Announced Inspection

Name of Establishment:	**Ballynahinch Dental Care**
Establishment ID No:	**11382**
Date of Inspection:	**17 February 2015**
Inspector's Name:	**Emily Campbell**
Inspection No:	**18191**

The Regulation and Quality Improvement Authority
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1.0 General Information

Name of establishment:	Ballynahinch Dental Care
Address:	11 Main Street Ballynahinch BT24 8DN
Telephone number:	028 9756 2676
Registered organisation / registered provider:	Dr Clare McGowan
Registered manager:	Dr Clare McGowan
Person in charge of the establishment at the time of Inspection:	Dr Clare McGowan
Registration category:	IH-DT
Type of service provision:	Private dental treatment
Maximum number of places registered: (dental chairs)	3
Date and type of previous inspection:	Announced Follow-up Inspection 21 January 2014
Date and time of inspection:	17 February 2015 9.55am - 1.15pm
Name of inspector:	Emily Campbell

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect dental practices providing private dental care and treatment. A minimum of one inspection per year is required.

This is a report of the announced inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection were met.

3.0 Purpose of the Inspection

The purpose of this inspection was to consider whether the service provided to patients was in accordance with their assessed needs and preferences and was in compliance with legislative requirements, minimum standards and other good practice indicators. This was achieved through a process of analysis and evaluation of available evidence.

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services. For this reason, inspection involves in-depth examination of an identified number of aspects of service provision.

The aims of the inspection were to examine the policies, practices and monitoring arrangements for the provision of dental care, and to determine the provider's compliance with the following:

- The HPSS (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;
- The Minimum Standards for Dental Care and Treatment 2011; and
- Health Technical Memorandum HTM 01-05: Decontamination in Primary Care Dental Practices and Professional Estates Letter (PEL) (13) 13.

Other published standards which guide best practice may also be referenced during the inspection process.

4.0 Methods/Process

Committed to a culture of learning, the RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the Minimum Standards.

The inspection process has three key parts; self-assessment (including completion of self-declaration), pre-inspection analysis and the inspection visit by the inspector.

Specific methods/processes used in this inspection include the following:

- a self-assessment was submitted prior to the inspection and has been analysed;
- discussion with Dr Clare McGowan, registered provider;
- examination of relevant records;
- consultation with relevant staff;
- tour of the premises; and
- evaluation and feedback.

Any other information received by RQIA about this practice has also been considered by the inspector in preparing for this inspection.

5.0 Consultation Process

During the course of the inspection, the inspector spoke with staff on duty. Questionnaires were provided to staff prior to the inspection by the practice, on behalf of the RQIA to establish their views regarding the service. Matters raised by staff were addressed by the inspector during the course of this inspection:

	Number	
Discussion with staff	2	
Staff Questionnaires	2 issued	2 returned

Prior to the inspection the registered person/s were asked, in the form of a declaration, to confirm that they have a process in place for consulting with service users and that a summary of the findings has been made available. The consultation process may be reviewed during this inspection.

6.0 Inspection Focus

The inspection sought to establish the level of compliance achieved with respect to the selected DHSSPS Minimum Standards for Dental Care and Treatment and a thematic focus incorporating selected standards and good practice indicators. An assessment on the progress in relation to the issues raised during and since the previous inspection was also undertaken.

In 2012 the DHSSPS requested that RQIA make compliance with best practice in local decontamination, as outlined in HTM 01-05 Decontamination in Primary Care Dental Premises, a focus for the 2013/14 inspection year.

The DHSSPS and RQIA took the decision to review compliance with best practice over two years. The focus of the two years is as follows:

- Year 1 – Decontamination – 2013/14 inspection year
- Year 2 - Cross infection control – 2014/15 inspection year

Standard 13 – Prevention and Control of Infection [Safe and effective care]

The dental service takes every reasonable precaution to make sure you are not exposed to risk of infection.

The decontamination section of the Infection Prevention Society Audit tool, which has been endorsed by the Department of Health, was used as a framework for development of a self-assessment tool and for planned inspections during 2013/14.

The following sections of the 2013 edition of the Infection Prevention Society Audit tool, which has been endorsed by the Department of Health have been used as a framework for the development of a self-assessment tool and for planned inspections in 2014/15:

- prevention of blood-borne virus exposure;
- environmental design and cleaning;
- hand hygiene;
- management of dental medical devices;
- personal protective equipment; and
- waste.

A number of aspects of the decontamination section of the audit tool have also been revisited.

RQIA have highlighted good practice guidance sources to service providers, making them available on our website where possible. Where appropriate, requirements will be made against legislation and recommendations will be made against DHSSPS Minimum Standards for Dental Care and Treatment (2011) and other recognised good practice guidance documents.

The registered provider/manager and the inspector have each rated the practice's compliance level against each section of the self-assessment.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance statements		
Compliance statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report.
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report.
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report.
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report.
4 – Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report.
5 – Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

7.0 Profile of Service

Ballynahinch Dental Care is located on the main street in Ballynahinch town centre, in a mid- terrace three storey property which has been converted to accommodate a dental practice.

Limited on-street car parking is available for patients but public car parking is situated within easy reach of the practice.

The establishment is not accessible for patients with a disability as it does not have a ground floor surgery; however arrangements are in place with the local community dental clinic in Ballynahinch to accommodate any patents who cannot be treated in the practice.

The practice currently provides three surgeries, a reception, staff room, and storage facilities. A waiting area and toilet for patient use are also available.

Ballynahinch Dental Care provides both private and NHS care. Dr McGowan works alongside a practice manager, a hygienist and a team of nursing staff who also undertake reception duties.

Dr McGowan has been the registered provider/manager for the practice since registration with RQIA in January 2012.

The establishment's statement of purpose outlines the range of services provided.

Ballynahinch Dental Care is registered as an independent hospital (IH) providing dental treatment (DT).

8.0 Summary of Inspection

This announced inspection of Ballynahinch Dental Care was undertaken by Emily Campbell on 17 February 2015 between the hours of 9.55am and 1.15pm. Dr McGowan, registered provider, was available during the inspection and for verbal feedback at the conclusion of the inspection.

The requirement made as a result of the previous inspection was also examined. Observations and discussion demonstrated that this has not been addressed. As this requirement, pertaining to enhanced AccessNI checks, had been stated for the third and final time, a serious concerns meeting was held with Dr McGowan on 16 March 2015. Further details are outlined below and in sections 9.0 and 11.5 of the report.

Prior to the inspection, Dr McGowan completed a self-assessment using the standard criteria outlined in the theme inspected. The comments provided by Dr McGowan in the self-assessment were not altered in any way by RQIA. Dr McGowan omitted to complete the assessed compliance levels against each section in the self-assessment. The self-assessment is included as appendix one in this report.

During the course of the inspection the inspector met with staff, discussed operational issues, examined a selection of records and carried out a general inspection of the establishment.

Questionnaires were also issued to staff; two were returned to RQIA within the timescale required. Review of submitted questionnaires and discussion with staff evidenced that staff were knowledgeable regarding the inspection theme with the exception of the management of spillages; a recommendation was made in this regard. Staff confirmed that they are familiar with the practice policies and procedures and have received infection prevention and control training. Clinical staff also confirmed that they have been immunised against Hepatitis B.

