Announced Inspection

Name of Establishment:	**Railway Dental Care**
Establishment ID No:	**11510**
Date of Inspection:	**21 October 2014**
Inspector's Name:	**Stephen O'Connor**
Inspection No:	**20207**

The Regulation and Quality Improvement Authority
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1.0 General Information

Name of establishment:	Railway Dental Care
Address:	9 Railway Street Strabane BT82 8EG
Telephone number:	028 71 382750
Registered organisation / registered provider:	Mr Gordon Kennedy
Registered manager:	Mr Gordon Kennedy
Person in charge of the establishment at the time of Inspection:	Mr Gordon Kennedy
Registration category:	IH-DT
Type of service provision:	Private dental treatment
Maximum number of places registered: (dental chairs)	1
Date and type of previous inspection:	Announced Follow Up Inspection 23 December 2013
Date and time of inspection:	21 October 2014 10:00am – 12:35pm
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 Gordon Kennedy, 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	1	
Staff Questionnaires	3 issued	0 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

Railway Dental Care is situated within a former residential building, which has been converted for use as a dental practice, located in Strabane. The practice is close to local amenities and public transport routes.

On street and public car parking is available for patients.

The establishment is accessible for patients with a disability. The surgery and a disabled toilet are located on the ground floor of the premises.

Railway Dental Care is registered to operate one dental chair, providing both private and NHS dental care. A waiting area and toilet facilities are available for patient use. Staff and storage facilities are also available. The practice has a separate decontamination room.

On the 30 September 2014 the inspector was contacted via telephone by an employee of the practice who enquired about the procedure to increase the number of registered dental surgeries from one to two. The inspector discussed the application process and arranged for a variation to registration application to be forwarded to Mr Kennedy. The application to vary the registration has not yet been submitted. Mr Kennedy confirmed during discussions that he is aware that a variation to registration application must be submitted and approved prior to private dental care and treatment being provided in the newly established dental surgery.

Mr Kennedy is supported in the practice by a practice manager, a team of dental nurses and reception staff.

Mr Kennedy has been the registered provider and manager of Railway Dental Care since initial registration with RQIA on the 4 March 2013.

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

This practice is registered as an independent hospital (IH) providing dental treatment (DT).

8.0 Summary of Inspection

This announced inspection of Railway Dental Care was undertaken by Stephen O'Connor on 21 October 2014 between the hours of 10:00am and 12:35pm. Mr Gordon Kennedy, registered provider, and the practice manager were both available during the inspection and for verbal feedback at the conclusion of the inspection.

The five requirements and five recommendations made as a result of the previous inspection were also examined. Observations and discussion demonstrated that one of the five requirements and two of the five recommendations have been addressed. The requirements made in relation to decontamination equipment logbooks and AccessNI checks have been partially addressed and the relevant aspects which have not been addressed have been stated for the third and final time. The requirements made in relation to patient consultation and the radiation protection advisor (RPA) report have not been addressed and these have been stated for the second time.

Observations and discussion demonstrated that the recommendation made during the previous inspection to develop the fire risk assessment further has not been addressed. This recommendation has been stated as a requirement. The recommendation made regarding the provision of make-up air in the decontamination room has not been addressed and has been stated for the second time. The recommendation made to further develop the legionella risk assessment has been partially addressed and the unaddressed component has been stated for the second time.

Lack of progress in relation to addressing the previous requirements and recommendations was disappointing to note. Mr Kennedy was informed of the need to continue progressing the requirements and recommendations as outlined in the Quality Improvement Plan (QIP). The inspector advised Mr Kennedy that a continued lack of progress could lead to enforcement action being taken. The detail of the action taken by Mr Kennedy can be viewed in the section following this summary.

Prior to the inspection, Mr Kennedy completed a self-assessment using the standard criteria outlined in the theme inspected. The comments provided by Mr Kennedy in the self-assessment were not altered in any way by RQIA. The self-assessment is included as appendix one in this report. The self-assessment was submitted to RQIA on the day prior to the inspection, and Mr Kennedy did not rate the practices level of compliance against each criterion. This was discussed with Mr Kennedy and the inspector advised that in the future self-assessments must be submitted within the identified timeframe and include the practices compliance levels. Mr Kennedy rated the practice's level of compliance during the inspection.

