

Inspection Report

9 March 2026



Lalor Clinic

Type of service: Independent Hospital (IH) – Dental Treatment

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www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

Information on legislation and standards underpinning inspections can be found on our website <https://www.rqia.org.uk/>, [The Independent Health Care Regulations \(Northern Ireland\) 2005](#) and the [Minimum Standards for Dental Care and Treatment \(March 2011\)](#)

1.0 Service information

Organisation/Registered Provider: Lalor Ltd	Registered Manager: Ms Aisling Lalor
Responsible Individual: Ms Aisling Lalor	Date registered: 14 October 2024
Person in charge at the time of inspection: Ms Aisling Lalor	Number of registered places: Three
Categories of care: Independent Hospital (IH) – Dental Treatment	
Brief description of how the service operates: Lalor Clinic is registered with the Regulation and Quality Improvement Authority (RQIA) as an independent hospital (IH) with a dental treatment category of care. The practice has three registered dental surgeries and provides general dental services, private and health service treatment and offers conscious sedation, if clinically indicated.	

2.0 Inspection summary

This was an announced inspection, undertaken by a care inspector and a pharmacy inspector on 9 March 2026 from 10.00 am to 5.00 pm.

It focused on the themes for the 2025/26 inspection year and assessed progress with any areas for improvement identified during the last care inspection.

Issues of concern were identified during the inspection in relation to recruitment and selection of staff; staff training; infection prevention and control (IPC); management of medical emergencies; radiology and radiation safety; management of complaints; management of medicines and governance arrangements.

As a result of the inspection findings and following consultation with senior management at RQIA, the registered person was invited to attend a serious concerns meeting. The meeting was then held on 16 April 2026 at RQIA head office.

Ahead of the meeting an action plan was submitted to RQIA by Ms Lalor detailing the actions taken to address the issues identified and to ensure the improvements necessary to achieve compliance with the regulations. During the meeting, Ms Lalor provided an account of the actions taken to address the issues identified.

Based on the discussions held and actions agreed, RQIA accepted the action plan and no further enforcement action will be taken at this point. RQIA will continue to monitor and review the quality of service provided in Lalor Clinic. It should be noted that continued non-compliance may lead to further enforcement action.

As a result of the inspection findings, six areas for improvement have been identified. Details of the areas for improvement can be found in the quality improvement plan (QIP) in section 6.0 of this report.

3.0 How we inspect

RQIA is required to inspect registered services in accordance with legislation. To do this, we gather and review the information we hold about the service, examine a variety of relevant records, meet and talk with staff and management and observe practices on the day of the inspection.

The inspection was facilitated by the interim clinic operations lead.

The information obtained is then considered before a determination is made on whether the practice is operating in accordance with the relevant legislation and minimum standards.

Examples of good practice are acknowledged and any areas for improvement are discussed with the person in charge and detailed in the quality improvement plan (QIP).

4.0 What people told us about the care and treatment?

We issued posters to the registered person prior to the inspection inviting patients and members of the dental team to complete an electronic questionnaire.

Two patients submitted responses. Patient responses indicated that they felt their care was safe and effective, that they were treated with compassion and that the service was well led. All patients indicated that they were very satisfied with each of these areas of their care. A number of patient responses included positive comments pertaining to the friendliness of staff and the service they received.

No completed staff questionnaires were received prior to the inspection.

5.0 The inspection

5.1 What action has been taken to meet any areas for improvement identified at or since last inspection?

The last inspection to Lalor Clinic was undertaken on 23 September 2024; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 Do recruitment and selection procedures comply with all relevant legislation?

There were recruitment and selection policies and procedures in place that adhered to legislation and best practice guidance.

Ms Lalor oversees the recruitment and selection of the dental team and approves all staff appointments.

A review of the staff register evidenced that a number of new staff members had been recruited since the previous inspection. A review of a sample of personnel files of newly recruited staff evidenced that a number of recruitment records were not in place. This was discussed with the clinic operations lead and following the inspection RQIA received confirmation that this matter had been addressed.