Inspection Theme – Cross infection control

Dental practices in Northern Ireland have been directed by the DHSSPS, that best practice recommendations in the Health Technical Memorandum (HTM) 01-05, Decontamination in primary care dental practices, along with Northern Ireland amendments, should have been fully implemented by November 2012. HTM 01-05 was updated in 2013 and Primary Care Dental Practices were advised of this through the issue of Professional Estates Letter (PEL) (13) 13 on 1 October 2013. The PEL (13) 13 advised General Dental Practitioners of the publication of the 2013 version of HTM 01-05 and the specific policy amendments to the guidance that apply in Northern Ireland.

RQIA reviewed the compliance of the decontamination aspect of HTM 01-05 in the 2013/2014 inspection year. The focus of the inspection for the 2014/2015 inspection year is cross infection control. A number of aspects of the decontamination section of HTM 01-05 have also been revisited.

A copy of HTM 01-05 Decontamination in primary dental care practices was available at the practice; however, this was not the 2013 edition. The 2013 edition was downloaded during the inspection for staff reference. There have been no recent audits undertaken in respect of compliance with HTM 01-05 and a recommendation was made in this regard.

The practice has a policy and procedure in place for the prevention and management of blood-borne virus exposure. However, the procedures for the management of spillages, sharps and inoculation incidents lacked detail. Staff were not clear on the actions to be taken in the event of a blood or bodily fluid spillage and a spillage kit was not available. A recommendation was made to address these matters.

Sharps boxes are signed and dated on final closure, but not on assembly and one sharps box was stored on the floor of a surgery. A blue lidded sharps box was in use in one surgery and purple lidded sharps boxes were not available for the disposal of pharmaceutical waste. A recommendation was made to address these matters.

Discussion with staff evidenced they are aware of the actions to be taken in the event of a sharps injury and advised that there had been no sharps injuries within recent years. The accident/incident recording book was not available in the practice and a recommendation was made in this regard.

Satisfactory arrangements are in place for the cleaning of the general environment and dental equipment. Recommendations were made to seal the flooring in surgeries, refurbish warped cabinetry in one surgery and review the positioning of supplements on display in one surgery. The practice is registered for three dental chairs; however, Dr McGowan advised that one surgery, located on the first floor, is not in use. The dental chair in this surgery has tears and should be repaired before it is brought back into operation. Dr McGowan will consider making application of variation to reduce the number of dental chairs if it is likely to be some time before this surgery is in use again.

The practice has a hand hygiene policy and procedure in place and staff demonstrated that good practice is adhered to in relation to hand hygiene. Dedicated hand washing basins are available in the appropriate locations. The stainless steel dedicated hand washing basins have overflows and a recommendation was made that these should be blanked off. Information promoting hand hygiene is provided for staff and patients.

A legionella risk assessment and written scheme for the prevention of legionella was not available and there are no control measures in place. A requirement was made that these should be developed and control measures implemented. Procedures are in place for the use, maintenance, service and repair of all medical devices. In general dental unit water lines (DUWLs) are appropriately managed, with the exception of purging arrangements. A recommendation was made in this regard.

The practice has a policy and procedure in place for the use of personal protective equipment (PPE) and staff spoken with demonstrated awareness of this. Observations made confirmed that PPE was readily available and used appropriately by staff.

The policy and procedure for the management and disposal of waste, lacked detail and a recommendation was made that this should be further developed. Waste was appropriately segregated and suitable arrangements were in place for the storage and collection of waste by a registered waste carrier. Clinical waste bins are not pedal operated and a recommendation was made in this regard. Relevant consignment notes are retained in the practice for at least three years.

A decontamination room is not available in the practice; however, the decontamination of reusable dental instruments arrangements has been outsourced to the Central Services Sterilisation Department (CSSD) at the Ulster Hospital, Dundonald. Review of documentation and discussion with Dr McGowan and staff confirmed that satisfactory arrangements are in place.

The evidence gathered through the inspection process concluded that Ballynahinch Dental Care is moving towards compliance with this inspection theme.

Dr McGowan confirmed on the submitted self-assessment that arrangements are in place for consultation with patients, at appropriate intervals, that feedback provided by patients has been used by the service to improve and that results of the consultation have been made available to patients. On requesting to see the summary of the most recent patient satisfaction survey, the inspector was advised that not enough questionnaires had been received to provide this. A recommendation was made that a more formalised approach is taken in regard to patient satisfaction surveys. The findings of questionnaires should be collated and a report complied of the results which should be made available to patients.

The RQIA certificate of registration was not on display on the day of the inspection. The practice has recently undergone refurbishment of the reception area of the practice and Dr McGowan advised that the certificate has been taken down during the refurbishment. Under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, the certificate of registration must be displayed in a conspicuous place in the practice. A requirement was made in this regard.

The practice has been registered with RQIA as Ballynahinch Dental Care, however, the signage outside the practice states the name of the practice as Ballynahinch Dental and Implant Centre. This may cause confusion for patients or interested bodies, particularly if they wish to review the RQIA reports about the practice. A recommendation was made in this regard.

Serious Concerns Meeting

During the previous inspection, on 21 January 2014, a requirement was stated for the third and final time to ensure that an AccessNI check was obtained for

an identified staff member and that all newly appointed staff have the required enhanced AccessNI checks in place prior to commencement of employment.

Dr McGowan and a dental nurse confirmed that there have been no new staff employed in the practice since the previous inspection. Dr McGowan confirmed that no new staff will be employed in the practice until an enhanced AccessNI check has been undertaken and received by the practice.

During this inspection the enhanced AccessNI check or records pertaining to it for the identified staff member were not available. Dr McGowan confirmed that the identified staff member was the nominated person for processing the enhanced AccessNI check and Dr McGowan did not know whether or not the check had been received. Subsequently Dr McGowan confirmed that an AccessNI check had been received; however, it was stored in the staff member's house.

The lack of oversight and governance arrangements in this regard is concerning to RQIA. As a result, a serious concerns meeting was held on 16 March 2015 to discuss this matter with Dr McGowan.

At the serious concerns meeting Dr McGowan advised she had still not been provided with the AccessNI check for the identified individual. During the meeting, it was emphasised that responsibility for ensuring that enhanced AccessNI checks are carried out and received lies with Dr McGowan solely. Dr McGowan confirmed that she understood this and provided assurances that appropriate measures would be taken in this regard.

Due to the specific issues regarding the processing of an AccessNI check for the identified staff member, whilst on long term leave, compliance with this requirement cannot be achieved. A requirement was therefore made that the identified staff member must not return to work in the practice until an enhanced AccessNI check has been undertaken and received. Dr McGowan should provide written confirmation to RQIA, prior to the staff member returning to work in the practice, confirming that a satisfactory enhanced AccessNI check has been received.

The retention of records was also discussed at the serious concerns meeting. Dr McGowan was informed that all records as specified in regulation 21 (3) (b), Schedule 3 Part II (6) and (8), of The Independent Health Care Regulations (Northern Ireland) 2005, must be retained in the practice and available for inspection at all times; this includes details of staff recruitment and enhanced AccessNI checks. A requirement was made in this regard.

Four requirements and 13 recommendations were made as a result of the announced inspection, details can be found in the main body of the report and the attached Quality Improvement Plan (QIP).

The inspector wishes to thank Dr McGowan and staff for their helpful discussions, assistance and hospitality throughout the inspection process.