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

Questionnaires were also issued to staff; none were returned to RQIA within the timescale required. During the inspection the practice manager confirmed that the questionnaires were distributed to staff by Mr Kennedy. Discussion with the practice manager demonstrated that she was knowledgeable regarding the inspection theme and she confirmed that staff have received training appropriate to their relevant roles. The practice manager confirmed that staff are familiar with the practice policies and procedures and have received infection prevention and control training.

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.

An electronic copy of the 2013 edition of HTM 01-05 Decontamination in primary dental care practices is available at the practice for staff reference. The practice manager was familiar with best practice guidance outlined in the document. Mr Kennedy confirmed that the Infection Prevention Society (IPS) audit tool has not been reviewed within the past year. A recommendation was made to address this.

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. A recommendation was made that records should be retained regarding the Hepatitis B immunisation status of all clinical staff. Review of documentation and discussion with Mr Kennedy and the practice manager demonstrated that appropriate arrangements are in place for the prevention and management of blood-borne virus exposure. The practice manager confirmed that staff are aware of, and are adhering to, the practice policy in this regard. In the main sharps management at the practice was observed to be in line with best practice. A recommendation was made that sharps containers suitable for the disposal of pharmaceutical waste must be provided.

The premises were clean and tidy and clutter was kept to a minimum. In the main satisfactory arrangements are in place for the cleaning of the general environment and dental equipment. The practice manager informed the inspector that one mop and one mop bucket are used to clean the floors. A recommendation was made to review the provision of cleaning equipment in

accordance with the National Patient Safety Agency and ensure that sufficient equipment is available to clean the different designated areas within the practice. Details of the colour coded system should also be included in the environmental cleaning policy. A recommendation was also made that the torn dental chair should be reupholstered.

The practice has a local policy and procedure for spillage in accordance with the Control of Substances Hazardous to Health (COSHH) and the practice manager spoken with demonstrated awareness of this. Discussion with Mr Kennedy demonstrated that COSHH risk assessments have not been completed. A recommendation was made that in keeping with COSHH regulations individual COSHH risk assessments must be completed for the chemical products used in the practice.

The practice has a hand hygiene policy and procedure in place and the practice manager demonstrated that good practice is adhered to in relation to hand hygiene.
Dedicated hand washing basins are available in the appropriate locations. Information promoting hand hygiene is provided for staff and patients.

A written scheme for the prevention of legionella is available. A recommendation stated for the second time was made to further develop the control measures to reduce the risk of legionella, to include monthly monitoring of hot and cold sentinel water temperatures. Procedures are in place for the use, maintenance, service and repair of all medical devices. Observations made and discussion with the practice manager 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 the practice manager 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. As discussed previously a recommendation was made in regards to the provision of sharps containers suitable for the disposal of pharmaceutical waste.

A decontamination room separate from patient treatment areas and dedicated to the decontamination process is available. Appropriate validated equipment, including a washer disinfector and a steam steriliser have been provided to meet the practice requirements. Review of documentation demonstrated that pre-printed logbooks are available for the washer disinfector and steam steriliser. However, although periodic tests are being undertaken for the washer disinfector, the machine logbook is not being completed. Details of periodic tests for the steam steriliser are recorded in the appropriate logbook with the exception of the details of the daily automatic control test (ACT). Machine logbooks and periodic testing regimes were discussed with Mr Kennedy and the practice manager and a requirement stated for the third and final time has

been made to address the identified issues. A recommendation was also made that the Secure Digital (SD) card of the steam steriliser is repaired or alternative suitable arrangements established to record the cycle parameters of this machine.

The evidence gathered through the inspection process concluded that Railway Dental Care is substantially compliant with this inspection theme.

Mr Kennedy 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. However, discussion with Mr Kennedy on the day of inspection demonstrated that a patient satisfaction survey has not been completed within the past year. A requirement stated for the second time has been made to address this.

Five requirements and nine 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). Four of the five requirements are stated for the second or third time, and two of the nine recommendations are stated for the second time.

During the announced follow-up inspection on 23 December 2013, a requirement was stated for the second time, to ensure that an enhanced AccessNI check is received prior to new staff commencing work in the practice and to process an enhanced AccessNI check for the identified staff member. Discussion with Mr Kennedy on the day of inspection demonstrated that this requirement has not been fully addressed. Additional information in this regard can be found in section 9.0 of this report. A requirement stated for the third and final time has been made to address this.

