Announced Care Inspection Report
20 February 2018

Gentle Dentistry Omagh

Type of service: Independent Hospital (IH) – Dental Treatment
Address: 6 New Brighton Terrace, Kevlin Road, Omagh, BT78 1LL
Tel no: 028 8224 2218
Inspector: Gerry Colgan

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered dental practice with 3 registered places.

3.0 Service details

Registered organisation/registered person: Mr Marius Monaghan	**Registered manager:** Mr Marius Monaghan
Person in charge of the practice at the time of inspection: Mr Marius Monaghan	**Date manager registered:** 16 September 2013
Categories of care: Independent Hospital (IH) – Dental Treatment	**Number of registered places:** 3

4.0 Inspection summary

An announced inspection took place on 20 February 2018 from 10.00 to 13.30.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, 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).

The inspection assessed progress with any areas for improvement identified during and since the last care inspection and to determine if the practice was delivering safe, effective and compassionate care and if the service was well led.

Examples of good practice were evidenced in all four domains. These related to patient safety in respect of staff training and development, recruitment, safeguarding, the management of medical emergencies, infection prevention and control, radiology and the environment. Other examples included health promotion, engagement to enhance the patients' experience and governance arrangements.

No areas requiring improvement were identified during this inspection.

The findings of this report will provide the practice with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients experience.

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.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mr Marius Monaghan, registered person and Ms Roisin Taggart ,practice manager, as part of the inspection process and can be found in the main body of the report.

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

4.2 Action/enforcement taken following the most recent care inspection dated 30 January 2017.

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 30 January 2017.

5.0 How we inspect

Prior to the inspection a range of information relevant to the practice was reviewed. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the establishment
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report
- submitted staffing information
- submitted complaints declaration

Questionnaires were provided to patients prior to the inspection by the practice on behalf of RQIA. No patient questionnaires were returned.

A poster in relation to staff questionnaires had been provided to the practice prior to the inspection. The practice manager confirmed that staff had completed questionnaires, however; no questionnaires had been received by RQIA. It is acknowledged that some difficulties have been experienced with the introduction of electronic questionnaires and RQIA continue to work to resolve the matter.

A poster informing patients that an inspection was being conducted was displayed.

During the inspection the inspector met with Mr Monaghan registered person, the practice manager and one dental nurse. A tour of the premises was also undertaken.

A sample of records was examined during the inspection in relation to the following areas:

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

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 30 January 2017

The most recent inspection of the practice was an announced care inspection.

The completed QIP was returned and approved by the care inspector.

6.2 Review of areas for improvement from the last care inspection dated 30 January 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 15 (1) (b) **Stated:** First time	The registered provider must ensure that the radiation protection file is reviewed. The review should include the following: • the recommendations made by the radiation protection advisor (RPA) should be addressed. Records should be retained confirming each recommendation has been actioned • updated local rules should be displayed near each x-ray machine • staff should sign to confirm they have	**Met**

	read the local rules and the radiation protection folder • entitlement and authorisation of clinical staff by the radiation protection supervisor (RPS) should be updated • x-ray quality grading audits should be undertaken and recorded six monthly • x-ray justification and clinical evaluation recording audits should be undertaken and recorded on an annual basis • staff training records should be retained • x-ray equipment should be serviced and maintained in accordance with manufacturer's instructions	
	Action taken as confirmed during the inspection: A review of the radiation protection file confirmed that the registered provider has updated the radiation protection file to include the following • the recommendations made by the radiation protection advisor (RPA) had been. Records are retained confirming each recommendation has been actioned • updated local rules are displayed near each x-ray machine • staff have signed to confirm they have read the local rules and the radiation protection folder • entitlement and authorisation of clinical staff by the radiation protection supervisor (RPS) has been updated • x-ray quality grading audits are undertaken and recorded six monthly • x-ray justification and clinical evaluation recording audits are undertaken and recorded on an annual basis • staff training records are retained • x-ray equipment is serviced and maintained in accordance with manufacturer's instructions	
Action required to ensure compliance with The Minimum Standards for Dental Care and Treatment (2011)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 11.4	A system should be established to ensure that all staff receive appropriate training to fulfil the duties of their role.	**Met**

Stated: First time	Training records should also be retained of any training provided in house. A system has been established by the practice manager to ensure that all staff receive appropriate training to fulfil the duties of their role. Training records are retained of any training provided in house and were available at inspection.	
Area for improvement 2 **Ref**: Standard 11 **Stated:** Second time	Information pertaining to the recruitment process should be retained in staff personnel files in respect of any new staff including self-employed staff, commencing work in the practice. This should include the following: • two written references • criminal conviction declaration • confirmation that the person was physically and mentally fit to fulfil the duties of their role **Action taken as confirmed during the inspection**: No staff have been recruited since the last care inspection. The practice manager confirmed that information pertaining to the recruitment process would be retained in staff personnel files in respect of any new staff including self-employed staff, commencing work in the practice. This would include the following: • two written references • criminal conviction declaration • confirmation that the person was physically and mentally fit to fulfil the duties of their role A recruitment checklist has 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.	**Met**

