Announced Care Inspection Report
4 August 2016

Derrylin Dental Implant Centre

Type of Service: Independent Hospital (IH) – Dental Treatment
Address: 77 Main Street, Derrylin, BT92 9PE
Tel No: 028 6774 8069
Inspector: Emily Campbell

1.0 Summary

An announced inspection of Derrylin Dental Implant Centre took place on 4 August 2016 from 10:00 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 Ms Grainne Flynn, lead dental nurse, 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. Two requirements were made in relation to the examination of the passenger lift and the inspection of pressure vessels. Six recommendations were made in relation to x-ray audit, equipment servicing, cleaning equipment, legionella risk assessment recommendations and fire safety training and evacuation drills.

Is care effective?

Observations made, review of documentation and discussion with Ms Flynn and staff demonstrated that in general 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. Suggestions were provided on how the quality assurance programme could be further developed. No requirements or recommendations have been made.

Is care compassionate?

Observations made, review of documentation and discussion with Ms Flynn 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. A number of quality assurance processes were in place. However, a number of issues were identified within the domains of is care safe and is care effective, which relate to quality assurance and good governance.

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	2	6

Details of the Quality Improvement Plan (QIP) within were discussed with Ms Grainne Flynn, lead dental nurse, 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 Aiden Malanaphy	**Registered manager:** Mr Aiden Malanaphy
Person in charge of the service at the time of inspection: Ms Grainne Flynn	**Date manager registered:** 06 March 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 inspector met with Ms Grainne Flynn, lead dental nurse, an associate dentist, a dental nurse and a receptionist. 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 01 October 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 01 October 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 19 (1) (c) **Stated:** First time	The registered person must ensure that the registration with the GDC of the identified dental nurse is progressed as a matter of urgency. RQIA should be kept informed of progress in this matter.	**Met**
	Action taken as confirmed during the inspection: The identified nurse was registered with the GDC in May 2016. Ms Flynn and the identified nurse confirmed that no clinical care had been provided by the dental nurse until registration had been confirmed by the GDC.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 11.1 **Stated:** First time	It is recommended that the following information is obtained and retained in personnel files of any new staff recruited: • two written references, one of which should be from the current/most recent employer, • details of full employment history, including an explanation of any gaps in employment; and • a criminal conviction declaration.	**Met**
	Action taken as confirmed during the inspection: No new staff have been recruited since the previous inspection, however, Ms Flynn confirmed that the above information would be sought and retained in respect of any staff recruited in the future. A revised recruitment and selection policy was provided to RQIA following the previous inspection which evidenced that the specified information above had been included.	

Recommendation 2 **Ref:** Standard 11.3 **Stated:** First time	It is recommended that induction programmes are formalised and a copy of completed induction records retained in the personnel files of newly employed staff.	**Met**
	Action taken as confirmed during the inspection: An induction folder had been established which covers the key components to be covered at induction. A sign-off sheet is then completed by the staff member and mentor to be filed in the staff member's personnel file. As discussed no new staff have been recruited since the previous inspection, therefore no completed sign-off sheets were available for review. It was suggested that the sign-off sheet is further developed to specify each relevant topic and facilitate the recording of the dates that each topic were covered within the induction period. Ms Flynn readily agreed to action this prior to any staff being recruited.	

4.3 Is care safe?

Staffing

Four dental surgeries are in operation in this practice. Discussion with Ms Flynn 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.

No new staff have been recruited since the previous care inspection, however, as discussed previously an induction folder has been established which covers the key components to be covered at induction. Ms Flynn agreed to further develop the sign-off sheet to specify each relevant topic and facilitate the recording of the dates that each topic was covered within the induction period.

Ms Flynn confirmed that staff appraisal had been introduced in 2015, however, these had not been documented. A formal documented appraisal process had been introduced this year and review of two appraisal records evidenced this. Staff confirmed that appraisals had taken place and 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.

A staff register was in place and was observed to be up to date.

Recruitment and selection

A review of the submitted staffing information and discussion with Ms Flynn confirmed that no new staff have been recruited since the previous inspection. It was confirmed that, should staff be recruited in the future robust systems and processes have been developed to ensure that all recruitment documentation as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 would be sought and retained for inspection.

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.

A copy of the new regional guidance Adult Safeguarding Prevention and Protection in Partnership (July 2015) was available in the practice. Ms Flynn confirmed that this would be shared with staff at the next staff meeting and the safeguarding vulnerable adults policy would be updated to reflect the adults at risk of harm 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. Ms Flynn was advised that the dosage of Buccolam provided for the administration in the event of status epilepticus should be reviewed and arrangements established to ensure that accurate dosage can be administered to the relevant age groups. 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.