During the announced follow-up inspection on the 23 December 2013 a requirement was made to ensure all recommendations made by the radiation protection advisor (RPA) are implemented, signed and dated by the radiation protection supervisor (RPS) and that a copy of the most recent RPA report should be retained in the practice for inspection. On the day of inspection Mr Kennedy confirmed that this requirement had not been addressed. A requirement stated for the second time has been made to address this.

During the announced follow-up inspection on the 23 December 2013 a recommendation was made to further develop the fire risk assessment. On the day of inspection Mr Kennedy confirmed that this recommendation had not been addressed. This recommendation has now been stated as a requirement.

Following this inspection, the lack of progress in relation to addressing the previous requirements and recommendations was reported to senior management in RQIA, following which a decision was taken to schedule a follow-up inspection. The purpose of the follow-up inspection will be to seek assurances that the issues identified in the QIP have been addressed. Mr Kennedy was informed that the follow-up inspection will be undertaken on the 13 January 2015.

The inspector wishes to thank Mr Kennedy 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	15 (2) (b)	The washer disinfector and steam steriliser should be validated and arrangements put in place to ensure annual revalidation thereafter.	Review of documentation demonstrated that the steam steriliser was validated during January 2014 and the washer disinfector was validated during May 2014. Mr Kennedy confirmed that arrangements are in place for the annual validation of these machines. This requirement has been addressed.	Compliant
2	15 (2) (b)	Log books should contain the following information; • Details of the machine and location; • Commissioning report; • Daily/weekly test record sheets; • Annual service/validation certification; • Fault history; • Process log; • Records to show staff have been trained in the correct use of the machine; • Relevant contacts e.g. service engineer.	It was observed that pre-printed logbooks are available for the washer disinfector and steam steriliser. The washer disinfector logbook has not been completed. This was discussed with Mr Kennedy and the practice manager who confirmed that between February and May 2014 the washer disinfector was not operational. Following repairs and validation of this machine, periodic tests were undertaken, however results were not documented. Review of the steam steriliser logbook demonstrated that with the exception of the details of the daily automatic control test (ACT) the logbook is being fully completed. The practice manager confirmed that the Secure Digital (SD) card connected to the steriliser to record cycle parameters is not operational. A recommendation was made to address this. Additional information can be found in section 10.7 of this report. This requirement has been	Moving towards compliance

			partially addressed. As the washer disinfector logbook has not been used to record periodic tests and the details of the ACT have not been recorded this requirement has been stated for the third and final time.	
3	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 member.	Discussion with Mr Kennedy and review of documentation demonstrated that an enhanced AccessNI check for the staff member identified during the previous inspection was issued on the 2 October 2014. The inspector was disappointed to note the time delay between this requirement being made on the 23 December 2013 and the submission of the AccessNI application form. Mr Kennedy also confirmed that a new dental nurse commenced work in the practice at the beginning of November 2014 and that although applied for an AccessNI check has not been receive. The practice manager confirmed that this dental nurse is currently undergoing induction and that she is not left unsupervised at any time. This requirement has been partially addressed and the unaddressed component has been stated for the third and final time.	Moving towards compliance
4	17 (1)	Introduce and maintain a system for reviewing at appropriate intervals the quality of treatment and other services provided to patients in or for the purposes of the establishment. A report detailing the findings of the patient consultation should be generated.	Mr Kennedy confirmed that the practice has not completed any patient satisfaction surveys within the past year. This requirement has not been addressed and has been stated for the second time. Additional information can be found in section 11.2 of this report.	Not compliant

5	15 (2) (b)	Ensure all recommendations made by the RPA are implemented, signed and dated by the RPS. A copy of the most recent RPA report should be retained in the practice for inspection.	Mr Kennedy confirmed that he does not have a copy of the most recent RPA report. However he confirmed that the recommendations were addressed when the report was issued during 2012. This requirement has not been addressed and has been stated for the second time.	Not compliant