Area for improvement 3 **Ref**: Standard 11 **Stated:** Second time	Enhanced AccessNI disclosure certificates should be disposed of in keeping with AccessNI's code of practice and a record retained of the dates the check was applied for and received, the unique identification number and the outcome of the assessment of the check.	**Met**
	Action taken as confirmed during the inspection: The practice manager confirmed that enhanced AccessNI disclosure certificates would be disposed of in keeping with AccessNI's code of practice and a record retained of the dates the check was applied for and received, the unique identification number and the outcome of the assessment of the check.	
Area for improvement 4 **Ref**: Standard 11 **Stated:** First time	The recruitment policy should be further developed to include the following: • enhanced AccessNI checks must be undertaken and received prior to staff commencing work in the practice (including self-employed staff) • one of the two written references should be from the current/most recent employer • physical and mental health assessment • full employment history, including dates, reasons for leaving and explanation of any gaps in employment The policy states that staff may be asked to attend for a trial period of one week prior to the offer of employment. Full employment checks as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005, including enhanced AccessNI checks, must be undertaken and obtained prior to the trial period. This should be reflected in the policy.	**Met**

	Action taken as confirmed during the inspection: The recruitment policy has been revised and now includes the following: • enhanced AccessNI checks must be undertaken and received prior to staff commencing work in the practice (including self-employed staff) • one of the two written references should be from the current/most recent employer • physical and mental health assessment • full employment history, including dates, reasons for leaving and explanation of any gaps in employment Full employment checks as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005, including enhanced AccessNI checks, must be undertaken and obtained prior to any trial period is now reflected in the revised recruitment policy.	
Area for improvement 5 **Ref**: Standard 15.3 **Stated:** First time	The safeguarding children and vulnerable adults policy should be further developed to provide a safeguarding children and adults at risk of harm policy. The policy should reflect the new regional guidance 'Adult Safeguarding Prevention and Protection in Partnership', July 2015, and 'Co-operating to safeguard children and young people in Northern Ireland', March 2016, and should include the following: • name of the safeguarding lead • definitions of abuse • types, and indicators of abuse • onward referral arrangements including contact information • documentation arrangements • training arrangements	

	Action taken as confirmed during the inspection: A review of the safeguarding policy confirmed that it has been further developed to provide a safeguarding children and adults at risk of harm policy. The policy now reflects the new regional guidance 'Adult Safeguarding Prevention and Protection in Partnership', July 2015, and 'Co-operating to safeguard children and young people in Northern Ireland', March 2016, and includes the following: • name of the safeguarding lead • definitions of abuse • types, and indicators of abuse • onward referral arrangements including contact information • documentation arrangements • training arrangements	
Area for improvement 6 **Ref**: Standard 15.3 **Stated:** First time	Safeguarding training should be provided on completion of the further development of the safeguarding policy. Arrangements should be established to provide refresher training every two years as outlined in the Minimum Standards for Dental Care and Treatment 2011.	**Met**
	Action taken as confirmed during the inspection: A review of staff training records confirmed that safeguarding training has been provided following the further development of the safeguarding policy. Arrangements have been established to provide refresher training every two years as outlined in the Minimum Standards for Dental Care and Treatment 2011.	
Area for improvement 7 **Ref**: Standard 12.1 **Stated:** Second time	An overarching policy for the management of medical emergencies should be developed.	**Met**
	Action taken as confirmed during the inspection: A review of policies confirmed that an overarching policy for the management of	

	medical emergencies has been developed.	
Area for improvement 8 **Ref**: Standard 13.4 **Stated:** First time	Logbooks should be established for each steriliser.	**Met**
	Action taken as confirmed during the inspection: A review of decontamination procedures confirmed that logbooks have been established for each steriliser.	
Area for improvement 9 **Ref**: Standard 13.2 **Stated:** First time	Compliance with Health Technical Memorandum (HTM) 01-05 should be audited on a six monthly basis using the 2013 edition of the Infection Prevention Society (IPS) audit tool.	**Met**
	Action taken as confirmed during the inspection: Mr Monaghan confirmed that compliance with Health Technical Memorandum (HTM) 01-05 has been audited on a six monthly basis using the 2013 edition of the Infection Prevention Society (IPS) audit tool. Records were available at inspection	
Area for improvement 10 **Ref**: Standard 11.6 **Stated:** First time	Minutes of staff meetings should be retained. Minutes should include details of who chaired the meeting, the staff who attended and the matters discussed.	**Met**
	Action taken as confirmed during the inspection: Staff meetings take place on a three monthly basis. Minutes of staff meetings are retained and were available at inspection. The minutes included details of who chaired the meeting, the staff who attended and the matters discussed.	
Area for improvement 11 **Ref**: Standard 9 **Stated:** First time	The patient satisfaction survey process should be further developed to include in the summary report the number of patients who participated, the outcome of results in relation to each specific question, and the actions taken, if any, to implement improvements.	

