Announced Care Inspection Report
22 June 2016

Cliftonville Dental Practice

Type of Service: Dental Service
Address: 46 Cliftonville Road, Belfast, BT14 6JY
Tel No: 028 9035 1372
Inspector: Stephen O'Connor

1.0 Summary

An announced inspection of Cliftonville Dental Practice took place on 22 June 2016 from 09:50 to 13:05.

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 Jeremy Turk, 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 has been made in relation to AccessNI enhanced disclosure checks. One recommendation made during the previous inspection in relation to staff personnel files has not been addressed and this has been stated for the second time. An additional three recommendations have been made in relation to periodic tests in respect of decontamination equipment, the servicing of x-ray equipment and monitoring of water temperatures.

Is care effective?

Observations made, review of documentation and discussion with Mr Turk 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 Turk 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 identified that further development is needed to ensure that effective leadership and governance arrangements are in place and create a culture focused on the needs of patients in order to deliver safe, effective and compassionate care. Areas reviewed included organisational and staff working arrangements, the arrangements for policy and risk assessment reviews, the arrangements for dealing with complaints, incidents and alerts, insurance arrangements and the registered provider's understanding of their role and responsibility in accordance with legislation. No requirements or recommendations have been made within the domain.

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 were discussed with Mr Jeremy Turk, 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: Cliftonville Healthcare Limited Mr Jeremy Turk	**Registered manager:** Mr Jeremy Turk
Person in charge of the service at the time of inspection: Mr Jeremy Turk	**Date manager registered:** 7 December 2011
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 Jeremy Turk, registered person, an associate dentist, the practice manager and a dental nurse. A tour of the premises was also undertaken.

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

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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 13 April 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 13 April 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 11.1 **Stated:** First time	It is recommended that the recruitment policy and procedures should be further developed to include the procedure for obtaining enhanced AccessNI disclosures for new staff.	**Met**
	Action taken as confirmed during the inspection: Review of the recruitment policy demonstrated that it had been further developed to include arrangements in respect of AccessNI checks. However, it was noted that the policy outlined that AccessNI checks would only be undertaken in respect of clinical staff members. This is not in keeping with best practice guidance as AccessNI checks should be undertaken and received prior to staff commencing employment for all staff irrespective of whether they are a clinical staff member or not. The policy was further developed during the inspection to fully reflect best practice guidance in respect of the procedure for undertaking and receiving AccessNI enhanced disclosure checks.	
Recommendation 2 **Ref**: Standard 11.1 **Stated:** First time	It is recommended that all staff who work in the practice are provided with a contract.	**Met**
	Action taken as confirmed during the inspection: Review of staff personnel files and discussion with Mr Turk and staff demonstrated that all staff including self-employed staff have a contract/ agreement in place.	

Recommendation 3 **Ref**: Standard 11.1 **Stated:** First time	It is recommended that a review of the procedure for establishing new staff personnel files is undertaken to ensure that any new files created will include all relevant documentation as specified in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005	**Not Met**
	Action taken as confirmed during the inspection: It was confirmed that two new members of staff have commenced work in the practice since the previous inspection. Review of the identified staff members' personnel files demonstrated that not all documents as specified in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 had been retained. This is discussed further in section 4.3 of this report. This recommendation has not been addressed and has been stated for the second time.	
Recommendation 4 **Ref**: Standard 9.3 **Stated:** First time	It is recommended that a system should be developed to ensure that a written record is retained of all complaints. This record should be separate from the patient records. The complaints record should include the following: • Details of the complainant; • Issues raised; • Details of the investigation findings- including any actions taken to resolve the complaint if applicable; • Outcome of the complaint investigation; • Whether the complainant was satisfied with the outcome; and • Learning taken from the complaints investigation and actions taken to improve the service if appropriate.	**Met**
	Action taken as confirmed during the inspection: Discussion with Mr Turk and staff demonstrated that a complaints folder has been established. Review of the complaints folder demonstrated that it contained the complaints policy, guidance for staff and templates to record information in regards to complaints. The file included written records of complaints received by the practice including all information as specified within this recommendation.	

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 sample of two evidenced that induction programmes had been completed when new staff joined the practice.

Procedures were 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 practice subscribes to an online service that offers verifiable Continuing Professional Development (CPD) for clinical staff, covering core subjects such as medical emergencies, radiology and cross infection. Mr Turk has access to this online training portal and can monitor CPD courses completed.

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 Turk confirmed that two staff have been recruited since the previous inspection. A review of the personnel files for these staff demonstrated that the following information had been retained:

- positive proof of identity, including a recent photograph in one file
- evidence that an enhanced AccessNI check was received prior to commencement of employment in one file
- evidence of current GDC registration, where applicable
- evidence of professional indemnity insurance, where applicable

It was noted that neither of the files reviewed included a criminal conviction declaration, written references, documentary evidence of relevant qualifications (where applicable) or details of full employment history, including an explanation of gaps in employment. Mr Turk was advised that staff personnel files should include all information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 in respect of any new staff employed in the future. As discussed previously a recommendation stated for the second time has been made in regards to staff personnel files.