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	14	The current fire risk assessment should be further developed to include: • An overall fire risk rating for the practice; • Specify the location of fire detection units and emergency lighting; • Identify sources of ignition, including electrical installations, and include a copy of BS7671 electrical inspection report; and • Specify if doors on escape routes are fire protected to FD30S standard.	Mr Kennedy confirmed that the fire risk assessment has not been updated to include this information. This recommendation has not been addressed and has been stated as a requirement.	Not compliant
2	14	The current legionella risk assessment should be further developed to include: • An overall legionella risk rating for the practice; • Identification of the people at risk from legionella; and • Commencement of monthly monitoring of sentinel water temperatures.	Review of the legionella risk assessment demonstrated that it has been further developed to include the overall legionella risk rating and the identification of people at risk. Mr Kennedy confirmed that monthly monitoring of sentinel water temperatures has not been implemented. This recommendation has been partially addressed and the unaddressed component has been stated for the second time. Additional information can be found in section 10.4 of this report.	Substantially compliant

3	13	A removable basin should be provided to rinse instruments following manual cleaning.	It was observed that a removable stainless steel basin is available for rinsing instruments following manual cleaning. This recommendation has been addressed.	Compliant
4	14.4	Ensure that all the relevant information in relation to the breakdown, maintenance and servicing of the washer disinfector is recorded in the log book for the machine.	Review of documentation demonstrated that relevant information in relation to the breakdown, maintenance and servicing of the washer disinfector has been recorded on templates prepared by the practice. The practice manager confirmed that in the future this information will be recorded in the washer disinfector logbook. This recommendation has been addressed.	Compliant
5	13	Further develop the ventilation system in the decontamination room to include the provision of make-up air in keeping with best practice as outlined in HTM 01-05.	Mr Kennedy confirmed that a make-up ventilation system has not been installed in the decontamination room. The inspector strongly advised that advice and guidance should be sought from Health Estates at the Department of Health in regards to the ventilation system. The inspector provided the contact information for Health Estates at the conclusion of the inspection. This recommendation has not been addressed and has been stated for the second time.	Not 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:
Mr Kennedy rated the practice arrangements for the prevention of blood-borne virus exposure as moving towards compliance during the inspection. 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 Mr Kennedy and the practice manager demonstrated 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; and • Mr Kennedy confirmed that in the future all newly recruited staff will receive an occupational health check. On the day of inspection records regarding the Hepatitis B immunisation of clinical staff could not be located. A recommendation was made that records should be retained regarding the Hepatitis B immunisation status of all clinical staff. Discussion with the practice manager demonstrated that she was aware of the policies and procedures in place for the prevention and management of blood-borne virus exposure. Observations made and discussion with the practice manager evidenced that sharps are appropriately handled. Sharps boxes are safely positioned to prevent unauthorised access, 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. A sharps container suitable for the disposal of pharmaceutical waste was not available in the practice. This is discussed further in section 10.6 of this report. Discussion with Mr Kennedy and the practice manager and review of documentation evidenced that arrangements are in place for the management of a sharps injury, including needle stick injury. The practice manager was 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	**Moving towards compliance**
Inspector's overall assessment of the dental practice's compliance level against the standard assessed	**Substantially 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:
Mr Kennedy rated the practice arrangements for environmental design and cleaning as moving towards compliance during the inspection. The practice has a policy and procedure in place for cleaning and maintaining the environment. The practice manager confirmed that one mop and one mop bucket are used in all areas of the practice. Best practice guidance in regards to colour coded cleaning equipment was discussed with Mr Kennedy and the practice manager. A recommendation has been made to review the provision of cleaning equipment in accordance with the National Patient Safety Agency guidance and ensure that sufficient equipment is available to clean the different designated areas within the practice. Details of the colour coded system should also be included in the environmental cleaning policy. Following this inspection the National Patient Safety Agency cleanliness guidelines were emailed to the practice. The inspector undertook a tour of the premises which were found to be maintained to a good standard of cleanliness. Clinical and decontamination areas were tidy and uncluttered and work surfaces were intact and easy to clean. Floor coverings are impervious and were sealed at the edges. In general fixtures, fittings, the dental chair and equipment were free from damage, dust and visible dirt. It was observed that the seat of the dental chair had a tear. This was discussed with Mr Kennedy and the practice manager and a recommendation was made that the dental chair should be re-upholstered. The walls in the dental surgery have been wallpapered with embossed wallpaper that has been painted. The use of wallpaper in clinical areas was discussed with Mr Kennedy. 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 the practice the use of wallpaper in clinical areas should be avoided, and that finished walls surfaces should adhere to the specifications as outlined in HTM 01-05. Discussion with the practice manager 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 stored in a non-clinical area; and • Dirty water is disposed of at an appropriate location. As discussed previously a recommendation was made in regards to the provision of colour coded cleaning equipment.