	Action taken as confirmed during the inspection: A review of the latest patient satisfaction survey confirmed that the process has been further developed, to include a summary report, the number of patients who participated and the outcome of results in relation to each specific question. The practice manager confirmed that if required, actions would be taken to implement improvements.	**Met**

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

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.

No new staff have been recruited since the previous care inspection, however, induction programme templates were in place relevant to specific roles within 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. A review of a sample of two evidenced that appraisals had been completed on an annual basis. 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 the practice manager 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 revised recruitment policy and procedure available. The policy was comprehensive and reflected best practice guidance.

Safeguarding

Staff 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. It was confirmed that the safeguarding lead has completed formal training in safeguarding adults in keeping with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016).

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

It was confirmed that copies of the regional policy entitled 'Co-operating to Safeguard Children and Young People in Northern Ireland' (March 2016) and the regional guidance document entitled 'Adult Safeguarding Prevention and Protection in Partnership' (July 2015) were both available for staff reference.

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.

The revised policy for the management of medical emergencies reflected best practice guidance. Protocols were available for staff reference outlining the local procedure for dealing with the various medical emergencies.

Infection prevention control and decontamination procedures

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

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

There was a nominated lead with responsibility for infection control and decontamination.

A decontamination room separate from patient treatment areas and dedicated to the decontamination process was available. Appropriate equipment, including a 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. 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 November 2017.

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

Radiography

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

A copy of the local rules was on display near each x-ray machine and appropriate staff had signed to confirm that they had read and understood these. Staff spoken with demonstrated sound knowledge of the local rules and associated practice.

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

The x-ray equipment has been serviced and maintained in accordance with manufacturer's instructions.

Quality assurance systems and processes were in place to ensure that all matters relating to x-rays reflect legislative and best practice guidance.

Environment

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

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

Arrangements are in place for maintaining the environment. The oil heating system was serviced in February 2018. Firefighting equipment was checked in January 2018. Fixed electrics were inspected in November 2016 and portable appliances were tested in November 2017.

Review of documentation confirmed that pressure vessels in the practice were inspected in keeping with the written scheme of examination.

A legionella risk assessment has been undertaken and water temperatures are monitored and recorded as recommended.

A fire risk assessment had been undertaken. Staff confirmed they received fire training and fire drills are completed on a six monthly basis. Staff demonstrated that they were aware of the action to take in the event of a fire.

It was confirmed that robust arrangements are in place for the management of prescription pads/forms and that written security policies are in place to reduce the risk of prescription theft and misuse.

Patient and staff views

No staff or patient submitted questionnaire responses were received by RQIA.

Areas of good practice

There were examples of good practice found in relation to staff recruitment, induction, training, appraisal, safeguarding, management of medical emergencies, infection prevention control and decontamination procedures, radiology and the environment.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Clinical records

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

The practice manager 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. 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 available for patients. Oral health promotion appointments were available for patients and are allocated based on patient need by the dentist. Mr Monaghan also confirmed that oral health is actively promoted on an individual level with patients during their consultations with the dentist.

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
- patient satisfaction

Communication

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

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

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

Patient and staff views

No staff or patient submitted questionnaire responses were received by RQIA.

Areas of good practice

There were examples of good practice found in relation to the management of clinical records, the range and quality of audits, health promotion strategies and ensuring effective communication between patients and staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Dignity, respect and involvement in decision making

Staff 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

No staff or patient submitted questionnaire responses were received by RQIA.

Areas of good practice

There were examples of good practice found in relation to maintaining patient confidentiality ensuring the core values of privacy and dignity were upheld and providing the relevant information to allow patients to make informed choices.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

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.

The practice manager 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 a yearly basis. Staff spoken with were aware of the policies and how to access them.

Arrangements were in place to review risk assessments.

A copy of the complaints procedure was 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 returned questionnaire indicated that no complaints have been received for the period 1 April 2016 to 31 March 2017.

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.

The practice manager 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 Monaghan demonstrated a clear understanding of his role and responsibility in accordance with legislation. Information requested by RQIA has been submitted within specified timeframes. It was confirmed that the statement of purpose and patient's guide are kept under review, revised and updated when necessary and available on request.

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

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

Patient and staff views

No staff or patient submitted questionnaire responses were received by RQIA.

Areas of good practice

There were examples of good practice found in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified during the inspection.

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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