Announced Care Inspection Report
8 August 2016

Cassidy & McCreesh Orthodontic Practice

Type of Service: Independent Hospital (IH) – Dental Treatment
Address: 45a Irvinestown Road, Enniskillen, BT74 6GU
Tel No: 028 6632 5545
Inspector: Stephen O'Connor & Loretto Fegan

1.0 Summary

An announced inspection of Cassidy & McCreesh Orthodontic Practice took place on 08 August 2016 from 09:55 to 13:00.

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

Is care safe?

Observations made, review of documentation and discussion with Mr McCreesh, registered person and staff demonstrated that in the main, systems and processes were in place to ensure that care to patients was 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. A recommendation has been made in regards to consistently recording periodic tests in respect of decontamination equipment.

Is care effective?

Observations made, review of documentation and discussion with Mr McCreesh 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 McCreesh 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	0	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mr McCreesh, 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 previous QIP there were no further actions required to be taken following the last inspection.

2.0 Service details

Registered organisation/ registered provider: Mr Mark McCreesh	**Registered manager:** Mr Mark McCreesh
Person in charge of the service at the time of inspection: Mr Mark McCreesh	**Date manager registered:** 25 January 2012
Categories of care: Independent Hospital (IH) – Dental Treatment	**Number of registered places:** 4

3.0 Methods/processes

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

During the inspection the inspectors met with Mr McCreesh, registered person, the practice manager, and two dental nurses. A tour of the premises was also undertaken.

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

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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 20 August 2015

The most recent inspection of the Cassidy & McCreesh Orthodontic Practice 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 20 August 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 19 (2) Schedule 2 **Stated: First time**	The registered person must address the following issues in relation to AccessNI checks: • an enhanced AccessNI check must be undertaken and received in respect of the identified staff members; • enhanced AccessNI checks must be undertaken and received prior to any new staff, including self-employed staff commencing work in the practice; and • AccessNI disclosure certificates must be handled in keeping with the AccessNI code of practice, a record must be retained of the date the check was applied for and received, the unique identification number and the outcome	**Met**
	Action taken as confirmed during the inspection: Review of records demonstrated that AccessNI enhanced disclosure checks had been undertaken and received in respect of the staff members identified during the previous inspection. Review of submitted staffing information demonstrated that one new member of staff has commenced work in the practice since the previous inspection. Review of the staff personnel file for this staff member demonstrated that an AccessNI enhanced disclosure check had been untaken and received prior to commencing work. Templates have been developed to record information in regards to AccessNI enhanced disclosure checks. It was suggested that this template is further developed to include the signature of the person reviewing the check.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 12.1 **Stated: First time**	It is recommended that the medical emergency policy is further developed to include: • the arrangements for providing medical emergency refresher training; • a list of the medical emergency equipment retained in the practice; • the procedures for checking emergency medicines and equipment; • the arrangements for staff debriefing following a medical emergency; and • the policy should be signed and date of implementation and planned review should be recorded	**Met**
	Action taken as confirmed during the inspection: Review of the medical emergency policy demonstrated that it had been further developed following the previous inspection to include the information contained within this recommendation.	
Recommendation 2 **Ref**: Standard 12.4 **Stated: First time**	It is recommended that the following issues in regards to medical emergency equipment are addressed: • portable suction should be provided in keeping with the Resuscitation Council (UK) guidelines; • oropharyngeal airways that have exceeded their expiry dates should be replaced; and • a system to check the expiry dates of all emergency equipment should be established	**Met**
	Action taken as confirmed during the inspection: Review of medical emergency equipment demonstrated that portable suction and oropharyngeal airways are available in the practice. It was confirmed that the practice manager is responsible for checking the emergency medicines and equipment monthly and records are retained.	