The practice manager confirmed that staff have 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 the practice manager spoken with demonstrated awareness of this. Discussion with Mr Kennedy demonstrated that COSHH risk assessments have not been completed. A recommendation was made that in keeping with COSHH regulations individual COSHH risk assessment must be completed for the chemical products used in the practice.

Provider's overall assessment of the dental practice's compliance level against the standard assessed	**Moving towards compliance**
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:
Mr Kennedy rated the practice arrangements for hand hygiene as moving towards compliance during the inspection. The practice has a hand hygiene policy and procedure in place. The practice manager confirmed that hand hygiene is included in the induction programme and that hand hygiene training is updated periodically. Discussion with the practice manager 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 surgery and the decontamination room and adequate supplies of liquid soap, paper towels and disinfectant rub/gel were available. The practice manager confirmed that nail brushes and bar soap are not used in the hand hygiene process in keeping with good practice. 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	**Moving towards compliance**
Inspector's overall assessment of the dental practice's compliance level against the standard assessed	**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:
Mr Kennedy rated the practice approach to the management of dental medical devices as moving towards compliance during the inspection. The practice has an infection control policy that includes procedures for the use, maintenance, service and repair of all medical devices. A review of the written scheme for the prevention of legionella contamination in water pipes and other water lines and discussion Mr Kennedy and the practice manager demonstrated that in the main this is adhered to. As discussed in section 9.0 of this report a recommendation was made, further develop the control measures to reduce the risk of legionella, to include monthly monitoring of hot and cold sentinel water temperatures, records must be retained for inspection. The practice manager confirmed that impression materials, prosthetic and orthodontic appliances are decontaminated prior to despatch to the laboratory and before being placed in the patient's mouth. Observations made and discussion with the practice manager 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 potable water to supply the DUWLs; • Self-contained water bottles are removed, flushed with potable 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; • 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	**Moving towards compliance**
Inspector's overall assessment of the dental practice's compliance level against the standard assessed	**Substantially 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:
Mr Kennedy rated the practice approach to the management of personal protective equipment (PPE) as moving towards compliance during the inspection. The practice has a policy and procedure in place for the use of PPE and the practice manager spoken with demonstrated awareness of this. The practice manager confirmed that the use of PPE is included in the induction programme. Observations made and discussion with the practice manager evidenced that PPE was readily available and in use in the practice. Discussion with the practice manager 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. The practice manager confirmed that staff are aware of the practice uniform policy.

Provider's overall assessment of the dental practice's compliance level against the standard assessed	**Moving towards compliance**
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:
Mr Kennedy rated the practice approach to the management of waste as moving towards compliance during the inspection. The practice has a policy and procedure in place for the management and disposal of waste in keeping with HTM 07-01. The practice manager 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 the practice manager demonstrated that she was aware of the different types of waste and appropriate disposal streams. Pedal operated bins are available throughout the practice. 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 suitable for general clinical waste throughout the practice. Sharps containers suitable for pharmaceutical waste were not available in the practice. A recommendation was made that sharps containers suitable for the disposal of pharmaceutical waste must be provided. Sharps containers 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	**Moving towards compliance**
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:
Mr Kennedy rated the decontamination arrangements of the practice as moving towards compliance during the inspection. A decontamination room separate from patient treatment areas and dedicated to the decontamination process is available. As discussed in section 9.0 of this report a recommendation stated for the second time has been made to further develop the ventilation system in the decontamination room to include the provision of make-up air in keeping with best practice as outlined in HTM 01-05. The inspector suggested that advice and guidance be sought from Health Estates at the Department of Health in this regard and provided the contact information for Health Estates at the conclusion of the inspection. Appropriate equipment, including a washer disinfector and a steam steriliser have been provided to meet the practice requirements. Review of documentation evidenced that equipment used in the decontamination process has been appropriately validated. As discussed in section 9.0 of this report it was observed that pre-printed logbooks are available for the washer disinfector and steam steriliser. The washer disinfector logbook has not been completed. This was discussed with Mr Kennedy and the practice manager who confirmed that between February and May 2014 the washer disinfector was not operational. Following repairs and validation of this machine, periodic tests were undertaken, however results were not documented. Review of the steam steriliser logbook demonstrated that with the exception of the details of the daily automatic control test (ACT) the logbook is being fully completed. A requirement was made, stated for the third time that logbooks should contain the following information; • Details of the machine and location; • Commissioning report; • Daily/weekly test record sheets; • Annual service/validation certification; • Fault history; • Records to show staff have been trained in the correct use of the machine; • Relevant contacts e.g. service engineer; and • Periodic testing should be undertaken and recorded in keeping with HTM 01-05. The practice manager confirmed that the Secure Digital (SD) card connected to the steriliser to record cycle parameters was not operational. A recommendation was made that the SD card connected to the steam steriliser must be repaired or alternative suitable arrangements established to record the cycle parameters of this machine. Records of cycle parameters must