There was evidence of job descriptions and induction checklists for the different staff roles. A review of records confirmed that if a professional qualification is a requirement of the post, a registration check is made with the appropriate professional regulatory body.

Discussion with members of the dental team confirmed they have been provided with a job description, contract of employment/agreement and received induction training when they commenced work in the practice.

As a result of the matters identified on the day of inspection, RQIA were concerned that robust systems were not in place to ensure the recruitment of the dental team complies with the legislation and best practice guidance and that evidence of such recruitment is not retained at the practice and made readily available for inspection at all times.

These concerns were discussed at the serious concerns meeting on 16 April 2026.

Based on the discussions held and actions agreed, and taking into account that assurances provided by Ms Lalor that relevant recruitment records as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 are now in place, RQIA considered the matter and confirmed that no further enforcement action will be taken at present.

An area for improvement has been made against the regulations in regards to ensure that the recruitment of staff complies with legislation, best practice guidance and that recruitment records as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005, for staff are retained for inspection.

Addressing the area for improvement will ensure the recruitment of the dental team complies with the legislation and best practice guidance to ensure suitably skilled and qualified staff work in the practice.

5.2.2 Is the dental team appropriately trained to fulfil the duties of their role?

During the inspection, mandatory training records and professional development activities undertaken by staff were reviewed.

Policies and procedures are in place that outline mandatory training to be undertaken, in line with any professional requirements, and the training guidance provided by RQIA.

A review of a sample of staff training records could not confirm that staff had completed all training as outlined in the training guidance provided by RQIA. This was discussed with the clinic operations lead and following the inspection, confirmation and evidence that staff training had been completed and was now up to date, was shared with RQIA.

As a result of the matters identified on the day of inspection, RQIA were concerned that robust systems were not in place to ensure staff undertake training in line with RQIA guidance and that evidence of such training is retained at the practice and is made readily available for inspection at all times.

These concerns were discussed at the serious concerns meeting on 16 April 2026.

Based on the discussions held and actions agreed, and taking into account that staff training has since been completed, RQIA considered the matter and confirmed that no further enforcement action will be taken at present.

An area for improvement has been made against the regulations to ensure all staff working within Lalor Clinic have completed training in accordance with their role and in keeping with RQIA training guidance and continuing professional development. Evidence of staff training should be retained and available for inspection at all times.

Addressing the area for improvement will ensure that the care and treatment of patients is being provided by a dental team that is appropriately trained to carry out their duties.

5.2.3 Is the practice fully equipped and is the dental team trained to manage medical emergencies?

The British National Formulary (BNF) and the Resuscitation Council (UK) specify the emergency medicines and medical emergency equipment that must be available to safely and effectively manage a medical emergency.

A review of the medical emergency policy and procedure identified that it required further development to reflect the local arrangements of the practice. This was discussed with the clinic operations lead and following the inspection, RQIA received evidence that this matter had been addressed.

Following the inspection RQIA received evidence that protocols were available to guide the dental team on how to manage recognised medical emergencies.

A review of the medical emergency equipment identified that some items were not available as specified and other items were required to be replaced.

This was discussed with the clinic operations lead and following the inspection, RQIA received evidence that these matters had been addressed.

A review of the emergency medicines identified that one item was required to be replaced. This was discussed with the clinic operations lead and following the inspection, RQIA received evidence that this matter had been addressed.

Managing medical emergencies is included in the induction programme and refresher training is undertaken annually.

Members of the dental team were able to describe the actions they would take, in the event of a medical emergency, and were familiar with the location of medical emergency medicines and equipment.

As a result of the action taken following the inspection, it was determined that sufficient emergency medicines and equipment were in place. The dental team is trained to manage a medical emergency as specified in the legislation, professional standards and guidelines.

5.2.4 Does the dental team provide dental care and treatment using conscious sedation in line with the legislation and guidance?

Conscious sedation helps reduce anxiety, discomfort, and pain during certain procedures. This is accomplished with medications or medical gases to relax the patient.