Recommendation 3 **Ref**: Standard 11.1 **Stated: First time**	It is recommended that the recruitment policy is further developed to include the procedure for undertaking enhanced AccessNI checks.	**Met**
	Action taken as confirmed during the inspection: Review of the recruitment policy demonstrated that it has been further developed to include the information in regards to the procedure for undertaking AccessNI enhanced disclosure checks.	
Recommendation 4 **Ref**: Standard **Stated: First time**	Information as outlined in Regulation 19 (2), Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 should be retained in the personnel files of any new staff recruited. In addition to the information currently retained this should include: • evidence of a criminal conviction declaration by the applicant; • confirmation of their physical and mental fitness to fulfil their duties; • two written references; and • a record detailing the topics discussed during induction	**Met**
	Action taken as confirmed during the inspection: As discussed the personnel file for the staff member who commenced employment following the previous inspection was reviewed. It was confirmed that the staff personnel file included all documents as specified in Regulation 19 (2), Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005.	
Recommendation 5 **Ref**: Standard 11.3 **Stated: First time**	It is recommended that a record of staff induction is retained in the personnel files of newly recruited staff.	**Met**
	Action taken as confirmed during the inspection: A formal induction programme has been developed. Review of the personnel file for the staff member recruited following the previous inspection demonstrated that the induction template had been completed.	

4.3 Is care safe?

Staffing

Four dental chairs are available in this practice; three of which are accommodated within a polyclinic. Discussion with Mr McCreesh and 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.

As discussed, induction programme templates were in place relevant to specific roles and responsibilities. A sample of one evidenced that an induction programme had been completed when the staff member joined the practice.

Procedures have recently been implemented 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. A review of a sample of one evidenced that the appraisal had been completed during July 2016. Mr McCreesh confirmed that appraisals will be undertaken annually.

There was a system in place to ensure that all staff receive appropriate training to fulfil the duties of their role. Discussion with Mr McCreesh and the practice manager evidenced that the practice had paid all fees associated with a dental nurse training to become an orthodontic therapist. This dental nurse has recently passed the course and is now registered with the General Dental Council (GDC) as an orthodontic therapist. This was a significant financial investment for the practice and evidences that the practice has a commitment to staff development. This is to be commended.

A review of records confirmed that a robust system was in place to review the GDC registration status and professional indemnity of all clinical staff. It was confirmed that the practice pays 50% of the GDC registration fee for dental nurses.

Recruitment and selection

As discussed a review of the submitted staffing information and discussion with the practice manager confirmed that one staff member has been recruited since the previous inspection. A review of the personnel file for the identified staff member demonstrated that all the relevant information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 has been sought and retained.

As discussed there was a recruitment policy and procedure available. The 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 all staff had received training in safeguarding children and adults as outlined in the Minimum Standards for Dental Care and Treatment 2011 during June and July 2016. It was confirmed that the safeguarding refresher training was scheduled as a result of the publication during March 2016, of a new regional policy entitled 'Co-operating to safeguard children and young people in Northern Ireland'. A copy of this new regional policy and the new regional guidance issued in July 2015 entitled 'Adult Safeguarding Prevention and Protection in Partnership' were available for staff reference. The scheduling of refresher training following the publication of new regional policies and guidance is to be commended.

Two separate policies were in place for the safeguarding and protection of adults and children. The policies included the types and indicators of abuse and distinct referral pathways in the event of a safeguarding issue arising with an adult or child. The relevant contact details for onward referral to the local Health and Social Care Trust should a safeguarding issue arise were included. The practice manager confirmed that the policies have been updated.

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 observed that the format of Midazolam retained was not in keeping with the format recommended by the Health and Social Care Board (HSCB). Mr McCreesh readily agreed to replace the Midazolam with Buccolam pre-filled syringes in keeping with the HSCB guidance. Glucagon was stored in the fridge, however a review of the records indicated that the daily fridge temperatures slightly exceeded the recommended range of between 2 and 8 degrees centigrade on occasions. It was agreed with Mr McCreesh that the glucagon would be stored in the emergency drug box with a revised expiry date of 18 months from the receipt of the medication. 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 discussed the policy for the management of medical emergencies reflected best practice guidance. Protocols were available for staff reference outlining the local procedure for dealing with the various medical emergencies.