9.0 Follow-up on Previous Issues

No	Regulation Ref.	Requirements	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	19 (2) (d) Schedule 2	Ensure that an AccessNI check is obtained for the identified staff member. Ensure that all newly appointed staff have the required enhanced AccessNI checks in place prior to commencement of employment.	Dr McGowan and a dental nurse confirmed that there have been no new staff employed in the practice since the previous inspection. Dr McGowan confirmed that no new staff will be employed in the practice until an enhanced AccessNI check has been undertaken and received by the practice. The enhanced AccessNI check or records pertaining to it for the identified staff member were not available. Dr McGowan confirmed that the identified staff member was now on long term leave and that this staff member was the nominated person for processing the enhanced AccessNI check. Dr McGowan was unaware if the check had been received. This requirement was stated for the third and final time during the previous inspection and had not been addressed. Following the inspection, Dr McGowan confirmed that having checked with the staff member, she could confirm that an AccessNI check had been received. However, the AccessNI check had been stored in the staff member's house. Without the physical evidence of a disclosure it cannot be confirmed if an enhanced AccessNI check had been undertaken. The lack of oversight and governance	Not compliant

			arrangements in this regard is concerning to RQIA. As a result, a serious concerns meeting was held on 16 March 2015 to discuss this matter with Dr McGowan. At this meeting Dr McGowan advised she had still not been provided with the AccessNI check for the identified individual. Due to the specific issues regarding the processing of an AccessNI check for the identified staff member, whilst they are on long term leave, compliance with this requirement cannot be achieved. A requirement was therefore made that the identified staff member must not return to work in the practice until a satisfactory enhanced AccessNI check has been undertaken and received. Dr McGowan should provide written confirmation to RQIA, prior to the staff member returning to work, confirming that an enhanced AccessNI check has been processed and received, detailing the date the check was received, the unique identifier number and the date the staff member will recommence work at the practice. A requirement was also made during the serious concerns meeting regarding the retention of information at the practice. Further details can be seen in section 11.5 of the report.	

10.0 Inspection Findings

10.1 Prevention of Blood-borne virus exposure

STANDARD 13 – Prevention and Control of Infection (Safe and effective care) **The dental service takes every reasonable precaution to make sure you are not exposed to risk of infection.**
Criteria Assessed: **11.2** You receive care and treatment from a dental team (including temporary members) who have undergone appropriate checks before they start work in the service. **13.2** Your dental service adheres to the appropriate infection control policies and procedures in line with current best practice and legislation. **13.3** Your dental service has systems in place, including induction and ongoing training, to make sure these policies and procedures are known, and are being appropriately applied to the service at all times.
Inspection Findings:
Dr McGowan omitted to rate the compliance level for the practice arrangements for the prevention of blood-borne virus exposure on the self-assessment. The practice has a policy and procedure in place for the prevention and management of blood-borne virus exposure, including management of spillages, sharps and inoculation incidents. However, the following issues were identified: • the procedure for the management of spillages only reflected that spillages should be reported to Dr McGowan and did not include detail of how the spillage should be managed; and • the procedure for the management of sharps and inoculation incidents, included the immediate actions to be taken and that it should be reported to Dr McGowan to assess further action to be taken. It did not detail what this would entail or that advice and guidance would be sought from the local Trust Occupational Health Department. Staff spoken with were not clear on the actions to be taken in the event of a blood or bodily fluid spillage and a spillage kit was not available. A recommendation was made that: • the procedures for the management of blood or bodily fluid spillage and sharps and inoculation incidents should be further developed to address the matters discussed; • staff should be made aware of the actions to be taken in the event of a spillage; and • A blood spillage kit should be provided and staff trained in its use. Dr McGowan was made aware of the availability of spillage kits from dental suppliers. Review of documentation and discussion with Dr McGowan and staff evidenced that: • the prevention and management of blood-borne virus exposure is included in the staff induction programme; • all newly appointed staff will receive an occupational health check; and • records are retained regarding the Hepatitis B immunisation status of clinical staff.

Sharps boxes are safely positioned to prevent unauthorised access; however the sharps box in one surgery was stored on the floor which is not in keeping with good infection control. Sharps boxes are signed and dated on final closure but not on assembly. A blue lidded sharps box was in use in one surgery and purple lidded sharps boxes were not available for the disposal of pharmaceutical waste. A recommendation was made to address these matters. Used sharps boxes are locked with the integral lock and stored ready for collection away from public access.

Discussion with staff evidenced they are aware of the actions to be taken in the event of a sharps injury and advised that there had been no sharps injuries within recent years.

On requesting to see the accident/incident recording book, Dr McGowan advised that this was at her home. A recommendation was made that the accident/ incident book must be retained in the practice at all times to ensure that any incidents or accidents can be recorded at the time of the event.

Provider's overall assessment of the dental practice's compliance level against the standard assessed	**No rating given**
Inspector's overall assessment of the dental practice's compliance level against the standard assessed	**Moving towards compliance**

10.2 Environmental design and cleaning

STANDARD 13 – Prevention and Control of Infection (Safe and effective care) **The dental service takes every reasonable precaution to make sure you are not exposed to risk of infection.**
Criterion Assessed: **13.1** Your dental service's premises are clean.
Inspection Findings:
Dr McGowan omitted to rate the compliance level for the practice arrangements for environmental design and cleaning on the self-assessment. The practice has a policy and procedure in place for cleaning and maintaining the environment. The inspector undertook a tour of the premises which were found to be maintained to a fair standard of cleanliness. The practice is registered for three dental chairs; however, Dr McGowan advised that one surgery, located on the first floor, is not in use. The dental chair in this surgery has two tears and Dr McGowan was advised that this should not be brought back into operation until the chair is re-upholstered. Dr McGowan will consider making application of variation to reduce the number of dental chairs if it is likely to be some time before this surgery is in use again. The relevant application was forwarded to Dr McGowan following the inspection. The remaining surgeries were tidy and uncluttered and work surfaces were intact and easy to clean, with the exception of supplement products which were on display on open shelving in one surgery. A recommendation was made in this regard. Floor coverings are impervious; however, they are not sealed at the edges or where cabinetry meets the flooring. A recommendation was made in this regard. Fixtures, dental chairs and equipment were free from damage, dust and visible dirt. The wood of one piece of cabinetry in the operational surgery on the first floor is warped and a recommendation was made that this should be refurbished. The walls of surgeries are wallpapered and painted. The inspector advised that wallpaper should be removed and made good or cladded over on the next refurbishment of the surgeries. Discussion with staff confirmed that appropriate arrangements are in place for cleaning including: • Equipment surfaces, including the dental chair, are cleaned between each patient; • Daily cleaning of floors, cupboard doors and accessible high level surfaces; • Weekly/monthly cleaning schedule; • Cleaning equipment is colour coded; • Cleaning equipment is stored in a non-clinical area; and • Dirty water is disposed of at an appropriate location. Discussion with staff and review of submitted questionnaires confirmed that staff had received relevant training to undertake their duties.