be retained for at least two years.

An electronic copy of the updated 2013 edition of HTM 01-05 Decontamination in primary care dental practices is available for staff reference. Mr Kennedy confirmed during discussion that the Infection Prevention Society (IPS) audit tool has not been completed within the past year. A recommendation was made that the IPS audit tool should be completed every six months in keeping with best practice guidance as outlined in the 2013 edition of HTM 01-05. Following this inspection a copy of the IPS audit tool was forwarded to the practice via email.

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

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 practice manager who is also a registered dental nurse. Questionnaires were also provided to staff prior to the inspection by the practice on behalf of the RQIA. None were returned to RQIA within the timescale required.

During the inspection the practice manager confirmed that the questionnaires were distributed to staff by Mr Kennedy. Discussion with the practice manager demonstrated that she was knowledgeable regarding the inspection theme and she confirmed that staff have received training appropriate to their relevant roles. The practice manager confirmed that staff are familiar with the practice policies and procedures and have received infection prevention and control training.

11.2 Patient Consultation

Mr Kennedy 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.

However, as discussed previously in section 9.0 of this report on the day of inspection Mr Kennedy confirmed that the practice had not completed any patient satisfaction surveys within the past year. A requirement stated for the second time was made to introduce and maintain a system for reviewing at appropriate intervals the quality of treatment and other services provided to patients in or for the purposes of the establishment. A report detailing the findings of the patient consultation should be generated.

11.3 Follow-up on Previous Issues

As discussed in section 8.0 of this report four of the five requirements and three of the five recommendations made as a result of the previous inspection have not been fully addressed.

During the announced follow-up inspection on 23 December 2013, a requirement was stated for the second time, to ensure that an enhanced AccessNI check is received prior to new staff commencing work in the practice and to process an enhanced AccessNI check for the identified staff member. Discussion with Mr Kennedy on the day of inspection demonstrated that this requirement has not been fully addressed. Additional information in this regard can be found in section 9.0 of this report. A requirement stated for the third and final time has been made to address this.

During the announced follow-up inspection on the 23 December 2013 a requirement was made to ensure all recommendations made by the radiation protection advisor (RPA) are implemented, signed and dated by the radiation

protection supervisor (RPS) and that a copy of the most recent RPA report should be retained in the practice for inspection. On the day of inspection Mr Kennedy confirmed that this requirement had not been addressed. A requirement stated for the second time has been made to address this.

During the announced follow-up inspection on the 23 December 2013 a recommendation was made to further develop the fire risk assessment. On the day of inspection Mr Kennedy confirmed that this recommendation had not been addressed. This recommendation has now been stated as a requirement.

Lack of progress in relation to addressing the previous requirements and recommendations was disappointing to note. Mr Kennedy was informed of the need to continue progressing the requirements and recommendations as outlined in the Quality Improvement Plan (QIP). The inspector advised Mr Kennedy that a continued lack of progress could lead to enforcement action being taken.

