Announced Inspection

Name of Establishment:	**Boyd Logue Associates**
Establishment ID No:	**11400**
Date of Inspection:	**06 August 2014**
Inspector's Name:	**Stephen O'Connor**
Inspection No:	**18286**

The Regulation and Quality Improvement Authority
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501

1.0 General Information

Name of establishment:	Boyd Logue Associates
Address:	4-6 Lodge Road COLERAINE BT52 1NB
Telephone number:	028 7034 4411
Registered organisation / Responsible persons:	Mr Terence Boyd Mr Stephen Boyd Mr Peter Boyd
Registered manager:	Mrs Gail Crawford
Person in charge of the establishment at the time of Inspection:	Mr Terence Boyd
Registration category:	IH-DT
Type of service provision:	Private dental treatment
Maximum number of places registered: (dental chairs)	7
Date and type of previous inspection:	Announced Inspection 26 April 2013
Date and time of inspection:	6 August 2014 09:55 – 12:10
Name of inspector:	Stephen O'Connor

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 Mr Terence Boyd, responsible person and Mrs Gail Crawford, registered manager;
- 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	5	
Staff Questionnaires	26 issued	19 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

Boyd Logue Associates dental practice is located in a former residential property comprising two mid terraced listed houses. The building has been extensively renovated and adapted to accommodate a dental surgery. The practice is close to Coleraine town centre and public transport routes.

Car parking is available for patients at the rear of the practice and includes a disabled bay.

The establishment is accessible for patients with a disability with two surgeries and a disabled toilet located on the ground floor of the practice.

The practice currently provides seven surgeries, a separate decontamination room, x ray room, reception area, staff and storage facilities. Waiting areas and toilets for patient use are also available.

Boyd Logue Associates operates seven dental chairs, providing both private and NHS dental care. Mr Boyd works alongside seven other associate dentists and a hygienist. The registered dental practitioners are supported by Mrs Gail Crawford, registered manager, an assistant practice manager, a team of dental nurses and administrative staff, a decontamination assistant and a maintenance/repair person. Mrs Crawford has been the registered manager for the practice since May 2012.

Following the previous inspection Mr Robert Logue notified RQIA that he is no longer a responsible person for Boyd Logue Associates. Responsible person applications in respect of Mr Stephen Boyd and Mr Peter Boyd were subsequently submitted to RQIA. Following review of these applications registration of Mr Stephen Boyd and Mr Peter Boyd was recommended, registration as responsible persons is effective from 9 January 2014.

The responsible persons and registered manager are also the responsible persons and registered manager of Boyd Logue Associates located in Portrush.

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

Boyd Logue Associates is registered as an independent hospital (IH) providing dental treatment (DT).

8.0 Summary of Inspection

This announced inspection of Boyd Logue Associates was undertaken by Stephen O'Connor on 6 August 2014 between the hours of 09:55 and 12:10. The inspection was facilitated by Mrs Gail Crawford, registered manager and the assistant practice manager, who were both available for verbal feedback at the conclusion of the inspection. Mr Terence Boyd, responsible person was available at the conclusion of the inspection for verbal feedback. Mr Stephen Boyd and Mr Peter Boyd, responsible persons do not undertake any clinical work in the practice.

The requirement and recommendations made as a result of the previous inspection were also examined. Observations and discussion demonstrated that the requirement and recommendations have been addressed and compliance achieved. The detail of the action taken by the responsible persons and registered manager can be viewed in the section following this summary.

Prior to the inspection, the responsible persons/registered manager completed a self-assessment using the standard criteria outlined in the theme inspected. The comments provided by the responsible persons/registered manager in the self-assessment were not altered in any way by RQIA. 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; 19 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 and that they have received training appropriate to their relevant roles. Staff confirmed that they are familiar with the practice policies and procedures and have received infection prevention and control training. Clinical staff 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 the 2013 edition of HTM 01-05 Decontamination in primary dental care practices is available at the practice for staff reference. Staff are familiar with best practice guidance outlined in the document and audit compliance on an ongoing basis.