Provider's overall assessment of the dental practice's compliance level against the standard assessed	**Not rating given**
Inspector's overall assessment of the dental practice's compliance level against the standard assessed	**Substantially compliant**

10.3 Hand Hygiene

STANDARD 13 – Prevention and Control of Infection (Safe and effective care) **The dental service takes every reasonable precaution to make sure you are not exposed to risk of infection.**
Criteria Assessed: **13.2** Your dental service adheres to the appropriate infection control policies and procedures in line with current best practice and legislation. **13.3** Your dental service has systems in place, including induction and ongoing training, to make sure these policies and procedures are known, and are being appropriately applied to the service at all times.
Inspection Findings:
Dr McGowan omitted to rate the compliance level for the practice arrangements for hand hygiene on the self-assessment. The practice did not have a hand hygiene policy and procedure; however, this was developed during the inspection. Staff confirmed that hand hygiene is included in the induction programme and that hand hygiene training is updated periodically. Discussion with staff confirmed that hand hygiene is performed before and after each patient contact and at appropriate intervals. Observations made evidenced that clinical staff had short clean nails and jewellery such as wrist watches and stoned rings were not worn in keeping with good practice. Dedicated hand washing basins are available in the dental surgeries and adequate supplies of liquid soap, paper towels and disinfectant rub/gel were available. The stainless steel dedicated hand washing basins have overflows and a recommendation was made that these should be blanked off with a stainless steel plate sealed with antibacterial mastic. Staff confirmed that nail brushes and bar soap are not used in the hand hygiene process in keeping with good practice. Laminated posters promoting hand hygiene were on display in dental surgeries, the decontamination room and toilet facilities.

Provider's overall assessment of the dental practice's compliance level against the standard assessed	**No rating given**
Inspector's overall assessment of the dental practice's compliance level against the standard assessed	**Substantially compliant**

10.4 Management of Dental Medical Devices

STANDARD 13 – Prevention and Control of Infection (Safe and effective care) **The dental service takes every reasonable precaution to make sure you are not exposed to risk of infection.**
Criterion Assessed: **13.4** Your dental service meets current best practice guidance on the decontamination of reusable dental and medical instruments.
Inspection Findings:
Dr McGowan omitted to rate the compliance level for the practice approach to the management of dental medical devices on the self-assessment. The practice has an infection control policy that includes procedures for the use, maintenance, service and repair of all medical devices. A legionella risk assessment and written scheme for the prevention of legionella was not available and there are no control measures in place. A requirement was made that these should be developed and control measures implemented as necessary. The risk assessment should include details of: • the distribution of hot and cold water supply to all areas of the practice; • identification of hazards; • identification of people at risk; • control measures in place or to be put in place; and • the overall level of assessed risk. The L8 document legionnaires' disease approved code of practice and guidance should be taken into consideration when completing the risk assessment. Staff confirmed that impression materials, prosthetic and orthodontic appliances are decontaminated prior to despatch to laboratory and before being placed in the patient's mouth. Observations made and discussion with staff confirmed that in general DUWLs are appropriately managed. This includes that: • An independent bottled-water system is used to dispense purified water to supply the DUWLs; • Self-contained water bottles are removed, flushed with purified water and left open to the air for drying on a daily basis in accordance with manufacturer's guidance; • DUWLs are drained at the end of each working day; • DUWLs are flushed at the start of each working day and between every patient; and • DUWLs and handpieces are fitted with anti-retraction valves. DUWLs are not purged using disinfectant and a recommendation was made to review the manufacturer's instruction and implement purging procedures as per manufacturer's recommendations. Dr McGowan confirmed that there are no filters in DUWLs which need to be replaced routinely.

Provider's overall assessment of the dental practice's compliance level against the standard assessed	**No rating given**
Inspector's overall assessment of the dental practice's compliance level against the standard assessed	**Moving towards compliance**

10.5 Personal Protective Equipment

STANDARD 13 – Prevention and Control of Infection (Safe and effective care) The dental service takes every reasonable precaution to make sure you are not exposed to risk of infection.
Criterion Assessed: **13.2** Your dental service adheres to the appropriate infection control policies and procedures in line with current best practice and legislation. **13.3** Your dental service has systems in place, including induction and ongoing training, to make sure these policies and procedures are known, and are being appropriately applied to the service at all times.
Inspection Findings:
Dr McGowan omitted to rate the compliance level for the practice approach to the management of personal protective equipment (PPE) on the self-assessment. The practice has a policy and procedure in place for the use of PPE and staff spoken with demonstrated awareness of this. Staff confirmed that the use of PPE is included in the induction programme. Observations made and discussion with staff evidenced that PPE was readily available and in use in the practice. Discussion with staff confirmed that: • Hand hygiene is performed before donning and following the removal of disposable gloves; • Single use PPE is disposed of appropriately after each episode of patient care; • Heavy duty gloves are available for domestic cleaning and decontamination procedures where necessary; and • Eye protection for staff and patients is decontaminated after each episode. Staff confirmed that they were aware of the practice uniform policy.

Provider's overall assessment of the dental practice's compliance level against the standard assessed	**No rating given**
Inspector's overall assessment of the dental practice's compliance level against the standard assessed	**Compliant**

10.6 Waste

STANDARD 13 – Prevention and Control of Infection (Safe and effective care) The dental service takes every reasonable precaution to make sure you are not exposed to risk of infection.
Criterion Assessed: **13.2** Your dental service adheres to the appropriate infection control policies and procedures in line with current best practice and legislation. **13.3** Your dental service has systems in place, including induction and ongoing training, to make sure these policies and procedures are known, and are being appropriately applied to the service at all times..
Inspection Findings:
Dr McGowan omitted to rate the compliance level for the practice approach to the management of waste on the self-assessment. The policy and procedure for the management and disposal of waste, lacked detail and did not identify the various waste streams as outlined in HTM 07-01 and a recommendation was made that this should be further developed. Staff confirmed that the management of waste is included in the induction programme and that waste management training is updated periodically. Review of documentation confirmed that contracted arrangements are in place for the disposal of waste by a registered waste carrier and relevant consignment notes are retained in the practice for at least three years. Observations made and discussion with staff confirmed that staff are aware of the different types of waste and appropriate disposal streams. Clinical waste bins are not pedal operated and a recommendation was made in this regard. Dr McGowan advised that pedal operated bins had been ordered. Appropriate arrangements are in place in the practice for the storage and collection of general and clinical waste, including sharps waste. As discussed in section 10.1 of the report, a recommendation was made regarding the arrangements for sharps and pharmaceutical waste.

Provider's overall assessment of the dental practice's compliance level against the standard assessed	**No rating given**
Inspector's overall assessment of the dental practice's compliance level against the standard assessed	**Substantially compliant**

10.7 Decontamination

STANDARD 13 – Prevention and Control of Infection (Safe and effective care) The dental service takes every reasonable precaution to make sure you are not exposed to risk of infection.
Criterion Assessed: 13.4 Your dental service meets current best practice guidance on the decontamination of reusable dental and medical instruments.
Inspection Findings:
Dr McGowan omitted to rate the compliance level for the decontamination arrangements of the practice on the self-assessment. A decontamination room is not available in the practice; however, the decontamination of reusable dental instruments arrangements has been outsourced to the CSSD at the Ulster Hospital, Dundonald. Review of documentation and discussion with Dr McGowan and staff confirmed that satisfactory arrangements are in place. A copy of HTM 01-05 Decontamination in primary dental care practices was available at the practice; however, this was not the 2013 edition. The 2013 edition was downloaded during the inspection for staff reference. There have been no recent audits undertaken in respect of compliance with HTM 01-05 and a recommendation was made in this regard. Audits should be undertaken on a six monthly basis. The inspector provided the practice with a copy of the Infection Prevention Society (IPS) 2013 edition HTM 01-05 audit tool following the inspection.