Infection prevention control and decontamination procedures

Clinical and decontamination areas were 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 observed to be adhering to best practice in terms of the uniform and hand hygiene policies.

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

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

A decontamination room separate from patient treatment areas and dedicated to the decontamination process was available. It was observed that a dedicated hand washing basin was not available in the decontamination room. However, a dedicated hand washing basin is available directly outside of the decontamination room and a dental nurse confirmed this basin is used to perform hand hygiene prior to and following the decontamination of reusable dental instruments.

Appropriate equipment, including a washer disinfector 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 pre-printed equipment logbooks evidenced that periodic tests are undertaken and recorded in keeping with Health Technical Memorandum (HTM) 01-05 Decontamination in primary care dental practices in respect of the steam steriliser. However, review of the washer disinfector logbook demonstrated that the results of periodic tests are not consistently recorded. The results of the daily cleaning efficacy test had not being recorded and periodic test results had not been recorded between 7 September 2015 and 11 April 2016. This was discussed with Mr McCreesh and a recommendation has been made to address this.

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 March 2016.

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

Radiography

The practice has a separate x-ray room with a digital orthopan tomogram (OPG) and combined cephalogram 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 x-ray audits and direct digital x-ray processing.

A copy of the local rules was on display in the x-ray room 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 high standard of maintenance and décor.

Detailed cleaning schedules were in place for all areas which were signed on completion. A colour coded cleaning system was in place.

Arrangements are in place for maintaining the environment to include annual servicing of the passenger lift, oil central heating burner, fire detection and fire-fighting equipment and the air conditioning units.

A legionella risk assessment was last undertaken on 20 June 2016 and water temperature are monitored and recorded as recommended.

A fire risk assessment had been undertaken on 28 July 2016 and records indicated staff attendance at fire awareness and fire drill training within the previous 6 months. Staff confirmed fire training and fire drills had been completed and demonstrated that they were aware of the action to take in the event of a fire.

A report dated 26 July 2016 indicated that a thorough and working examination of pressure vessels and associated protective devices had been undertaken and no repairs were required.

Patient and staff views

Fourteen patients submitted questionnaire responses to RQIA. All indicated that they felt safe and protected from harm. Comments provided included the following:

- "Very safe environment and caring staff"
- "Always well maintained, clean with a very friendly approach"
- "Environment noticeable clean and tidy"

Eight staff submitted questionnaire responses. All indicated that they felt that patients are safe and protected from harm. Comments provided included the following:

- "Staff appraisal not in place"
- "No appraisals yet, but are in the process"

As discussed it was established that arrangements had been recently implemented in regards to staff appraisals and staff spoken with confirmed that appraisals had been completed.

Areas for improvement

Results of all periodic tests should be consistently recorded in keeping with HTM 01-05.

Number of requirements	0	Number of recommendations:	1

4.4 Is care effective?

Clinical records

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

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

Computerised records are maintained; should paper records be generated/received by the practice these are scanned onto the electronic records management system and then destroyed. Historic paper records are appropriately stored. 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. It was confirmed that 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.

Health promotion

The practice has a strategy for the promotion of oral health and hygiene. Mr McCreesh and staff confirmed that oral health is actively promoted on an individual level with patients during their consultations. Oral health and hygiene information leaflets are available and a range of orthodontic specific oral health products are available for purchase in the practice. The practice uses a software programme called 'patient trainer' during discussion about oral health and caring for braces. It was confirmed that the practice Facebook page includes information in regards to oral health and hygiene and that a dental nurse in the practice has an additional qualification in oral health. If required, patients are referred back to their dentist for treatment. The emphasis placed on oral health and hygiene is to be commended.

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
- bond failure and rate of buccal tubes
- peer assessment rating (PAR)
- health and safety

If required an action plan is developed and embedded into practice to address any shortfalls identified during the audit process.

The audits undertaken in the practice exceeds mandatory and legislative requirements and the PAR audit is specific to orthodontic treatment. A high emphasis is placed on audits and evidence was available to demonstrate that audits are used to improve the quality of care delivered.