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 in accordance with national guidance. Review of documentation and discussion with Mrs Crawford and staff evidenced that appropriate arrangements are in place for the prevention and management of blood-borne virus exposure. Staff confirmed that they are aware of and are adhering to the practice policy in this regard. Sharps management at the practice was observed to be in line with best practice.

The premises were clean and tidy and clutter was kept to a minimum. Satisfactory arrangements are in place for the cleaning of the general environment and dental equipment. It was observed that a number of surgeries are partially carpeted and two surgeries have decorative curtains in place. Best practice in to these issues was discussed with Mr Boyd and Mrs Crawford and recommendations were made to address them.

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. A recommendation was made that overflows in all dedicated hand washing basins should be blanked off using stainless steel plates and sealed with antibacterial mastic. Information promoting hand hygiene is provided for staff and patients.

A written scheme for the prevention of legionella is available. Procedures are in place for the use, maintenance, service and repair of all medical devices. Observations made and discussion with staff confirmed that dental unit water lines (DUWLs) are appropriately managed.

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.

Appropriate arrangements were in place for the management of general and clinical waste, including sharps. Waste was appropriately segregated and suitable arrangements were in place for the storage and collection of waste by a registered waste carrier. Relevant consignment notes are retained in the practice for at least three years.

A decontamination room separate from patient treatment areas and dedicated to the decontamination process is available. Appropriate validated equipment, including two washer disinfectors and four steam sterilisers have been provided to meet the practice requirements. Equipment logbooks evidenced that periodic tests are undertaken and recorded in keeping with HTM 01-05.

The evidence gathered through the inspection process concluded that Boyd Logue Associates is substantially compliant with this inspection theme.

The responsible persons/registered manager 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.

Three 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 Mr Boyd, Mrs Crawford 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(2)	Ensure that an enhanced AccessNI check is received prior to new staff commencing work in the practice. Process an enhanced AccessNI check for the identified staff members.	Review of documentation and discussion with Mrs Crawford demonstrated that AccessNI checks have been received for the staff members identified during the previous inspection. Mrs Crawford confirmed that AccessNI checks were received prior to staff commencing work for all staff recruited since the previous inspection. Best practice guidance in regards to the management of disclosure certificates was discussed with Mrs Crawford and the assistant practice manager during the inspection. This requirement has been addressed.	Compliant

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	13.2	Ensure transport containers are disinfected following each use using a disinfectant specifically formulated for use on medical devices.	Discussion with staff demonstrated that transport containers are appropriately cleaned following use. This recommendation has been addressed.	Compliant
2	13.2	Ensure that all wrapped sterilised instruments are clearly dated with the use-by date as opposed to the date they were processed.	Observation and discussion with staff demonstrated that wrapped instruments are dated with a use-by date. This recommendation has been addressed.	Compliant
3	14.4	Ensure that the ultrasonic cleaner is maintained and validated in line with HTM 01-04 or the manufacturer's instructions and records are retained for inspection.	Review of documentation demonstrated that the ultrasonic cleaner was validated following the previous inspection. Mrs Crawford and staff confirmed that the ultrasonic cleaner has been decommissioned, and the use of an ultrasonic cleaner is no longer incorporated in the decontamination process. This recommendation has been addressed.	Compliant

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:
The responsible persons/registered manager rated the practice arrangements for the prevention of blood-borne virus exposure as compliant 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 in accordance with national guidance. Review of documentation and discussion with Mrs Crawford and staff evidenced that: • the prevention and management of blood-borne virus exposure is included in the staff induction programme; • staff training has been provided for clinical staff; • all recently appointed staff have received an occupational health check; and • records are retained regarding the Hepatitis B immunisation status of clinical staff. Discussion with staff confirmed that staff are aware of the policies and procedures in place for the prevention and management of blood-borne virus exposure. Observations made and discussion with staff evidenced that sharps are appropriately handled. Sharps boxes are positioned to prevent unauthorised access, appropriately used, signed and dated on assembly and final closure. Used sharps boxes are locked with the integral lock and stored ready for collection away from public access. Discussion with staff and review of documentation evidenced that arrangements are in place for the management of a sharps injury, including needle stick injury. Staff are aware of the actions to be taken in the event of a sharps injury.