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. Appropriate equipment, including a washer disinfector and a steam steriliser, has been provided to meet the practice requirements. A review of documentation evidenced that equipment used in the decontamination process has been appropriately validated. A review of equipment logbooks evidenced that periodic tests are undertaken 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 July 2016 and an action plan for compliance had been developed.

Radiography

The practice has four surgeries, three of which have 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 measures are taken to optimise dose exposure. This included the use of rectangular collimation, x-ray quality grading audits and digital x-ray processing. The practice changed from chemically processing x-rays to digital processing in June 2016, following which a quality grading audit was carried out. As a result of the findings of the audit an action plan was developed and the audit will be repeated in three months.

Review of records evidenced that the most recent justification and clinical evaluation recording audits were completed in July 2014 and December 2015 and these were in respect of Mr Malanaphy only. A recommendation was made to ensure that justification and clinical evaluation recording audits are carried out in respect of all dentists on an annual basis.

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 was last serviced in January 2014. A recommendation was made to ensure that x-ray equipment is serviced and maintained in accordance with manufacturer's instructions.

Environment

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

Cleaning schedules were in place for all areas and colour coded cleaning system was in place. However, whilst colour coded mops had been provided in keeping with the National Patient Safety Agency (NPSA) guidance, there was only one mop bucket available. A recommendation was made that colour coded mop buckets are provided for use with the associated coloured mops.

Arrangements in place for maintaining the environment included reviews of risk assessments in respect of health and safety, control of substances hazardous to health (COSHH), legionella and fire. Dental chairs are serviced annually and portable appliance and fixed electrical wiring testing were in date. There was no evidence available that the following had been serviced/maintained:

- oil fired burner
- air conditioning (last service August 2013)
- passenger lift
- pressure vessels

A requirement was made that arrangements are established to ensure that a thorough examination of the passenger lift is carried out every six months in keeping with the Lifting Operations and Lifting Equipment Regulations (Northern Ireland) 1999.

A requirement was made that arrangements are established to ensure that pressure vessels are inspected under the written scheme of examination of pressure vessels at the appropriate intervals.

A recommendation was made that the oil fired burner is serviced annually and the air conditioning and passenger lift are serviced in keeping with the manufacturer's instructions.

It was suggested that a template is drawn up listing equipment, required servicing intervals and dates servicing is due to assist with monitoring and ensuring equipment is serviced at the appropriate times.

Legionella risk assessments were undertaken by an external contractor in 2011, 2013 and most recently in July 2016. The report of the July 2016 assessment has not yet been received and a recommendation was made that any recommendations made in the report are addressed. Water temperatures were monitored and recorded on a monthly basis.

The fire risk assessment had been reviewed annually and a fire logbook was retained in respect of equipment testing and servicing. However, although staff demonstrated that they were aware of the action to take in the event of a fire, there had been no provision of fire safety training or fire evacuation drills since August 2014. A recommendation was made that these should be implemented on an annual basis.

Patient and staff views

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

Four 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.

Areas for improvement

X-ray justification and clinical evaluation recording audits should be carried out in respect of all dentists on an annual basis.

X-ray equipment should be serviced and maintained in accordance with manufacturer's instructions.

Colour coded mop buckets should be provided for use with the associated coloured mops.

Arrangements should be established to ensure that a thorough examination of the passenger lift is carried out every six months.

Arrangements should be established to ensure that pressure vessels are inspected under the written scheme of examination of pressure vessels at the appropriate intervals.

The oil fired burner should be serviced annually and the air conditioning and passenger lift serviced in keeping with the manufacturer's instructions.

Recommendations made in the legionella risk assessment report for July 2016 should be addressed.

Fire safety training should be provided and fire evacuation drills performed on an annual basis.

Number of requirements	**2**	**Number of recommendations**:	**6**

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. Written treatment plans including estimated costs are provided to patients as appropriate.

Manual records were previously maintained, however, the practice implemented an electronic record system in June 2016. 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.

The practice is registered with the Information Commissioner's Office (ICO).

Health promotion

The practice has a strategy for the promotion of oral health and hygiene. There was a range of health promotion information available in the waiting area of the practice. The associate dentist 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
- IPS HTM 01-05 compliance
- review of complaints/accidents/incidents
- patient satisfaction survey

As discussed previously x-ray justification and clinical evaluation recording audits had been performed but these were not carried out on an annual basis and did not include all dentists. A recommendation was made in this regard.