Communication

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

Staff meetings are held every six to eight weeks 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.

Patient and staff views

All 14 patients who submitted questionnaire responses indicated that they get the right care, at the right time and with the best outcome for them. Comments provided included the following:

- "Always very good. Very obliging when needing an appointment for the kids"
- "Emergency appointments and advice always available during treatment"

All eight 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. 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 were observed to converse with patients and conduct telephone enquiries in a professional and confidential manner.

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

It was confirmed that treatment options, including the risks and benefits, were discussed with each patient. This ensures 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. As discussed the practice also has a Facebook page which facilitates patients to leave comments and rate the service.

It was confirmed that a policy and procedure was in place in relation to confidentiality.

Patient and staff views

All 14 patients who submitted questionnaire responses indicated that they are treated with dignity and respect and are involved in decision making affecting their care. Comments provided included the following:

- "Most definitely at all times. A very caring and experienced staff"
- "In one area where treatment is carried out there are three beds and hence treatment can be ongoing on several patients at the same time. Whilst beds are spaced well apart, there is no partition and for a patient who is maybe a little anxious when awaiting their treatment to start it could possibly alleviate their concerns if they weren't able to see/hear any of what was going on with other patients. That said the open layout gives a lovely bright feel to the practice"
- "All staff very courteous, pleasant and communicative. Appears good staff morale and respect for each other"

As discussed three dental chairs are accommodated within a polyclinic. Polyclinics are a common feature in orthodontic practices. A radio was available and used in the polyclinic to provide background noise. Mr McCreesh and staff confirmed that all confidential discussions are held in the x-ray room and where appropriate, the separate dental chair is used to treat patients who may be anxious.

All eight 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. The following comment was included in a questionnaire response.

- "…. some more explanation perhaps for some patients who are unsure of treatment plans etc more time perhaps needed"

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 McCreesh 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 an annual 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 returned questionnaire indicated that no complaints have been received for the period 1 April 2015 to 31 March 2016.

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

Mr McCreesh 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. As discussed previously the PAR audit is specific to orthodontic treatment.

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

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.

An invisalign platinum elite award was observed on the main reception desk. Mr McCreesh confirmed that he was presented with this award earlier in the year. The platinum elite award is based on the relative number of historical invisalign treatments completed.

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

Mr McCreesh demonstrated a clear understanding of his role and responsibilities in accordance with legislation.

Patient and staff views

All 14 patients who submitted questionnaire responses indicated that they felt that the service is well managed. Comments provided included the following:

- "Very professional leadership & staff"
- "Excellent service. Staff are very knowledgeable caring and kind"
- "All of my three children have had orthodontic treatment within this practice. I have always found them extremely professional and results have been good".
- "An extremely professional service provided throughout the course of treatment. Staff were approachable and friendly. On occasion when unforeseen problems arose, they were very accommodating in arranging emergency appointments"
- "Appointments always run in a timely manner with staff providing care in a professional manner".
- "All work carried out has been overseen and approved by Mr McCreesh"

All eight submitted staff questionnaire responses indicated that they felt that the service is well led. The following comment was included in a questionnaire response:

- "Staffing changes have "Blurred" communication lines – overall I think staff could do with some training on practice policies etc. – not necessarily just for their specific roles"

Areas for improvement

No areas for improvement were identified during the inspection.

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

5.0 Quality improvement plan

Any issue identified during this inspection is detailed in the QIP. Details of the QIP were discussed with Mr Mark McCreesh, 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 the 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 may enhance service, quality and delivery.

5.3 Actions taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return completed QIP to independent.healthcare@rqia.org.uk 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	
Recommendations	
Recommendation 1 **Ref**: Standard 13.4 **Stated:** First time **To be completed by:** 22 August 2016	Periodic tests results in respect of all equipment used during the decontamination process must be consistently recorded in keeping with HTM 01-05.
	Response by registered provider detailing the actions taken: These are now filled in daily and kept up to date.

The Regulation and Quality Improvement Authority

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