Provider's overall assessment of the dental practice's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the dental practice's compliance level against the standard assessed	**Compliant**

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:
The responsible persons/registered manager rated the practice arrangements for environmental design and cleaning as compliant 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 good standard of cleanliness. The inspector had the opportunity to review the arrangements in the decontamination room and surgeries one and four. Clinical and decontamination areas were tidy and uncluttered and work surfaces were intact and easy to clean. In general floor coverings are impervious and were sealed at the edges. It was observed that the floor in surgery one is partially carpeted, and staff informed the inspector that the floor in surgeries two and seven are also partially carpeted. Best practice in this regard was discussed with Mr Boyd and Mrs Crawford and a recommendation was made. Fixtures, fittings, dental chairs and equipment were free from damage, dust and visible dirt. It was observed that windows in surgery one are dressed with ornate fabric curtains and pelmets, and staff informed the inspector that the windows in surgery two also have fabric curtains and pelmets. Best practice in this regard was discussed with Mr Boyd and Mrs Crawford and a recommendation was made. A fabric covered chair was observed in surgery four; this was discussed with Mrs Crawford who confirmed that the practice is in the process of reupholstering fabric chairs. A number of the fabric chairs in clinical areas have already been reupholstered resulting in a cleanable finish. Mrs Crawford confirmed that the plans are in place to reupholster the remaining fabric covered chairs. This was acceptable to the inspector. It was observed that the walls in surgeries one and four are partially wall papered with decorative wall paper. Staff informed the inspector that decorative wall paper has been used in the majority of surgeries. The use of wall paper in clinical areas was discussed with Mr Boyd and Mrs Crawford. Mr Boyd confirmed that all wall paper used in clinical areas is cleanable. The inspector advised that in accordance with HTM 01-05 wall surfaces should be non-porous, suitable for frequent cleaning, tolerate the use of cleaning agents, and the use of joints should be avoided. The inspector advised that on the next refurbishment of surgeries the use of wall paper should be avoided, and that finished walls surfaces should adhere to the specifications as outlined in HTM 01-05. 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.

The practice has a local policy and procedure for spillage in accordance with the Control of Substances Hazardous to Health (COSHH) and staff spoken with demonstrated awareness of this.

Provider's overall assessment of the dental practice's compliance level against the standard assessed	**Compliant**
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:
The responsible persons/registered manager rated the practice arrangements for hand hygiene as compliant on the self-assessment. The practice has a hand hygiene policy and procedure in place. Mrs Crawford and 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 the decontamination room and adequate supplies of liquid soap, paper towels and disinfectant rub/gel were available. It was observed that the dedicated hand washing basin in surgery four had an overflow. Best practice guidance in this regard was discussed with Mr Boyd and Mrs Crawford. The inspector was informed that a refurbishment programme to refurbish hand washing basins is currently underway, works have already been completed to replace taps and that blanking off overflows is the next item to be addressed. A recommendation was made in this regard. Staff confirmed that nail brushes and bar soap are not used in the hand hygiene process in keeping with good practice. The inspector observed that laminated /wipe-clean 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	**Compliant**
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:
The responsible persons/registered manager rated the practice approach to the management of dental medical devices as substantially compliant 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. The inspector reviewed the written scheme for the prevention of legionella contamination in water pipes and other water lines and discussion with Mrs Crawford and staff confirmed that this is adhered to. 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 DUWLs are appropriately managed. This includes that: • Filters are cleaned/replaced as per manufacturer's instructions; • An independent bottled-water system is used to dispense distilled water to supply the DUWLs in four of the seven surgeries; • Self-contained water bottles are removed, flushed with distilled water and left open to the air for drying on a daily basis in accordance with manufacturer's guidance; • Water supply to the DUWLs for three of the seven surgeries is provided through the direct mains water supply. Staff confirmed on discussion that there is a physical air gap separating DUWLs from mains water systems; • DUWLs are flushed at the start of each working day and between every patient; • DUWLs and handpieces are fitted with anti-retraction valves; and • DUWLs are purged using disinfectant as per manufacturer's recommendations.

