Announced Care Inspection Report
14 June 2016

Crossgar Dental Practice

Type of Service: Dental Service
Address: 48 Killyleagh Street, Crossgar, BT30 9DQ
Tel No: 028 4483 2585
Inspector: Norma Munn

1.0 Summary

An announced inspection of Crossgar Dental Practice took place on 14 June 2016 from 10:10 to 13:10.

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 O'Hare, 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 undertaking and receiving AccessNI checks and one recommendation has been made for a second time in relation to the recording of AccessNI checks. In addition, four recommendations have been made in relation to information to be retained in staff personnel files, safeguarding training, infection prevention and control and waste management.

Is care effective?

Observations made, review of documentation and discussion with Mr O'Hare 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 O'Hare 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. One recommendation has been made in relation to the management of records within this domain.

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 five recommendations within the safe domain have been made in order to progress improvement in identified areas. It is important these are kept under review to ensure improvements are sustained.

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	6

Details of the Quality Improvement Plan (QIP) within were discussed with Mr Paul O'Hare, 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 Paul O'Hare	**Registered manager:** Mr Paul O'Hare
Person in charge of the service at the time of inspection: Mr Paul O'Hare	**Date manager registered:** 9 May 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 O'Hare and three 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 16 November 2015

The most recent inspection of the dental practice was an announced estates inspection. The completed QIP was returned and approved by the estates inspector. This QIP will be validated by the specialist inspector at their next inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 27 October 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 12.4 **Stated:** First time	It is recommended that Glucagon medication is stored in keeping with the manufacturer's guidance. If stored at room temperature a revised expiry date of 18 months from the date of receipt should be recorded on the medication packaging and the expiry date checklist to show that the cold chain has been broken. If stored in the fridge, daily fridge temperatures should be taken and recorded to evidence that the cold chain has been maintained.	**Met**
	Action taken as confirmed during the inspection: It was observed that the Glucagon medication had been stored out of the fridge and the expiry date had been revised.	

Recommendation 2 **Ref:** Standard 12.4 **Stated:** First time	It is recommended that a self-inflating bag with reservoir suitable for use with children is provided.	**Met**
	Action taken as confirmed during the inspection: It was observed that a self-inflating bag with reservoir suitable for use with children has been provided.	
Recommendation 3 **Ref:** Standard 12.4 **Stated:** First time	It is recommended that the expired oropharyngeal airways are replaced and more robust arrangements implemented to ensure emergency equipment does not exceed their expiry date.	**Met**
	Action taken as confirmed during the inspection: It was observed that the airways had been replaced and discussion with Mr O'Hare confirmed that a more robust system to check expiry dates has been implemented.	
Recommendation 4 **Ref:** Standard 11.1 **Stated:** First time	It is recommended that enhanced AccessNI disclosure certificates are handled in keeping with the AccessNI code of practice. A record must be retained of the date the application form was submitted to the umbrella organisation, the date the check was received by the practice, the unique AccessNI reference number on the check and the outcome of the review of the check.	**Partially Met**
	Action taken as confirmed during the inspection: Discussion with Mr O'Hare confirmed that AccessNI disclosure certificates have been disposed of in keeping with the AccessNI code of practice. No AccessNI certificates were observed in the practice on the day of the inspection. Mr O'Hare confirmed that one member of staff has been recruited since the previous inspection. A review of their personnel file evidenced that a record had been retained of the AccessNI unique disclosure number, however, the dates had not been recorded when the AccessNI check had been applied for or when it had been received. This is discussed further in section 4.3 of this report. This recommendation has not been fully addressed and has been stated for a second time.	

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 one 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. 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 O'Hare confirmed that one member of staff has been recruited since the previous inspection. A review of the personnel file for this staff member demonstrated that the following information had been retained:

- positive proof of identity, including a recent photograph
- evidence of the enhanced AccessNI check disclosure number
- details of full employment history, including an explanation of any gaps in employment
- evidence of qualifications obtained
- evidence of current GDC registration
- confirmation that the person is physically and mentally fit to fulfil their duties
- evidence of professional indemnity insurance, where applicable

As discussed previously a record of the date the AccessNI check had been applied for and received had not been recorded. A recommendation has been stated for a second time in regards to the recording of Access NI checks.

Discussion with Mr O'Hare and the newly recruited member of staff confirmed that the AccessNI check had been received after commencing work in the practice. A requirement has been made in this regard.

The file did not contain two written references. Mr O'Hare confirmed that references had not been sought. Mr O'Hare was informed that in relation to recruitment; staff personnel files should contain all information as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005. A recommendation has been made.

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.

Discussion with Mr O'Hare and staff confirmed that staff had not received training in safeguarding children and adults as outlined in the Minimum Standards for Dental Care and Treatment 2011. Mr O'Hare has agreed to source this training for staff to attend. A recommendation has been made.

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 should a safeguarding issue arise were included. Mr O'Hare has agreed to provide a copy of the new regional guidance issued in July 2015 entitled "Adult Safeguarding Prevention and Protection in Partnership" for staff reference and will update the practice's policy for safeguarding adults in keeping with 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 with the exception of an oropharyngeal airway size zero. Mr O'Hare agreed to purchase this item on the day of the inspection. 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.

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 uniform policy and hand hygiene. However, Chlorhexidine (Hibiscrub) was observed in the surgeries and staff confirmed that this product has been used to routinely clean hands. This is not in keeping with best practice and a recommendation has been made.

Mr O'Hare confirmed that local anaesthetic cartridges were not being disposed of in sharps containers suitable for pharmaceutical waste. Mr O'Hare agreed to provide the recommended sharps boxes and will dispose of all local anaesthetic cartridges and pharmaceutical waste in accordance with Health Technical Memorandum (HTM) 07-01 PEL (13)14. A recommendation has been made.