As discussed above, one personnel file included evidence that an enhanced AccessNI check has been undertaken and received prior to the identified staff member commencing work. There was no evidence that an AccessNI enhanced disclosure check had been undertaken and received in respect of the second identified staff member. This was discussed with Mr Turk who advised that an AccessNI check had not been undertaken for the identified staff member as he was of the understanding that AccessNI checks only pertained to clinical staff. Mr Turk was advised that AccessNI enhanced disclosure checks must be undertaken and received for all newly recruited staff. A requirement has been made in this regard.

Safeguarding

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

Review of records demonstrated that all staff had received training in safeguarding children and adults as outlined in the Minimum Standards for Dental Care and Treatment 2011 at a staff meeting during January 2016. In addition some staff in the practice have completed online safeguarding training.

Policies and procedures were in place for the safeguarding and protection of adults and children. The policy 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 (HSCT) should a safeguarding issue arise were included. A copy of the new regional guidance issued in July 2015 entitled 'Adult Safeguarding Prevention and Protection in Partnership' was available in the practice for staff reference.

Mr Turk confirmed that since the previous inspection one safeguarding issue with a patient had been identified in the practice. Discussion with Mr Turk and staff demonstrated that this safeguarding issue had been managed in keeping with best practice guidance including onward referral to the appropriate HSCT and documentation of the issue.

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.

It was confirmed that a policy for the management of medical emergencies and protocols outlining the local procedure for dealing with the various medical emergencies were available in the practice.

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.

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 two steam sterilisers have been provided to meet the practice requirements. A review of documentation evidenced that equipment used in the decontamination process has been appropriately validated.

A review of equipment logbooks evidenced that in the main periodic tests are undertaken and recorded in keeping with Health Technical Memorandum (HTM) 01-05 Decontamination in primary care dental practices. It was noted that a weekly protein residue test in not undertaken in respect of the DAC Universal and that a daily Time Steam Temperature (TST) test is one of the tests undertaken in respect of the vacuum steriliser. In keeping with HTM 01-05 a daily steam penetration test should be undertaken in respect of a vacuum steriliser. The TST test undertaken is not a steam penetration test. These issues were discussed with Mr Turk and staff. Mr Turk advised that the periodic testing regime was discussed with a service engineer who was facilitating training and the engineer confirmed that the tests being undertaken were sufficient and in keeping with HTM 01-05. A recommendation has been made to address the issues identified in regards to periodic tests.

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 2016 and it was established that Mr Turk had commenced a new audit.

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. In addition there is an orthopan tomogram machine (OPG), which is located in a separate room.

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, x-ray audits and digital x-ray processing.

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 reports of the most recent visits by the RPA demonstrated that the recommendations made have been addressed.

It was confirmed that the most recent occasion the x-ray equipment had been serviced was during March 2013. Mr Turk confirmed that he had not reviewed the manufacturer's instructions for the equipment to establish the frequency of servicing. A recommendation was made in this regard.

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. It was established that since the previous inspection new windows have been installed in the patient waiting area and some areas of the practice to include the halls stairs and landing have been redecorated. It was also confirmed that some structural repairs have been completed to the main roof of the practice.

Mr Turk confirmed that an external organisation has been appointed to provide advice and guidance to the practice in regards to all matters relating to health and safety to include the environment. It was also confirmed that this external organisation provided an environmental health and safety audit which is completed monthly by the practice manager.

Detailed cleaning schedules were in place for all areas. A colour coded cleaning system was in place.

Arrangements are in place for maintaining the environment to include annual servicing of the gas heating boiler, the intruder alarm and firefighting equipment. Portable appliance testing (PAT) in respect of all electrical appliances has been undertaken annually and review of documents confirmed fixed electrical installations are inspected every five years.

A legionella risk assessment has been completed by Mr Turk and this is reviewed on an annual basis. Legionella control measures are in place to include the management of Dental Unit Water Lines (DUWLs) and water sampling. Mr Turk confirmed that water temperatures are not monitored. A recommendation has been made in this regard.

A fire risk assessment had been completed by Mr Turk and this is reviewed annually. Records confirmed that routine checks are undertaken in respect of the smoke detectors and firefighting equipment. Staff demonstrated that they were aware of the action to take in the event of a fire.

Patient and staff views

Eleven patients submitted questionnaire responses to RQIA. All indicated that they felt safe and protected from harm. The following comment was included:

- "They are always very nice and willing to fit you in when you have pain"

Nine 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. No comments were included under this domain.