Following this inspection, the lack of progress in relation to addressing the previous requirements and recommendations was reported to senior management in RQIA, following which a decision was taken to schedule a follow-up inspection. The purpose of the follow-up inspection will be to seek assurances that the issues identified in the QIP have been addressed. Mr Kennedy was informed that the follow-up inspection will be undertaken on the 13 January 2015.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mr Kennedy and the practice manager 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

_____ _____

Stephen O'Connor **Date**
Inspector/Quality Reviewer

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Announced Inspection

Railway Dental Care

21 October 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 Gordon Kennedy and the practice manager 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	15 (2) (b)	Logbooks should contain the following information: • Details of the machine and location; • Commissioning report; • Daily/weekly test record sheets; • Annual service/validation certification; • Fault history; • Records to show staff have been trained in the correct use of the machine; • Relevant contacts e.g. service engineer; and • Periodic testing should be undertaken and recorded in keeping with HTM 01-05. **Ref: 9.0 & 10.7**	Three	COMPLETED AS REQUIRED.	One month
2	19 (2) (d) Schedule 2 (2)	Ensure that an enhanced AccessNI check is received prior to new staff commencing work in the practice. **Ref: 9.0**	Three	COMPLETED	Immediate and on-going
3	17 (1)	Introduce and maintain a system for reviewing at appropriate intervals the quality of treatment and other services provided to patients in or for the purposes of the establishment. A report detailing the findings of the patient	Two	INITIATED.	Two months

		consultation should be generated. **Ref: 9.0 & 11.2**			
4	15 (2) (b)	Ensure all recommendations made by the RPA are implemented, signed and dated by the RPS. A copy of the most recent RPA report should be retained in the practice for inspection. **Ref: 9.0**	Two	AS REQUESTED	One month
5	25 (4) (f)	The current fire risk assessment should be further developed to include: • An overall fire risk rating for the practice; • Specify the location of fire detection units and emergency lighting; • Identify sources of ignition, including electrical installations, and include a copy of BS7671 electrical inspection report; and • Specify if doors on escape routes are fire protected to FD30S standard. **Ref: 9.0**	One	REQUESTED DETAILS INCLUDED	Two months

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	Further develop the control measures to reduce the risk of legionella, to include monthly monitoring of hot and cold sentinel water temperatures. Records must be retained for inspection. **Ref: 9.0 & 10.4**	Two	INITIATED	One month
2	13	Further develop the ventilation system in the decontamination room to include the provision of make-up air in keeping with best practice as outlined in HTM 01-05. **Ref: 9.0 & 10.7**	Two	VENTILATION SYSTEM FURTHER DEVELPED.	Three months
3	13	Records should be retained regarding the Hepatitis B immunisation status of all clinical staff. **Ref 10.1**	One	RECORDS RETAINED.	Three months
4	13	Review the provision of cleaning equipment in accordance with the National Patient Safety Agency guidance and ensure that sufficient equipment is available to clean the different designated areas within the practice. Details of the colour coded system should also be included in the environmental cleaning policy. **Ref: 10.2**	One	COMPLETED AS REQUESTED.	One month

5	13	The dental chair in the identified surgery should be re-upholstered. **Ref 10.2**	One	AS REQUESTED.	Two months
6	13	In keeping with COSHH regulations individual COSHH risk assessment must be completed for the chemical products used in the practice. **Ref: 10.2**	One	COSHH ASSESSMENT. COMPLETED AS REQUESTED.	Three months
7	13	Sharps containers suitable for the disposal of pharmaceutical waste must be provided. **Ref: 10.6**	One	PROVIDED.	One month
8	13	The Secure Digital (SD) card connected to the steam steriliser must be repaired or alternative suitable arrangements established to record the cycle parameters of this machine. Records of cycle parameters must be retained for at least two years. **Ref: 10.7**	One	AS REQUESTED	Two months
9	13	In keeping with best practice guidance as outlined in the 2013 edition of HTM 01-05 the Infection Prevention Society (IPS) audit tool must be completed every six months. **Ref: 10.7**	One	AUDIT TOOL COMPLETED.	Two months

The Regulation and Quality Improvement Authority

Self Assessment audit tool of compliance with

HTM01-05 - Decontamination - Cross Infection Control

Name of practice:	**Railway Dental Care**
RQIA ID:	**11510**
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)	✓		
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)?	✓		
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)	N/A	N/A	
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)	N/A	N/A	
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))	✓		
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))		✓	NOT SUPPLED TO US YET.
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)	✓		
7.2 Does the practice have washer disinfector(s) in sufficient numbers to meet the practice requirements? (PEL(13)13)	✓		
7.3 Are all reusable instruments being disinfected using the washer disinfector? (PEL(13)13)	✓		
7.4 Does the practice have steam sterilisers in sufficient numbers to meet the practice requirements?	✓		
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)	✓		
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)	✓		

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?	✓ ✓		
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: Railway 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