The clinic operations lead confirmed that conscious sedation is offered if clinically indicated using inhalation sedation (IH).

Due to time constraints during the inspection and assurances provided by the clinic operations lead that the IH equipment was not currently on site due to servicing arrangements, conscious sedation will be reviewed during the next inspection.

5.2.5 Does the dental team adhere to infection prevention and control (IPC) best practice guidance?

The IPC arrangements were reviewed throughout the practice to evidence that the risk of infection transmission to patients, visitors and staff was minimised.

The infection prevention and control measures to prevent transmission of respiratory illnesses in the practice was discussed with the clinic operations lead. It was confirmed that arrangements are in place in keeping with the Health and Social Care Public Health Agency guidance [Infection Prevention and Control Measures for Respiratory illnesses March 2023](#) and the [Infection Prevention and Control Manual for Northern Ireland](#). The clinic operations lead confirmed arrangements are in place to check Department of Health (DoH) websites for further advisory information, guidance and alerts in this regard.

There was an overarching IPC policy and associated procedures in place. Review of these documents demonstrated that they reflected legislation and best practice guidance. The clinic operations lead confirmed there was a nominated lead dental nurse who had responsibility for IPC and decontamination in the practice.

The lead dental nurse had undertaken IPC and decontamination training in line with their continuing professional development and had retained the necessary training certificates as evidence.

During a tour of some areas of the practice, it was observed that clinical and decontamination areas were clean, tidy and uncluttered. All areas of the practice observed were equipped to meet the needs of patients however, it was identified that some matters required further attention. These were discussed with the clinic operations lead and following the inspection, RQIA received confirmation and evidence that these matters had been addressed.

The arrangements for personal protective equipment (PPE) were reviewed and it was noted that appropriate PPE was readily available for the dental team in accordance with the treatments provided.

Using the Infection Prevention Society (IPS) audit tool, IPC audits are routinely undertaken by members of the dental team to self-assess compliance with best practice guidance. The purpose of these audits is to assess compliance with key elements of IPC, relevant to dentistry, including the arrangements for environmental cleaning; the use of PPE; hand hygiene practice; and waste and sharps management. This audit also includes the decontamination of reusable dental instruments which is discussed further in the following section of this report. A review of these audits and discussion with the lead nurse with responsibility for IPC and decontamination confirmed that these audits would be completed on a six monthly basis and, where applicable, an action plan would be generated to address any improvements required.

Hepatitis B vaccination is recommended for clinical members of the dental team as it protects them if exposed to this virus. Following the inspection, RQIA received confirmation that relevant members of the dental team have received this vaccination.

As a result of the matters identified on the day of inspection, RQIA were concerned that robust systems were not in place to ensure standards of IPC at the practice are monitored in line with best practice guidance. These concerns were discussed at the serious concerns meeting on 16 April 2026. Based on the discussions held and actions agreed, RQIA considered the matter and confirmed that no further enforcement action will be taken at present. An area for improvement against the standards has been made to strengthen IPC arrangements within the practice.

Addressing the area for improvement will ensure that the dental team adheres to best practice guidance to minimise the risk of infection transmission to patients, visitors and staff.

5.2.6 Does the dental team meet current best practice guidance for the decontamination of reusable dental instruments?

Robust procedures and a dedicated decontamination room must be in place to minimise the risk of infection transmission to patients, visitors and staff in line with Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the DoH.

There was a range of policies and procedures in place for the decontamination of reusable dental instruments that were comprehensive and reflected legislation, minimum standards and best practice guidance.

There was a designated decontamination room separate from patient treatment areas and dedicated to the decontamination process. The design and layout of this room complied with best practice guidance and the equipment was sufficient to meet the requirements of the practice. Records evidencing that the equipment for cleaning and sterilising instruments was inspected, validated, maintained and used in line with the manufacturers' guidance were reviewed. Review of equipment logbooks demonstrated that all required tests to check the efficiency of the machines had been undertaken.