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 one washer disinfector 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. Discussion with Mr O'Hare and staff confirmed that periodic tests are undertaken and recorded in keeping with Health Technical Memorandum (HTM) 01-05 Decontamination in primary care dental practices.

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 May 2016.

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, 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 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.

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

Arrangements were in place for maintaining the environment. Portable appliance testing (PAT) had been undertaken in November 2015 and the servicing of the fire- fighting equipment had been undertaken during August 2015.

Discussion with Mr O'Hare confirmed that a legionella risk assessment had been undertaken and water temperature is monitored as recommended.

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

A written scheme of examination of pressure vessels had been undertaken in January 2016.

Patient and staff views

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

Comments provided included the following:

'Very helpful.'
'Very nice people.'
'Completely safe, excellent service, informed, 1st class dental care.'
'Very clean and professional, uniforms always worn.'

Eight 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;

'I believe there to be a high standard of care provided to pts with appropriate training and support to staff to ensure the high standards are maintained.'

Areas for improvement

Enhanced AccessNI checks must be undertaken and received prior to the commencement of employment of any new staff, including self-employed staff.

Access NI checks must be handled in keeping with the AccessNI Code of Practice. A record must be retained of the date the application was submitted to the umbrella organisation, the date the check was received by the practice, the unique AccessNI reference number and the outcome of the check.

Two written references, including one from the present or most recent employer should be obtained and retained in the personnel files of any newly recruited staff.

Refresher training in safeguarding of adults and children should be provided in accordance with the Minimum Standards for Dental Care and Treatment (2011).

Review the use of Chlohexidine (Hibiscrub) in relation to hand hygiene in accordance with HTM 01-05.

Review the disposal of anaesthetic cartridges and pharmaceutical waste in accordance with HTM 07-01 PEL (13) 14.

Number of requirements	**1**	**Number of recommendations**:	**5**

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 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 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. There was a range of health promotion information leaflets available in the reception area. On the day of the inspection the practice had arranged for a member of staff to attend a local school to deliver a health promotion programme that included a range of information leaflets and activities to help the children learn about oral health and hygiene and about the benefits of healthy snacks. The children receive information regarding health promotion to take home. Mr O'Hare confirmed that oral health is actively promoted on an individual level with patients during their consultations.

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
- clinical records

Communication

Mr O'Hare confirmed that arrangements are in place for onward referral in respect of specialist treatments.

Staff meetings are held frequently to discuss clinical and practice management issues. Review of documentation demonstrated that most recent staff meeting was held during May 2016 and the minutes were 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 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. No comments were provided.

All 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 provided.

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 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

All 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:

'Staff are always pleasant, very informative, knowledgeable and reassuring at all times from dentist to dental nurses.'

All 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 provided.

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 O'Hare 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 three yearly basis. Staff spoken with were aware of the policies and how to access them.

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 O'Hare 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 O'Hare 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.

Arrangements were in place to review risk assessments. However, the actual date the legionella risk assessment was undertaken had not been recorded and the dates of water temperature checks and fire drills had also not been recorded. A recommendation has been made in this regard.

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 five recommendations within the safe domain 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 of the patients who submitted questionnaire responses indicated that they felt that the service is well managed. No comments were provided.

All 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 provided.

Areas for improvement

Ensure that records are accurately dated in relation to the legionella risk assessment, water temperature checks and the frequency of fire drills.

Number of requirements	0	Number of recommendations:	1

5.0 Quality improvement plan

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

The registered provider 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 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) Schedule 2 **Stated:** First time **To be completed by:** 14 June 2016	The registered provider must ensure enhanced AccessNI checks are undertaken and received prior to the commencement of employment of any new staff, including self-employed staff.
	Response by registered person detailing the actions taken: This will be done
Recommendations	
Recommendation 1 **Ref:** Standard 11.1 **Stated:** Second time **To be completed by:** 14 June 2016	It is recommended that enhanced AccessNI disclosure certificates are handled in keeping with the AccessNI code of practice. A record must be retained of the date the application form was submitted to the umbrella organisation, the date the check was received by the practice, the unique AccessNI reference number on the check and the outcome of the review of the check.
	Response by registered provider detailing the actions taken: this will be done
Recommendation 2 **Ref:** Standard 11.1 **Stated:** First time **To be completed by:** 14 June 2016	Two written references, including one from the present or most recent employer should be obtained and retained in the personnel files of any newly recruited staff.
	Response by registered provider detailing the actions taken: this will be done
Recommendation 3 **Ref:** Standard 15.3 **Stated:** First time **To be completed by:** 14 August 2016	Refresher training in safeguarding of adults and children should be carried out for all staff in accordance with the Minimum Standards for Dental Care and Treatment (2011).
	Response by registered person detailing the actions taken: this will be done

Recommendation 4 **Ref:** Standard 13 **Stated:** First time **To be completed by:** 14 June 2016	Review the use of Chlorhexidine (Hibiscrub) for hand hygiene in keeping with HTM01-05.
	Response by registered person detailing the actions taken: this is done
Recommendation 5 **Ref:** Standard 13 **Stated:** First time **To be completed by:** 14 June 2016	Review the disposal of anaesthetic cartridges and pharmaceutical waste in accordance with HTM 07-01 PEL (13) 14.
	Response by registered provider detailing the actions taken: awaiting lids from supplier
Recommendation 6 **Ref:** Standard 14 **Stated:** First time **To be completed by:** 14 June 2016	Ensure that records are accurately dated in relation to the legionella risk assessment, water temperature checks and the frequency of fire drills.
	Response by registered provider detailing the actions taken: this is done

Please ensure this document is completed in full and returned to independent.healthcare.@rqia.org.uk from the authorised email address*

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