Provider's overall assessment of the dental practice's compliance level against the standard assessed	**No rating given**
Inspector's overall assessment of the dental practice's compliance level against the standard assessed	**Substantially compliant**

Inspector's overall assessment of the dental practice's compliance level against the standard assessed	**Compliance Level**
	Moving towards compliance

11.0 Additional Areas Examined

11.1 Staff Consultation/Questionnaires

During the course of the inspection, the inspector spoke with two dental nurses, one of whom is acting as the temporary practice manager. Questionnaires were also provided to staff prior to the inspection by the practice on behalf of the RQIA. Two were returned to RQIA within the timescale required.

Review of submitted questionnaires and discussion with staff evidenced that staff were knowledgeable regarding the inspection theme with the exception of the management of spillages as identified previously. Staff confirmed that they are familiar with the practice policies and procedures and have received infection prevention and control training. Clinical staff also confirmed that they have been immunised against Hepatitis B.

11.2 Patient Consultation

Dr McGowan confirmed on the submitted self-assessment that arrangements are in place for consultation with patients, at appropriate intervals, that feedback provided by patients has been used by the service to improve and that results of the consultation have been made available to patients. On requesting to see the summary of the most recent patient satisfaction survey, the inspector was advised that not enough questionnaires had been received to provide this. Questionnaires are left at reception for patients to complete if they wish. This was discussed with Dr McGowan and a recommendation was made that a more formalised approach is taken in regard to patient satisfaction surveys. The findings of questionnaires should be collated and a report complied of the results which should be made available to patients. The inspector discussed ways in which a more proactive approach could be taken.

11.3 Certificate of Registration

The RQIA certificate of registration was not on display on the day of the inspection. The practice has recently undergone refurbishment of the reception area of the practice and Dr McGowan advised that the certificate has been taken down during the refurbishment.

Under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, the certificate of registration must be displayed in a conspicuous place in the practice. A requirement was made in this regard.

11.4 Signage

The practice has been registered with RQIA as Ballynahinch Dental Care; however, the signage outside the practice states the name of the practice as Ballynahinch Dental and Implant Centre. This may cause confusion for patients or interested bodies, particularly if they wish to review the RQIA reports about the practice. The dental nurse, acting as practice manager, confirmed that the practice used to be

known as Ballynahinch Dental and Implant Centre, however, the name changed when the implant service ceased. The dental nurse advised that new signage was being arranged in the near future. A recommendation was made in this regard.

11.5 Serious Concerns Meeting

During the previous inspection, on 21 January 2014, a requirement was stated for the third and final time to ensure that an AccessNI check was obtained for an identified staff member and that all newly appointed staff have the required enhanced AccessNI checks in place prior to commencement of employment.

Dr McGowan and a dental nurse confirmed that there have been no new staff employed in the practice since the previous inspection. Dr McGowan confirmed that no new staff will be employed in the practice until an enhanced AccessNI check has been undertaken and received by the practice.

The response in the inspection QIP for 21 January 2014, submitted by Dr McGowan, indicated that she had not yet received an AccessNI check and that the identified staff member was no longer working at the practice. However, during this inspection, it was clarified that the identified staff member had not left the practice but was on long term leave.

The enhanced AccessNI check and records pertaining to it for the identified staff member were not available. Dr McGowan confirmed that the identified staff member, was the nominated person for processing the enhanced AccessNI check and Dr McGowan did not know if the check had been received. On 18 February 2015, Dr McGowan confirmed that having checked with the staff member that an AccessNI check had been received. However, the AccessNI check had been stored in the staff member's house. Without the physical evidence of a disclosure it cannot be confirmed if an enhanced AccessNI check had been undertaken.

The lack of oversight and governance arrangements in this regard is concerning to RQIA. As a result, a serious concerns meeting was held on 16 March 2015 to discuss this matter with Dr McGowan.

At the serious concerns meeting Dr McGowan advised she had still not been provided with the AccessNI check for the identified individual.

During the serious concerns meeting, it was emphasised that the responsibility for ensuring that enhanced AccessNI checks are carried out and received lies with Dr McGowan solely, and if she delegates responsibility to someone else for progressing checks, she must have appropriate governance arrangements in place to oversee this. Dr McGowan confirmed that she fully understood this and provided assurances that appropriate measures would be taken in this regard.

Due to the specific issues regarding the processing of an AccessNI check for the identified staff member, whilst they are on long term leave, compliance with this requirement cannot be achieved. A requirement was therefore made that the identified staff member must not return to work in the practice until an enhanced AccessNI check has been undertaken and received by the practice. Dr McGowan should provide written confirmation to RQIA, prior to the staff member returning to

work in the practice, confirming that a satisfactory enhanced AccessNI check has been processed and received, detailing the date the check was received, the unique identifier number and the date the staff member will recommence work at the practice.

The retention of records was also discussed at the serious concerns meeting. Dr McGowan was informed that all records as specified in regulation 21 (3) (b), Schedule 3 Part II (6) and (8), of The Independent Health Care Regulations (Northern Ireland) 2005, must be retained in the practice and available for inspection at all times; this includes details of staff recruitment and enhanced AccessNI checks. A requirement was made in this regard. Dr McGowan provided verbal assurance during the meeting that arrangements would be put in place to ensure that all appropriate records are retained in the practice.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Dr Clare McGowan as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider/manager is required to record comments on the Quality Improvement Plan.

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

Enquiries relating to this report should be addressed to:

Emily Campbell
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

The Regulation and Quality Improvement Authority

Self Assessment audit tool of compliance with

HTM01-05 - Decontamination - Cross Infection Control

Name of practice:	**Ballynahinch Dental Care**
RQIA ID:	**11382**
Name of inspector:	**Emily Campbell**

This self-assessment tool should be completed in reflection of the current decontamination and cross infection control arrangements in your practice.

THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501

1 Prevention of bloodborne virus exposure			
Inspection criteria *(Numbers in brackets reflect HTM 01-05/policy reference)*	**Yes**	**No**	**If NO provide rationale and actions to be taken with timescales to achieve compliance with HTM 01-05.**
1.1 Does the practice have a policy and procedure/s in place for the prevention and management of blood borne virus exposure, including management of spillages, sharps and inoculation incidents in accordance with national guidance? (2.6)	✓		
1.2 Have all staff received training in relation to the prevention and management of blood-borne virus exposure? (1.22, 9.1, 9.5)	✓		
1.3 Have all staff at risk from sharps injuries received an Occupational Health check in relation to risk reduction in blood-borne virus transmission and general infection? (2.6)	✓		
1.4 Can decontamination and clinical staff demonstrate current immunisation with the hepatitis B vaccine e.g. documentation? (2.4s, 8.8)	✓		
1.5 Are chlorine-releasing agents available for blood /bodily fluid spillages and used as per manufacturer's instructions? (6.74)	✓		
1.6 ***Management of sharps*** **Any references to sharps management should be read in conjunction with The Health and Safety (Sharp Instruments in Healthcare) Regulations (Northern Ireland) 2013** Are sharps containers correctly assembled?	✓		

