1 **Ref:** Standard 11 **Stated:** First time **To be completed by:** 21 April 2017	A system should be implemented for appraising staff performance at least on an annual basis.
	Response by registered provider detailing the actions taken: A system has been set in place to provide staff appraisals on an annual basis.
Recommendation 2 **Ref:** Standard 15.3 **Stated:** First time **To be completed by:** 21 April 2017	All staff should complete refresher training in safeguarding children and adults, every two years, as outlined in the Minimum Standards for Dental Care and Treatment 2011.
	Response by registered provider detailing the actions taken: Enquiries have been made and are ongoing about sourcing outside providers of training in safeguarding.
Recommendation 3 **Ref:** Standard 13.4 **Stated:** First time **To be completed by:** 21 February 2017	All records in relation to decontamination should be recorded accurately in keeping with HTM 01-05 Decontamination in primary care dental practices.
	Response by registered provider detailing the actions taken: Decontamination record-keeping has been modified to comply with HTM 01-05
Recommendation 4 **Ref:** Standard 13 **Stated:** First time **To be completed by:** 21 March 2017	Implement monthly monitoring of the sentinel water temperatures, and retain records for inspection.
	Response by registered provider detailing the actions taken: A monthly record is now kept of water temperatures.

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

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