Provider'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	**Compliant**

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:
The responsible persons/registered manager rated the practice approach to the management of personal protective equipment (PPE) as compliant 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. Mrs Crawford and 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	**Compliant**
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:
The responsible persons/registered manager rated the practice approach to the management of waste as compliant on the self-assessment. The practice has a policy and procedure in place for the management and disposal of waste in keeping with HTM 07-01. Mrs Crawford and 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 housed in cupboards, and these can be operated using a non-touch technique. Appropriate arrangements are in place in the practice for the storage and collection of general and clinical waste, including sharps waste. The inspector observed adequate provision of sharps containers including those for pharmaceutical waste, throughout the practice. These were being appropriately managed as discussed in section 10.1 of the report.

Provider's overall assessment of the dental practice's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the dental practice's compliance level against the standard assessed	**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:
The responsible persons/registered manager omitted to rate the decontamination arrangements of the practice on the self-assessment. A decontamination room separate from patient treatment areas and dedicated to the decontamination process is available. Appropriate equipment, including two washer disinfectors and four steam sterilisers have been provided to meet the practice requirements. Review of documentation evidenced that equipment used in the decontamination process has been appropriately validated. Review of equipment logbooks evidenced that periodic tests are undertaken and recorded in keeping with HTM 01-05.

Provider's overall assessment of the dental practice's compliance level against the standard assessed	**Not completed**
Inspector's overall assessment of the dental practice's compliance level against the standard assessed	**Compliant**

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

11.0 Additional Areas Examined

11.1 Staff Consultation/Questionnaires

During the course of the inspection, the inspector spoke with the assistant practice manager, two registered dental nurses, the decontamination assistant and a maintenance/repair person. Questionnaires were also provided to staff prior to the inspection by the practice on behalf of the RQIA. Nineteen 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 and that they have received training appropriate to their relevant roles. Staff confirmed that they are familiar with the practice policies and procedures and have received training in infection prevention and control. Clinical staff confirmed that they have been immunised against Hepatitis B.

Staff who met with the inspector spoke very positively regarding working in Boyd Logue Associates, staff felt valued as a member of the team and supported by management.

11.2 Patient Consultation

The responsible persons/registered manager 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.

A report generated during May 2014, outlining the results of the most recent patient satisfaction survey was reviewed during the inspection.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mr Terence Boyd and Mrs Gail Crawford 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:

Stephen O'Connor
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Self Assessment audit tool of compliance with

HTM01-05 - Decontamination - Cross Infection Control

Name of practice:	**Boyd Logue Associates (Coleraine)**
RQIA ID:	**11400**
Name of inspector:	**Stephen O'Connor**

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)	yes		
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)	yes		
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)	yes		
1.4 Can decontamination and clinical staff demonstrate current immunisation with the hepatitis B vaccine e.g. documentation? (2.4s, 8.8)	yes		
1.5 Are chlorine-releasing agents available for blood /bodily fluid spillages and used as per manufacturer's instructions? (6.74)	yes		
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?	yes		

1.7 Are in-use sharps containers labelled with date, locality and a signature?	yes			
1.8 Are sharps containers replaced when filled to the indicator mark?	yes			
1.9 Are sharps containers locked with the integral lock when filled to the indicator mark? Then dated and signed?	yes			
1.10 Are full sharps containers stored in a secure facility away from public access?	yes			
1.11 Are sharps containers available at the point of use and positioned safely (e.g. wall mounted)?	yes			
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)	yes			
1.13 Are inoculation injuries recorded?	yes			
1.14 Are disposable needles and disposable syringes discarded as a single unit?	yes			
Provider's level of compliance				Compliant