Discussion with members of the dental team confirmed that they had received training on the decontamination of reusable dental instruments in keeping with their role and responsibilities. They demonstrated good knowledge and understanding of the decontamination process and were able to describe the equipment treated as single use and the equipment suitable for decontamination.

Decontamination arrangements demonstrated that the dental team are adhering to current best practice guidance on the decontamination of dental instruments.

5.2.7 How does the dental team ensure that appropriate radiographs (x-rays) are taken safely?

The arrangements regarding radiology and radiation safety were reviewed to ensure that appropriate safeguards were in place to protect patients, visitors and staff from the ionising radiation produced by taking an x-ray.

Dental practices are required to notify and register any equipment producing ionising radiation with the Health and Safety Executive Northern Ireland (HSENI). A review of records evidenced the practice had registered with the HSENI.

The practice has three surgeries each of which has an intra-oral x-ray machine. In addition, there is an orthopan tomogram (OPG) machine, which is located in a separate room. The equipment inventory reflected all the radiography equipment in place. A review of documentation evidenced that the x-ray equipment had been serviced and maintained in accordance with manufacturer's instructions.

A radiation protection advisor (RPA), medical physics expert (MPE) and radiation protection supervisor (RPS) have been appointed in line with legislation however, it was identified that this appointment was due to be renewed during August 2025. This was discussed with the clinic operations lead and following the inspection, RQIA received evidence that this matter had been addressed.

A dedicated radiation protection file containing the relevant local rules, employer's procedures and other additional information was retained.

A review of the file identified that the Employer had not appropriately entitled all of the dental team who have specific roles and responsibilities associated with radiology. It could also not be confirmed that all of these staff had completed appropriate training. This was discussed with the clinic operations lead and following the inspection, RQIA received confirmation that this matter had been addressed.

The RPS oversees radiation safety within the practice. A review of the radiation protection file could not confirm that the RPS regularly reviews the radiation protection file to ensure that it is accurate and up to date. This was discussed with the clinic operations lead and following the inspection, RQIA received confirmation that this matter had been addressed.

The appointed RPA must undertake a critical examination and acceptance test of all new x-ray equipment; thereafter the RPA must complete a quality assurance test every three years as specified within the legislation.

Ms Lalor confirmed that no new radiology equipment had been installed since the previous RQIA inspection.

The most recent report generated by the RPA during September 2024 was reviewed and it was identified that recommendations made by the RPA had not been signed actioned. This was discussed with the clinic operations lead and following the inspection, RQIA received confirmation that this matter had been addressed.

A copy of the local rules was on display near each x-ray machine observed however, relevant staff had yet to sign the folder to confirm that they had read and understood these. This was brought to the attention of the clinic operations lead and following the inspection, RQIA received confirmation that this matter had been addressed.

A review of the quality assurance systems and processes in place identified that they required further development to ensure that all matters relating to x-rays reflect legislation and best practice guidance. It was noted that rectangular collimators were not in use. This was discussed with the clinic operations lead and following the inspection, RQIA received evidence that this matter had been addressed. A review of the x-ray audit programme identified that it required further development to include the clinical evaluation of x-rays. This was discussed with the clinic operations lead and following the inspection, RQIA received confirmation of the arrangements in place to address this matter.

As a result of the matters identified on the day of inspection, RQIA were concerned that robust systems were not in place to ensure all documentation relating to radiology and radiation safety within the practice are reviewed regularly by the RPS and actioned when necessary. These concerns were discussed at the serious concerns meeting on 16 April 2026. Based on the discussions held and actions agreed, RQIA considered the matter and confirmed that no further enforcement action will be taken at present. An area for improvement has been made against the standards to ensure the radiation protection file is reviewed at least annually by the RPS and that the radiation safety documentation within is kept up to date and made available for inspection.

Addressing the area for improvement will ensure that procedures are in place to ensure that appropriate x-rays are taken safely.

5.2.8 Are complaints being effectively managed?

The arrangements for the management of complaints were reviewed to ensure that they were being managed in keeping with legislation and best practice guidance.