It was suggested that the quality assurance programme could be further developed to include audits in areas such as clinical waste management, hand hygiene and clinical records.

Communication

The associate dentist confirmed that arrangements are in place for onward referral in respect of specialist treatments.

Staff meetings are held on a regular 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 and formal 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 patients who submitted questionnaire responses indicated that they get the right care, at the right time and with the best outcome for them.

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.

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. As discussed previously, written treatment plans, including estimated costs are provided as appropriate. Staff demonstrated how consent would be obtained.

Patients with a physical disability or who require wheelchair access can be accommodated in the practice with one surgery located on the ground floor and a passenger lift is available for access to surgeries on the first floor. The toilet facility is suitable for disabled access. Ms Flynn confirmed that an interpreter service would be sought if required in the event of a patient attending who did not speak English.

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. The most recent patient satisfaction report was on display in the waiting area.

Patient and staff views

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

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.

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. There was a 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 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.

Ms Flynn 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. Review of complaints investigation records confirmed that learning from complaints was shared with staff and resulted in a change to practice.

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 Malanaphy, registered person, was not available during the inspection, however, discussion with Ms Flynn confirmed that Mr Malanaphy had a clear understanding of his role and responsibility in accordance with legislation. Information requested by RQIA has been submitted within specified timeframes. It was confirmed that the statement of purpose and patient's guide are kept under review, revised and updated when necessary and available on request.

The RQIA certificate of registration was up to date and displayed appropriately.

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

Evidence gathered during the inspection has identified a number of issues which could affect the delivery of safe and effective care, which have an impact on quality assurance and good governance. Two requirements and six recommendations have been made in order to progress improvement in identified areas.

Patient and staff views

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

All submitted staff questionnaire responses indicated that they feel that the service is well led. Staff spoken with during the inspection concurred with this.

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 Ms Grainne Flynn, lead dental nurse, as part of the inspection process. The timescales commence from the date of inspection.

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

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

5.1 Statutory requirements

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

5.2 Recommendations

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

Statutory requirements	
Requirement 1 **Ref**: Regulation 15 (2) **Stated:** First time **To be completed by:** 4 October 2016	The registered provider must establish arrangements to ensure that a thorough examination of the passenger lift is carried out every six months in keeping with the Lifting Operations and Lifting Equipment Regulations (Northern Ireland) 1999.
	Response by registered provider detailing the actions taken: inspection/examination of lift is being arranged
Requirement 2 **Ref**: Regulation 15 (2) **Stated:** First time **To be completed by:** 4 October 2016	The registered provider must establish arrangements to ensure that pressure vessels are inspected under the written scheme of examination of pressure vessels at the appropriate intervals.
	Response by registered provider detailing the actions taken: inspection/examination of pressure vessels has been arranged
Recommendations	
Recommendation 1 **Ref**: Standard 8.3 **Stated:** First time **To be completed by:** 4 October 2016	X-ray justification and clinical evaluation recording audits should be carried out in respect of all dentists on an annual basis.
	Response by registered provider detailing the actions taken: audits will be carried annually by both dentists
Recommendation 2 **Ref**: Standard 14.4 **Stated:** First time **To be completed by:** 4 November 2016	Ensure that x-ray equipment is serviced and maintained in accordance with manufacturer's instructions.
	Response by registered provider detailing the actions taken: service of xray equipment has been arranged

Recommendation 3 **Ref**: Standard 13 **Stated:** First time **To be completed by:** 18 August 2016	Colour coded mop buckets should be provided for use with the associated coloured mops.
	Response by registered provider detailing the actions taken: colour coded buckets now used with corresponding mops
Recommendation 4 **Ref**: Standard 14.2 **Stated:** First time **To be completed by:** 4 November 2016	The oil fired burner should be serviced annually. The air conditioning and passenger lift should be serviced in keeping with the manufacturer's instructions.
	Response by registered provider detailing the actions taken: service of above equipment being arranged
Recommendation 5 **Ref**: Standard 14.2 **Stated:** First time **To be completed by:** 4 November 2016	Recommendations made in the legionella risk assessment report for July 2016 should be addressed.
	Response by registered provider detailing the actions taken: recommendations from assessment are being addressed
Recommendation 6 **Ref**: Standard 12.5 **Stated:** First time **To be completed by:** 4 November 2016	Fire safety training should be provided and fire evacuation drills performed on an annual basis.
	Response by registered provider detailing the actions taken: fire safety training revised and drills will be performed annually.

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

The Regulation and Quality Improvement Authority

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