1.7 Are in-use sharps containers labelled with date, locality and a signature?	✓		
1.8 Are sharps containers replaced when filled to the indicator mark?	✓		
1.9 Are sharps containers locked with the integral lock when filled to the indicator mark? Then dated and signed?	✓		
1.10 Are full sharps containers stored in a secure facility away from public access?	✓		
1.11 Are sharps containers available at the point of use and positioned safely (e.g. wall mounted)?		✓	Not wall mounted but kept behind cupboard out of reach of patiences
1.12 Is there a readily-accessible protocol in place that ensures staff are dealt with in accordance with national guidance in the event of blood-borne virus exposure? (2.6)	✓		
1.13 Are inoculation injuries recorded?	✓		
1.14 Are disposable needles and disposable syringes discarded as a single unit?	✓		

Provider's level of compliance	Provider to complete

2 Environmental design and cleaning			
Inspection criteria	**Yes**	**No**	**If NO provide rationale and actions to be taken with timescales to achieve compliance with HTM 01-05.**
2.1 Does the practice have a policy and procedure for cleaning and maintaining the environment? (2.6, 6.54)	✓		
2.2 Have staff undertaking cleaning duties been fully trained to undertake such duties? (6.55)	✓		
2.3 Is the overall appearance of the clinical and decontamination environment tidy and uncluttered? (5.6)	✓		
2.4 Is the dental chair cleaned between each patient? (6.46, 6.62)	✓		
2.5 Is the dental chair free from rips or tears? (6.62)	✓		
2.6 Are all surfaces i.e. walls, floors, ceilings, fixtures and fittings and chairs free from damage and abrasion? (6.38)	✓		
2.7 Are all work-surface joints intact, seamless, with no visible damage? (6.46, 6.47)	✓		
2.8 Are all surfaces i.e. walls, floors, ceilings, fixtures and fittings and chairs free from dust and visible dirt? (6.38)	✓		
2.9 Are the surfaces of accessible ventilation fittings/grills cleaned at a minimum weekly? (6.64)	✓		
2.10 Are all surfaces including flooring in clinical and decontamination areas impervious and easy to clean? (6.46, 6.64)	✓		

2.11 Do all floor coverings in clinical and decontamination areas have coved edges that are sealed and impervious to moisture? (6.47)	✓		
2.12 Are keyboard covers or "easy-clean" waterproof keyboards used in clinical areas? (6.66)	✓		
2.13 Are toys provided easily cleaned? (6.73)	✓		
2.14 Confirm free standing or ceiling mounted fans are not used in clinical/ decontamination areas? (6.40)	✓		
2.15 Is cleaning equipment colour-coded, in accordance with the National Patient Safety Agency recommendations as detailed in HTM 01-05? (6.53)	✓		
2.16 Is cleaning equipment stored in a non-clinical area? (6.60)	✓		
2.17 Where disposable single-use covers are used, are they discarded after each patient contact? (6.65)	✓		
2.18 Are the surfaces of equipment cleaned between each patient (E.g. work surfaces, dental chairs, curing lamps, delivery units, inspection handles and lights, spittoons, external surface of aspirator and X-ray heads)? (6.62)	✓		
2.19 Are all taps, drainage points, splash backs, sinks, aspirators, drains, spittoons, cleaned after every session with a surfactant/detergent? (6.63)	✓		
2.20 Are floors, cupboard doors and accessible high level surfaces and floors cleaned daily? (6.63)	✓		

2.21 Is there a designated area for the disposal of dirty water, which is outside the kitchen, clinical and decontamination areas; for example toilet, drain or slop-hopper (slop hopper is a device used for the disposal of liquid or solid waste)?	✓		
2.22 Does the practice have a local policy and procedure/s for spillage in accordance with COSHH? (2.4d, 2.6)	✓		
Provider's level of compliance			Provider to complete

3 Hand hygiene			
Inspection criteria	**Yes**	**No**	**If NO provide rationale and actions to be taken with timescales to achieve compliance with HTM 01-05.**
3.1 Does the practice have a local policy and procedure for hand hygiene? (2.6 Appendix 1)	✓		
3.2 Is hand hygiene an integral part of staff induction? (6.3)	✓		
3.3 Is hand hygiene training provided periodically throughout the year? (1.22, 6.3)	✓		
3.4 Is hand hygiene carried out before and after every new patient contact? (Appendix 1)	✓		
3.5 Is hand hygiene performed before donning and following the removal of gloves? (6.4, Appendix 1)	✓		
3.6 Do all staff involved in any clinical and decontamination procedures have short nails that are clean and free from nail extensions and varnish? (6.8, 6.23, Appendix 1)	✓		
3.7 Do all clinical and decontamination staff remove wrist watches, wrist jewellery, rings with stones during clinical and decontamination procedures? (6.9, 6.22)	✓		
3.8 Are there laminated or wipe-clean posters promoting hand hygiene on display? (6.12)	✓		
3.9 Is there a separate dedicated hand basin provided for hand hygiene in each surgery where clinical practice takes place? (2.4g, 6.10)	✓		

3.10 Is there a separate dedicated hand basin available in each room where the decontamination of equipment takes place? (2.4u, 5.7, 6.10)	✓		
3.11 Are wash-hand basins free from equipment and other utility items? (2.4g, 5.7)	✓		
3.12 Are hand hygiene facilities clean and intact (check sinks taps, splash backs, soap and paper towel dispensers)? (6.11, 6.63)	✓		
3.13 Do the hand washing basins provided in clinical and decontamination areas have : • no plug; and • no overflow. Lever operated or sensor operated taps.(6.10)	✓		
3.14 Confirm nailbrushes are not used at wash-hand basins? (Appendix 1)	✓		
3.15 Is there good quality, mild liquid soap dispensed from single-use cartridge or containers available at each wash-hand basin? Bar soap should not be used. (6.5, Appendix 1)	✓		
3.16 Is skin disinfectant rub/gel available at the point of care? (Appendix 1)	✓		
3.17 Are good quality disposable absorbent paper towels used at all wash-hand basins? (6.6, Appendix 1)	✓		

3.18 Are hand-cream dispensers with disposable cartridges available for all clinical and decontamination staff? (6.7, Appendix 1)	✓		
Provider's level of compliance			Provider to complete

4 Management of dental medical devices			
Inspection criteria	**Yes**	**No**	**If NO provide rationale and actions to be taken with timescales to achieve compliance with HTM 01-05.**
4.1 Does the practice have an infection control policy that includes procedures for the use, maintenance, service and repair of all medical devices? (1.18, 2.4a, 2.6, 2.7, 3.54)	✓		
4.2 Has the practice carried out a risk assessment for legionella under the Health and Safety Commission's "Legionnaires' disease - the control of legionella bacteria in water systems Approved Code of Practice and Guidance" (also known as L8)? (6.75-6.90, 19.0)	✓		
4.3 Has the practice a written scheme for prevention of legionella contamination in water pipes and other water lines?(6.75, 19.2)	✓		
4.4 Impression material, prosthetic and orthodontic appliances: Are impression materials, prosthetic and orthodontic appliances decontaminated in the surgery prior to despatch to laboratory in accordance with manufacturer's instructions?(7.0)	✓		
4.5 Impression material, prosthetic and orthodontic appliances: Are prosthetic and orthodontic appliances decontaminated before being placed in the patient's mouth? (7.1b)	✓		
4.6 Dental Unit Water lines (DUWLs): Are in-line filters cleaned/replaced as per manufacturer's instructions?(6.89, 6.90)	✓		