A review of the complaints policy and procedure identified that it required further development to ensure it is in keeping with legislation and best practice guidance. This was discussed with the clinic operations lead and following the inspection, RQIA received evidence that this matter had been addressed. Patients and/or their representatives were made aware of how to make a complaint by way of the patient's guide.

Arrangements were in place to record any complaint received in a complaints register. Advice and guidance was provided to further develop these arrangements to ensure details of any investigation were recorded and all communication with the complainant is documented. The clinic operations lead was receptive to this advice and following the inspection, RQIA received confirmation that this matter had been addressed.

A review of records concerning complaints evidenced that complaints had been managed in accordance with best practice guidance. The clinic operations lead confirmed that arrangements are in place to undertake a complaints audit to identify trends, drive quality improvement and to enhance service provision.

The dental team was knowledgeable on how to deal with and respond to complaints in accordance with legislation, minimum standards and the DoH guidance.

Arrangements were in place to share information with the dental team about complaints including any learning outcomes, and also compliments received.

As a result of the actions taken following the inspection, it is determined that systems are in place to ensure that complaints are being managed effectively in accordance with legislation and best practice guidance.

5.2.9 How does a registered provider who is not in day to day management of the practice assure themselves of the quality of the services provided?

Where the business entity operating a dental practice is a corporate body or partnership or an individual owner who is not in day to day management of the practice, unannounced quality monitoring visits by the registered provider must be undertaken and documented every six months; as required by Regulation 26 of The Independent Health Care Regulations (Northern Ireland) 2005.

Ms Lalor was in day to day management of the practice, therefore the unannounced quality monitoring visits by the registered provider are not applicable.

5.2.10 Medicines Management

Written policies and standard operating procedures for the management of medicines were in place. However, the policies and procedures did not contain sufficient detail to direct staff on all aspects of medicines management. An area for improvement against the regulations has been made in this regard.

The procedure for managing emergency dental treatments was discussed with the lead dentist and staff on duty. They advised that patients were triaged by the dentist via telephone consultation.

Patients were then requested to come to the surgery out of hours, directed to the emergency on-call dentist or an appointment booked for the next day. A small number of antibiotics were held in the practice for dental emergencies, a record was maintained each time these were supplied to a patient. Running balances correlated with the stock held in the practice.

Emergency medicines, antibiotics and analgesics were ordered from a dental wholesaler by designated staff under the direction of the lead dentist. Records of medicine orders were maintained electronically. It was agreed that each authorised member of staff would be assigned an individual profile for ordering medicines. Records for the receipt of medicines were maintained in the emergency medicine file and antibiotic log sheet to facilitate a clear audit trail. All medicines were stored securely to prevent unauthorised access. Emergency medicines were checked monthly to ensure they were in date.

Ms Lalor advised that medicines for aesthetic procedures were individually prescribed at each consultation. Prescriptions were transferred electronically to an on-line pharmacy and each patient's medicines were delivered to the dental practice. These medicines were observed to be stored in the medicines refrigerator and a locked cupboard in the surgery; dispensing labels included the patient's name. Ms Lalor advised that these medicines were administered only to the patient for whom they were prescribed.

Medicines which require cold storage must be stored between 2°C and 8°C to maintain their stability and efficacy. In order to ensure that this temperature range is maintained, it is necessary to monitor the maximum and minimum temperatures of the medicines refrigerator each day and to then reset the thermometer. The medicines refrigerator was not locked and only the current temperature was monitored each day. An area for improvement against the regulations has been made in this regard.

Review of the controlled drug record book indicated that previous records for the administration of midazolam, for conscious sedation, had been well maintained. The current balance recorded in the controlled drug record book correlated with stock held in the controlled drug cupboard. It was agreed that midazolam ampoules would be returned to the community pharmacy for disposal and this was confirmed following the inspection.

Medicines were disposed of either by disposal into the sharps bins or return to the community pharmacy. Records of return to the community pharmacy were maintained.