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)	yes		
2.2 Have staff undertaking cleaning duties been fully trained to undertake such duties? (6.55)			we have outside cleaners that come in to clean the premises
2.3 Is the overall appearance of the clinical and decontamination environment tidy and uncluttered? (5.6)	yes		
2.4 Is the dental chair cleaned between each patient? (6.46, 6.62)	yes		
2.5 Is the dental chair free from rips or tears? (6.62)	yes		
2.6 Are all surfaces i.e. walls, floors, ceilings, fixtures and fittings and chairs free from damage and abrasion? (6.38)	yes		
2.7 Are all work-surface joints intact, seamless, with no visible damage? (6.46, 6.47)	yes		
2.8 Are all surfaces i.e. walls, floors, ceilings, fixtures and fittings and chairs free from dust and visible dirt? (6.38)	yes		
2.9 Are the surfaces of accessible ventilation fittings/grills cleaned at a minimum weekly? (6.64)	yes		
2.10 Are all surfaces including flooring in clinical and decontamination areas impervious and easy to clean? (6.46, 6.64)	yes		

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

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)?	yes			
2.22 Does the practice have a local policy and procedure/s for spillage in accordance with COSHH? (2.4d, 2.6)	yes			
Provider's level of compliance				Compliant

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)	yes		
3.2 Is hand hygiene an integral part of staff induction? (6.3)	yes		
3.3 Is hand hygiene training provided periodically throughout the year? (1.22, 6.3)	yes		
3.4 Is hand hygiene carried out before and after every new patient contact? (Appendix 1)	yes		
3.5 Is hand hygiene performed before donning and following the removal of gloves? (6.4, Appendix 1)	yes		
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)	yes		
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)	yes		
3.8 Are there laminated or wipe-clean posters promoting hand hygiene on display? (6.12)	yes		
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)	yes		

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)	yes		
3.11 Are wash-hand basins free from equipment and other utility items? (2.4g, 5.7)	yes		
3.12 Are hand hygiene facilities clean and intact (check sinks taps, splash backs, soap and paper towel dispensers)? (6.11, 6.63)	yes		
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)	yes		
3.14 Confirm nailbrushes are not used at wash-hand basins? (Appendix 1)	yes		
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)	yes		
3.16 Is skin disinfectant rub/gel available at the point of care? (Appendix 1)	yes		
3.17 Are good quality disposable absorbent paper towels used at all wash-hand basins? (6.6, Appendix 1)	yes		

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

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)	yes		
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)	yes		
4.3 Has the practice a written scheme for prevention of legionella contamination in water pipes and other water lines?(6.75, 19.2)	yes		
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)	yes		
4.5 Impression material, prosthetic and orthodontic appliances: Are prosthetic and orthodontic appliances decontaminated before being placed in the patient's mouth? (7.1b)		no	lab work arrives in the surgery in sealed bags - some lab work is not able wet before fitting into the patients mouth.
4.6 Dental Unit Water lines (DUWLs): Are in-line filters cleaned/replaced as per manufacturer's instructions?(6.89, 6.90)	yes		

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)	yes		
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)	yes		
4.9 Dental Unit Water lines (DUWLs): Are the DUWLs drained down at the end of every working day?(6.82)	yes		
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)	yes		
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)	yes		
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)	yes		
4.13 Dental Unit Water lines (DUWLs): Are all DUWL and hand pieces fitted with anti-retraction valves? (6.87)	yes		
4.14 Dental Unit Water lines (DUWLs): Are DUWLs either disposable or purged using manufacturer's recommended disinfectants? (6.84-6.86)	yes		

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

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)	yes		
5.2 Are staff trained in the use of personal protective equipment as part of the practice induction? (6.13)	yes		
5.3 Are powder-free CE marked gloves used in the practice? (6.20)	yes		
5.4 Are alternatives to latex gloves available? (6.19, 6.20)	yes		
5.5 Are all single-use PPE disposed of after each episode of patient care? (6.21, 6.25, 6.36c)	yes		
5.6 Is hand hygiene performed before donning and following the removal of gloves? (6.4 Appendix 1)	yes		
5.7 Are clean, heavy duty household gloves available for domestic cleaning and decontamination procedures where necessary? (6.23)	yes		
5.8 Are heavy-duty household gloves washed with detergent and hot water and left to dry after each use? (6.23)	yes		
5.9 Are heavy-duty household gloves replaced weekly or more frequently if worn or torn? (6.23)	yes		