4.7 Dental Unit Water lines (DUWLs): Is there an independent bottled-water system used to dispense distilled, reverse osmosis (RO) or sterile water to supply the DUWL? (6.84)	✓		
4.8 Dental Unit Water lines (DUWLs): For dental surgical procedures involving irrigation; is a separate single-use sterile water source used for irrigation? (6.91)	✓		
4.9 Dental Unit Water lines (DUWLs): Are the DUWLs drained down at the end of every working day?(6.82)	✓		
4.10 Dental Unit Water lines (DUWLs): Are self-contained water bottles (bottled water system) removed, flushed with distilled or RO water and left open to the air for drying on a daily basis, and if necessary overnight, and in accordance with manufacturer's guidance? (6.83)	✓		
4.11 Dental Unit Water lines (DUWLs): Where bottled water systems are not used is there a physical air gap separating dental unit waterlines from mains water systems. (Type A)?(6.84)	✓		
4.12 Dental Unit Water lines (DUWLs): Are DUWLs flushed for a minimum of 2 minutes at start of each working day and for a minimum of 20-30 seconds between every patient? (6.85)	✓		
4.13 Dental Unit Water lines (DUWLs): Are all DUWL and hand pieces fitted with anti-retraction valves? (6.87)	✓		
4.14 Dental Unit Water lines (DUWLs): Are DUWLs either disposable or purged using manufacturer's recommended disinfectants? (6.84-6.86)	✓		

4.15 Dental Unit Water lines (DUWLs): Are DUWL filters changed according to the manufacturer's guidelines? (6.89)	✓		
Provider's level of compliance			Provider to complete

5 Personal Protective Equipment			
Inspection criteria	**Yes**	**No**	**If NO provide rationale and actions to be taken with timescales to achieve compliance with HTM 01-05.**
5.1 Does the practice have a policy and procedures for the use of personal protective equipment? (2.6, 6.13)	✓		
5.2 Are staff trained in the use of personal protective equipment as part of the practice induction? (6.13)	✓		
5.3 Are powder-free CE marked gloves used in the practice? (6.20)	✓		
5.4 Are alternatives to latex gloves available? (6.19, 6.20)	✓		
5.5 Are all single-use PPE disposed of after each episode of patient care? (6.21, 6.25, 6.36c)	✓		
5.6 Is hand hygiene performed before donning and following the removal of gloves? (6.4 Appendix 1)	✓		
5.7 Are clean, heavy duty household gloves available for domestic cleaning and decontamination procedures where necessary? (6.23)	✓		
5.8 Are heavy-duty household gloves washed with detergent and hot water and left to dry after each use? (6.23)	✓		
5.9 Are heavy-duty household gloves replaced weekly or more frequently if worn or torn? (6.23)	✓		

5.10 Are disposable plastic aprons worn during all decontamination processes or clinical procedures where there is a risk that clothing/uniform may become contaminated? (6.14, 6.24-6.25)	✓		
5.11 Are single-use plastic aprons disposed of as clinical waste after each procedure? (6.25)	✓		
5.12 Are plastic aprons, goggles, masks or face shields used for any clinical and decontamination procedures where there is a danger of splashes? (6.14, 6.26-6.29)	✓		
5.13 Are masks disposed of as clinical waste after each use? (6.27, 6.36)	✓		
5.14 Are all items of PPE stored in accordance with manufacturers' instructions? (6.14)	✓		
5.15 Are uniforms worn by all staff changed at the end of each day and when visibly contaminated? (6.34)	✓		
5.16 Is eye protection for staff used during decontamination procedures cleaned after each session or sooner if visibly contaminated? (6.29)	✓		
5.17 Is eye protection provided for the patient and staff decontaminated after each episode of patient care? (6.29)	✓		
Provider's level of compliance			Provider to complete

6 Waste			
Inspection criteria	**Yes**	**No**	**If NO provide rationale and actions to be taken with timescales to achieve compliance with HTM 07-01.**
6.1 Does the practice have a policy and procedure/s for the management and disposal of waste? (2.6, 6.1 (07-01) 6.4 (07-01))	✓		
6.2 Have all staff attended induction and on-going training in the process of waste disposal? (1.22, 6.43 (07-01) 6.51 (07-01))	✓		
6.3 Is there evidence that the waste contractor is a registered waste carrier? (6.87 (07-01) 6.90 (07-01))	✓		
6.4 Are all disposable PPE disposed of as clinical waste? (6.26, 6.27, 6.36, HTM 07-01 PEL (13) 14)	✓		
6.5 Are orange bags used for infectious Category B waste such as blooded swabs and blood contaminated gloves? (HTM 07-01, PEL (13) 14, 5.39 (07-01) Chapter 10 - Dental 12 (07-01))	✓		
6.6 Are black/orange bags used for offensive/hygiene waste such as non-infectious recognisable healthcare waste e.g. gowns, tissues, non-contaminated gloves, X-ray film, etc, which are not contaminated with saliva, blood, medicines, chemicals or amalgam? (HTM 07-01, PEL (13) 14, 5.50 (07-01) Chapter 10-Dental 8 (07-01))	✓		
6.8 Are black/clear bags used for domestic waste including paper towels? (HTM 07-01, PEL (13) 14, 5.51 (07-01))	✓		

6.9 Are bins foot operated or sensor controlled, lidded and in good working order? (5.90 (07-01))		✓	no foot pedles as of yet however they have been ordered in.
6.10 Are local anaesthetic cartridges and other Prescription Only Medicines (POMs) disposed of in yellow containers with a purple lid that conforms to BS 7320 (1990)/UN 3291? (HTM 07-01 PEL (13) 14, Chapter 10 - Dental 11 (07-01))	✓		
6.11 Are clinical waste sacks securely tied and sharps containers locked before disposal? (5.87 (07-01))	✓		
6.12 Are all clinical waste bags and sharps containers labelled before disposal? (5.23 (07-01), 5.25 (07-01))	✓		
6.13 Is waste awaiting collection stored in a safe and secure location away from the public within the practice premises? (5.33 (07-01), 5.96 (07-01))	✓		
6.14 Are all clinical waste bags fully described using the appropriate European Waste Catalogue (EWC) Codes as listed in HTM 07-01 (Safe Management of Healthcare Waste)?(3.32 (07-01))	✓		
6.15 Are all consignment notes for all hazardous waste retained for at least 3 years?(6.105 (07-01))	✓		
6.16 Has the practice been assured that a "duty of care" audit has been undertaken and recorded from producer to final disposal? (6.1 (07-01), 6.9 (07-01))	✓		
6.17 Is there evidence the practice is segregating waste in accordance with HTM 07-01? (5.86 (07-01), 5.88 (07-01), 4.18 (07-01))	✓		
Provider's level of compliance			Provider to complete