Systems were in place for the management of drug and medical device alerts and to report any safety problems relating to medicines, medical devices, blood and defective medicines to the Medicines and Healthcare Regulatory Agency (MHRA).

There were incident reporting systems in place for identifying, recording, reporting, analysing and learning from adverse incidents and near misses involving medicines and medicinal products.

5.3 Does the dental team have suitable arrangements in place to record equality data?

The arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients was discussed with the clinic operations lead.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005 and the Minimum Standards for Dental Care and Treatment (March 2011).

	Regulations	Standards
Total number of Areas for Improvement	4	2

Areas for improvement and details of the QIP were discussed with Ms Lalor, Responsible Individual, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005	
Area for improvement 1 Ref: Regulation 19 (2) Schedule 2, as amended Stated: First time To be completed by: 9 March 2026	The registered person shall ensure that the recruitment of staff complies with legislation, best practice guidance and that recruitment records as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005, for staff are retained for inspection. Ref: 5.2.1 Response by registered person detailing the actions taken: Recruitment processes were addressed immediately and required dates added to the employee records. Evidence was provided to the RQIA. We developed robust checklists and audited all employee records to ensure all records were compliant as per Regulation 19 (2).

Area for improvement 2 Ref: Regulation 18 Stated: First time To be completed by: 9 March 2026	The registered person shall have systems in place to ensure that all staff working within Lalor Clinic have completed training in accordance with their role and in keeping with RQIA training guidance and continuing professional development. A record of the training should be maintained. Ref 5.2.2
	Response by registered person detailing the actions taken: CPD is undertaken by all employees and dental providers, certificates are stored in individual folders. A centralised training plan has been developed to ensure all topics are covered to include essential clinical and non clinical topics reflective of policies, procedures and treatments at the clinic. The training plan is monitored and maintained. Signed training logs and certificates are stored in the respective folders to demonstrate compliance during inspection as per Regulation 18.
Area for improvement 3 Ref: Regulation 15 (6) Stated: First time To be completed by: 9 June 2026	The registered person shall review and update the medicines management policy and procedures to ensure they contain sufficient detail to direct staff on all aspects of medicines management. Ref 5.2.10
	Response by registered person detailing the actions taken: Medicine Managements policies and procedures have been updated to reflect current procedures at the practice. Staff have received training in line with regulation 15 (6)
Area for improvement 4 Ref: Regulation 15 (2) Stated: First time To be completed by: 9 March 2026	The registered person shall ensure that the maximum and minimum temperature of the medicine refrigerator is monitored each day to ensure that medicines are stored at the manufacturers' recommended temperature. Corrective action must be taken if temperatures are outside the recommended range. Ref 5.2.10
	Response by registered person detailing the actions taken: The thermometer was replaced with a digital max and min thermometer with immediate effect, temperature logs have been amended to reflect the max and min daily temperatures and monitored daily.

Action required to ensure compliance with the Minimum Standards for Dental Care and Treatment (March 2011)	
Area for improvement 1 Ref: Standard 13.2 Stated: First time To be completed by: 9 March 2026	The registered person shall ensure that the dental service adheres to the appropriate infection control policies and procedures, in line with current best practice and legislation. Ref: 5.2.5
	Response by registered person detailing the actions taken: Recommendations were actioned and photographic evidence provided to the RQIA.
Area for improvement 2 Ref: Standard 8.3 Stated: First time To be completed by: 9 March 2026	The registered person shall ensure the radiation protection file is reviewed at least annually by the RPS and that the radiation safety documentation within is kept up to date and made available for inspection. Ref 5.2.7
	Response by registered person detailing the actions taken: The recommendations were addressed, evidence of actions taken were provided and report signed accordingly. An audit of the folder was carried out internally and externally by the RPA during their quality assurance equipment test on the 19 th June 2026. All entitlements in place and training logs signed, evidence provided to the RQIA. The report will be actioned and signed once received and made available for inspection. The auditing process has been developed further as per RQIA recommendations and available for inspection.

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