Areas for improvement

An AccessNI enhanced disclosure check must be undertaken for the identified staff member. AccessNI enhanced disclosure checks must be received prior to any new staff commencing work in the practice.

Staff personnel files should include all the relevant information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 in respect of any new staff employed in the future.

Ensure periodic tests are undertaken in keeping with HTM 01-05.

Review the manufacturer's instruction for the intra-oral x-ray machines and OPG to establish the servicing arrangements of the machines. Any recommendations made in the manufacturer's instructions should be actioned.

Ensure that water temperatures are monitored and recorded in keeping with best practice guidance.

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.

It was 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.

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. 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 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. It was confirmed that oral health is actively promoted on an individual basis with patients during their consultations. A range of resources are available within the practice when promoting oral health to include a pictures for patients book produced by The British Dental Foundation, models and information leaflets. A range of oral health products are available for purchase in the practice and samples of oral health products are freely distributed to patients.

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
- environmental health and safety audit

Communication

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

Staff meetings are held routinely, at least on a quarterly 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.

Patient and staff views

All 11 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:

- "I am afraid of the dentist but he is great with me"
- "Reception staff very helpful to me"

All nine 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 under this domain.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations:	0

4.5 Is care compassionate?

Dignity, respect and involvement in decision making

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

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

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

The practice undertakes patient satisfaction surveys on an annual basis. Review of the most recent patient satisfaction report dated February 2016 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.

Patient and staff views

All 11 patients who submitted questionnaire responses indicated that they are treated with dignity and respect and are involved in decision making affecting their care. The following comment was included:

- "My dentist always talks to me about treatment would like to have evening/weekend appointment"

All nine 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 under this domain.

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 Turk is the nominated individual with overall responsibility for the day to day management of the practice.

Policies and procedures were available for staff reference. Observations made confirmed that policies and procedures were indexed, dated and 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 displayed 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, review of documents and discussion with Mr Turk and staff 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 Turk 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 Turk 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.

As discussed previously issues in relation to the delivery of care were identified under the "Is care safe?" domain which have an impact on quality assurance and good governance. One requirement and three recommendations have been made in order to progress improvement in identified areas. It is important these are kept under review to ensure improvements are sustained.

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

All 11 patients who submitted questionnaire responses indicated that they felt that the service is well managed. The following comment was included:

- "I am very happy with all the care I have ever received at this practice"

All nine 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 under this domain.

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 this QIP were discussed with Mr Jeremy Turk, 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 service. 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 person 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 review by the inspector.

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

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 19 (2) (d) Schedule 2 **Stated:** First time **To be completed by:** 22 June 2016	The registered person must ensure that the following issues in relation to AccessNI enhanced disclosure checks are addressed: • an AccessNI enhanced disclosure check must be undertaken for the identified staff member • AccessNI enhanced disclosure checks must be undertaken and received prior to any new staff commencing work in the practice
	Response by registered provider detailing the actions taken: Staff member has had Access NI Enhanced Disclosure Check completed.
Recommendations	
Recommendation 1 **Ref**: Standard 11.1 **Stated:** Second time **To be completed by:** 22 August 2016	It is recommended that a review of the procedure for establishing new staff personnel files is undertaken to ensure that any new files created will include all relevant documentation as specified in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005.
	Response by registered provider detailing the actions taken: A checklist of relevant documentation has been created for refernece when establishing new personnel files.
Recommendation 2 **Ref**: Standard 13.4 **Stated:** First time **To be completed by:** 22 July 2016	Review the periodic tests undertaken in respect of the equipment used in the decontamination process to ensure that periodic test are undertaken and recorded in keeping with HTM 01-05. A weekly protein residue test should be undertaken in respect of the DAC Universal and a daily steam penetration test should be undertaken in respect of the vacuum steriliser.
	Response by registered provider detailing the actions taken: Weekly protein residue test for DAC Universal is now undertaken and recorded. Quad helix test now carried out for vacuum autoclave.
Recommendation 3 **Ref**: Standard 14.4 **Stated:** First time **To be completed by:** 22 August 2016	Review the manufacturer's instruction for the intra-oral x-ray machines and OPG and establish the servicing arrangements. Any recommendations made in the manufacturer's instructions and as a result from the servicing should be actioned.
	Response by registered provider detailing the actions taken: This has proved quite difficult as original manufacturers guidelines have not been obtainable for 2 of the intra-oral units. However discussion with HPA Endland and local service engineers has established routine function test to be carried out yearly for all equipment. Arrangements have been made.

Recommendation 4 **Ref**: Standard 13.2	Ensure that water temperatures are monitored and recorded in keeping with best practice guidance as outlined in Legionnaires' disease Part 2: The control of legionella bacteria in hot and cold water systems.
Stated: First time **To be completed by:** 22 August 2016	**Response by registered provider detailing the actions taken:** Recording proforma now used to record monitoring of hot and cold water temperatures.

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