7 Decontamination			
Inspection criteria	**Yes**	**No**	**If NO provide rationale and actions to be taken with timescales to achieve compliance with HTM 01-05.**
7.1 Does the practice have a room separate from the patient treatment area, dedicated to decontamination meeting best practice standards? (5.3–5.8)		✓	All Decontamination of instraments is carried out by CSSD
7.2 Does the practice have washer disinfector(s) in sufficient numbers to meet the practice requirements? (PEL(13)13)		✓	All Decontamination is carried out by CSSD
7.3 Are all reusable instruments being disinfected using the washer disinfector? (PEL(13)13)		✓	All Decontamination of instraments is carried out by CSSD
7.4 Does the practice have steam sterilisers in sufficient numbers to meet the practice requirements?		✓	All Decontamination of instraments is carried out by CSSD
7.5 a Has all equipment used in the decontamination process been validated? **7.5 b** Are arrangements in place to ensure that all equipment is validated annually? (1.9, 11.1, 11.6, 12,13, 14.1, 14.2, 15.6)		✓	All Decontamination of instraments is carried out by CSSD
7.6 Have separate log books been established for each piece of equipment? Does the log book contain all relevant information as outlined in HTM01-05? (11.9)		✓	All CSSD records are kepted in log books

7.7 a Are daily, weekly, monthly periodic tests undertaken and recorded in the log books as outlined in HTM 01-05? (12, 13, 14) **7.7 b** Is there a system in place to record cycle parameters of equipment such as a data logger?		✓	All CSSD records are kepted in log books
Provider's level of compliance			Provider to complete

Please provide any comments you wish to add regarding good practice

Appendix 1

The Regulation and Quality Improvement Authority

Name of practice: Ballynahinch Dental Care

Declaration on consultation with patients

The need for consultation with patients is outlined in The Independent Health Care Regulations (Northern Ireland) 2005, Regulation 17(3) and The Minimum Standards for Dental Care and Treatment 2011, Standard 9.

1 Do you have a system in place for consultation with patients, undertaken at appropriate intervals?

Yes ☑ No ☐

If no or other please give details:

2 If appropriate has the feedback provided by patients been used by the service to improve?

Yes ☑ No ☐

3 Are the results of the consultation made available to patients?

Yes ☑ No ☐

Quality Improvement Plan

Announced Inspection

Ballynahinch Dental Care

17 February 2015

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with Dr Clare McGowan either during or after the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers/managers should note that failure to comply with regulations may lead to further enforcement and/or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider/manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

STATUTORY REQUIREMENTS

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Independent Health Care Regulations (NI) 2005 as amended.

NO.	REGULATION REFERENCE	REQUIREMENTS	NUMBER OF TIMES STATED	DETAILS OF ACTION TAKEN BY REGISTERED PERSON(S)	TIMESCALE
1	19 (2) (d) Schedule 2	The identified staff member must not return to work in the practice until a satisfactory enhanced AccessNI check has been undertaken and received by the practice. Dr McGowan should provide written confirmation to RQIA, prior to the staff member returning to work, confirming that an enhanced AccessNI check has been processed and received, detailing the date the check was received, the unique identifier number and the date the staff member will recommence work at the practice. **Note** A requirement was stated for the third and final time, during the previous inspection, in relation to obtaining enhanced AccessNI checks for staff prior to commencing work. Due to the specific issues regarding the processing of an AccessNI check for an identified staff member, whilst they are on long term leave, compliance with this requirement cannot be achieved. Subsequently this requirement has been made. **Ref 9.0 & 11.5**	One	staff member has been made redundant	Prior to the identified staff member returning to work.

2	21 (3) (b), Schedule 3 Part II (6) (8)	All records as specified in regulation 21 (3) (b), Schedule 3 Part II (6) and (8) of The Independent Health Care Regulations (Northern Ireland) 2005, must be retained in the practice and available for inspection at all times. **Ref 9.0 & 11.5**	One		From 16 March 2015 and ongoing
3	25 (2)	A legionella risk assessment and written scheme for the prevention of legionella should be developed and control measures implemented as necessary. The legionella risk assessment should include details of: • the distribution of hot and cold water supply to all areas of the practice; • identification of hazards; • identification of people at risk; • control measures in place or to be put in place; and • the overall level of assessed risk. The L8 document legionnaires' disease approved code of practice and guidance should be taken into consideration when completing the risk assessment. **Ref 10.4**	One	complete	Three months

4	The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 28 (1)	The RQIA certificate of registration must be displayed in a conspicuous place in the practice. **Ref 11.3**	One	please provide a copy of this	One week

RECOMMENDATIONS

These recommendations are based on The Minimum Standards for Dental Care and Treatment (2011), research or recognised sources. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

NO.	MINIMUM STANDARD REFERENCE	RECOMMENDATIONS	NUMBER OF TIMES STATED	DETAILS OF ACTION TAKEN BY REGISTERED PERSON(S)	TIMESCALE
1	13	The procedures for • the management of blood or bodily fluid spillage; and • sharps and inoculation incidents should be further developed as identified in the body of the report. Staff should be made aware of the actions to be taken in the event of a spillage. A blood spillage kit should be provided and staff trained in its use. **Ref 10.1**	One	complete and blood pillages kit ordered	Three months
2	13	Sharps boxes should be signed and dated on assembly. Sharps boxes should not be stored on the floor. General sharps waste should be disposed of in an orange lidded sharps boxes - blue lidded sharps boxes should not be in use. Purple lidded sharps boxes should be provided for the disposal of pharmaceutical waste. **Ref 10.1**	One	complete	Immediate and ongoing One month

3	13	The accident/ incident book must be retained in the practice at all times to ensure that any incidents or accidents can be recorded at the time of the event. **Ref 10.1**	One	complete	Immediate and ongoing
4	13	Review the positioning of supplement products in the identified surgery and ensure they are enclosed to facilitate effective cleaning or removed from the surgery. **Ref 10.2**	One	complete	One month
5	13	Floor coverings in surgeries should be sealed at the edges and where cabinetry meets the flooring. **Ref 10.2**	One	complete	Three months
6	13	The warped cabinetry in the operational surgery on the first floor should be refurbished. **Ref 10.2**	One	complete	Three months
7	13	The overflows of the dedicated hand washing basins in surgeries should be blanked off with a stainless steel plate sealed with antibacterial mastic. **Ref 10.3**	One	complete	Three months
8	13	Review the manufacturer's instruction and ensure dental unit water lines (DUWLs) are purged with a disinfectant as recommended by the manufacturer. **Ref 10.4**	One	complete	One month

9	13	The policy and procedure for the management and disposal of waste should be further developed and should include details of the various waste streams as outlined in HTM 07-01. **Ref 10.6**	One	complete	Three months
10	13	Clinical waste bins should be pedal operated. **Ref 10.6**	One	ordered	One month
11	13	The Infection Prevention Society (IPS) audit for the 2013 edition HTM 01-05 should be undertaken on a six monthly basis. **Ref 10.7**	One	complete	Three months
12	9.4	A more formalised approach should be taken in regard to patient satisfaction surveys. The findings of questionnaires should be collated and a report complied of the results which should be made available to patients. **Ref 11.2**	One	complete	Three months
13	1	The signage outside the practice should be replaced to reflect the name of the practice as Ballynahinch Dental Care and not Ballynahinch Dental and Implant Centre. **Ref 11.4**	One	ongoing	Three months

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person and return to independent.healthcare@rqia.org.uk

Name of Registered Manager Completing QIP	
Name of Responsible Person / Identified Responsible Person Approving QIP	Dr Clare McGowan

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	yes	Emily Campbell	21.5.15
Further information requested from provider			