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)	yes		
5.11 Are single-use plastic aprons disposed of as clinical waste after each procedure? (6.25)	yes		
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)	yes		
5.13 Are masks disposed of as clinical waste after each use? (6.27, 6.36)	yes		
5.14 Are all items of PPE stored in accordance with manufacturers' instructions? (6.14)	yes		
5.15 Are uniforms worn by all staff changed at the end of each day and when visibly contaminated? (6.34)	yes		
5.16 Is eye protection for staff used during decontamination procedures cleaned after each session or sooner if visibly contaminated? (6.29)	yes		
5.17 Is eye protection provided for the patient and staff decontaminated after each episode of patient care? (6.29)	yes		
Provider's level of compliance			Compliant

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))	yes		
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))	yes		
6.3 Is there evidence that the waste contractor is a registered waste carrier? (6.87 (07-01) 6.90 (07-01))	yes		
6.4 Are all disposable PPE disposed of as clinical waste? (6.26, 6.27, 6.36, HTM 07-01 PEL (13) 14)	yes		
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))		no	yellow bags are used which are clearly marked clinical waste - hazard
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))			n/a all our waste would normally be contaminated with salvia etc - we have separate pots where we put our waste amalagam and this is lifted by cannon.
6.8 Are black/clear bags used for domestic waste including paper towels? (HTM 07-01, PEL (13) 14, 5.51 (07-01))	yes		

6.9 Are bins foot operated or sensor controlled, lidded and in good working order? (5.90 (07-01))	yes			
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))	yes			
6.11 Are clinical waste sacks securely tied and sharps containers locked before disposal? (5.87 (07-01))	yes			
6.12 Are all clinical waste bags and sharps containers labelled before disposal? (5.23 (07-01), 5.25 (07-01))	yes			
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))	yes			
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))	yes			
6.15 Are all consignment notes for all hazardous waste retained for at least 3 years?(6.105 (07-01))	yes			
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))	yes			
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))	yes			
Provider's level of compliance				Compliant

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)	yes		
7.2 Does the practice have washer disinfector(s) in sufficient numbers to meet the practice requirements? (PEL(13)13)	yes		
7.3 Are all reusable instruments being disinfected using the washer disinfector? (PEL(13)13)	yes		
7.4 Does the practice have steam sterilisers in sufficient numbers to meet the practice requirements?	yes		
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)	yes yes		
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)	yes yes		

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?	yes yes		
Provider's level of compliance			Provider to complete

Please provide any comments you wish to add regarding good practice

Appendix 1

Name of practice: Boyd Logue Associates

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 [x] 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 [x] No [ ]

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

Yes [x] No [ ]

Inspection ID: 18286

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Announced Inspection

Boyd Logue Associates (Coleraine)

6 August 2014

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 Mr Terence Boyd, Mrs Gail Crawford 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.

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	In keeping with best practice guidance as outlined in HTM 01-05 flooring in clinical areas must be imperious and coved or sealed at the edges. Carpets should be removed from the identified surgeries. **Ref: 10.2**	One	We have organised for an architect to come to the surgery on 03/10/2014 and carpets will be removed and replaced with an appropriated surface	Three months
2	13	In the interests of infection prevention and control fabric curtains should be removed from the identified surgeries. **Ref: 10.2**	One	As above curtains will be removed and any refurbishment will done in accordance with HTM 01-05	Three months
3	13	Overflows in all dedicated hand washing basins should be blanked off using a stainless steel plate and sealed with antibacterial mastic. **Ref: 10.3**	One	Completed.	Two 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	Gail Gawford
Name of Responsible Person / Identified Responsible Person Approving QIP	Peter Boyd.

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	✓	STEPHEN O Connor	26.05.14
Further information requested from provider	no	STEPHEN O'Connor	26.05.14