Announced Inspection

Name of Establishment:	**Roe Valley Dental Practice**
Establishment ID No:	**11676**
Date of Inspection:	**11 December 2014**
Inspector's Name:	**Emily Campbell**
Inspection No:	**20598**

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:	Roe Valley Dental Practice
Address:	11 Irish Green Street Limavady BT49 9AA
Telephone number:	028 7776 2336
Registered organisation / registered provider:	Ms Winifred McLaughlin
Registered manager:	Ms Winifred McLaughlin
Person in charge of the establishment at the time of Inspection:	Ms Winifred McLaughlin
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 Inspection 6 August 2013
Date and time of inspection:	11 December 2014 10.00am – 12.40pm
Name of inspector:	Emily Campbell

2.0 Introduction

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

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

3.0 Purpose of the Inspection

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

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

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

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003;
- The Independent Health Care Regulations (Northern Ireland) 2005;
- The Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspections) (Amendment) Regulations (Northern Ireland) 2011;
- The Minimum Standards for Dental Care and Treatment 2011; and
- Health Technical Memorandum HTM 01-05: Decontamination in Primary Care Dental Practices and Professional Estates Letter (PEL) (13) 13.

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

4.0 Methods/Process

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

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

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

- a self-assessment was submitted prior to the inspection and has been analysed;
- discussion with Ms Winifred McLaughlin, 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	4 issued	1 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

Roe Valley Dental Practice is a residential building located centrally in the town of Limavady. Limited on street car parking is available, however additional car parking is available within walking distance.

The establishment is a converted cottage that has been adapted and extended to provide a dental surgery, decontamination room, waiting area, toilet, office, and staff and storage facilities. The practice facilities on the ground floor are accessible for patients with a disability. However, the toilet facilities on the first floor are not.

Roe Valley Dental Practice operates one chair, providing both private and NHS dental care. Ms McLaughlin, works as a sole practitioner and is not supported by a dental nurse. Ms McLaughlin is supported in her role by reception staff. Ms McLaughlin has been the registered provider/manager since registration of the practice with RQIA in June 2011.

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

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

8.0 Summary of Inspection

This announced inspection of Roe Valley Dental Practice was undertaken by Emily Campbell on 11 December 2014 between the hours of 10.00am and 12.40pm. Ms Winifred McLaughlin, registered provider, was available during the inspection and for verbal feedback at the conclusion of the inspection.

The requirements and recommendations made as a result of the previous inspection were also examined. Observations and discussion demonstrated that the two requirements have not been addressed, one of the four recommendations made have been addressed, two have been partially addressed and one has not been addressed. Requirements in relation to the decontamination room environment and validation of equipment have been stated for the second time. Recommendations have been stated for the second time regarding patient consultation and the overflow of the hand washing basin in the decontamination room. A recommendation made regarding ventilation in the decontamination room is now stated as a requirement. The detail of the action taken by Ms McLaughlin can be viewed in the section following this summary.

Prior to the inspection, Ms McLaughlin completed a self-assessment using the standard criteria outlined in the theme inspected. The comments provided by Ms McLaughlin 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 the receptionist, discussed operational issues, examined a selection of records and carried out a general inspection of the establishment.

Ms McLaughlin, works as a sole practitioner and is not supported by a dental nurse. Questionnaires were issued to staff; one was returned to RQIA within the timescale required. Review of the submitted questionnaire and discussion with the receptionist evidenced that staff have received training relevant to their roles and have the opportunity to participate in practice meetings and training updates.

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.

Ms McLaughlin has an overarching policy in relation to infection control which includes the arrangements for this inspection theme. The policy has limited advice and guidance in general, however, as Ms McLaughlin is the only clinician in the practice, the arrangements in place only relate to her.

The overarching policy in relation to infection control which includes the arrangements 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 Ms McLaughlin should identify the type and dilution rate of the solution to be used in the event of a blood/bodily fluid spillage and be knowledgeable of the protocol for the management of a sharps injury. A recommendation was also made that partially discharged local anaesthetic (LA) cartridges should be disposed of in purple lidded sharps boxes and the practice of expelling LA in the sink should cease with immediate effect.

The inspector undertook a tour of the premises which were found to be maintained in general to a good standard of cleanliness. Only two mops and buckets were in place for cleaning the practice and Ms McLaughlin was unsure of what mops the cleaner used to clean which areas. A recommendation was made in this regard.

A number of issues were identified in relation to the decontamination room remain outstanding from the previous inspection and additional issues were identified during this inspection. Requirements have been made to address these. A number of issues were also identified in relation to the dental surgery which impact on infection control and a recommendation has been made to address these. Further details can be seen in section 10.2 of the report.

Ms McLaughlin 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 for the second time that the overflow of the hand washing basin in the decontamination room should be blanked off using a stainless steel plate and sealed with anti-bacterial mastic. A recommendation was also made during this inspection that the plug should be removed from the dedicated hand washing basin in the dental surgery and the overflow blanked off. Only hand sanitiser is available in the toilet facility; this is not effective if hands are visibly dirty. A recommendation was made in this regard. Information promoting hand hygiene is provided for staff and patients.

Procedures are in place for the use, maintenance, service and repair of all medical devices. Observations made and discussion with Ms McLaughlin confirmed that dental unit water lines (DUWLs) are appropriately managed.

Ms McLaughlin demonstrated good awareness of the use of personal protective equipment (PPE). Observations made confirmed that PPE was readily available and used appropriately.

Observations made and discussion with Ms McLaughlin confirmed that she is aware of the different types of waste and appropriate disposal streams. Clinical waste is disposed of into a bin in the surgery which is then transferred to the clinical waste bin located at the dirty side of the decontamination room. Neither bin is pedal operated and a recommendation was made in this regard. Appropriate arrangements are in

place in the practice for the collection of general and clinical waste, including sharps waste.

A decontamination room separate from patient treatment areas and dedicated to the decontamination process is available. As discussed previously, a number of issues were identified in relation to the decontamination environment and requirements were made to address these.

A washer disinfector, an ultrasonic cleaner and a steam steriliser have been provided to meet the practice requirements. The washer disinfector has areas of rust on the exterior and needs re-skinned and there is a crack on the lid of the ultrasonic cleaner. A recommendation was made in this regard.

Review of documentation evidenced that none of the decontamination equipment has current validation. A requirement was stated for the second time regarding validation of the ultrasonic cleaner and the steriliser and for the first time in relation to the washer disinfector.

Ms McLaughlin confirmed that all reusable dental instruments are processed through the washer disinfector in keeping with best practice outlined in HTM 01-05. However, the portals for the positioning of dental hand pieces in the washer disinfector have broken, and handpieces are processed in the washer disinfector without these. A recommendation was made in this regard.

Although Ms McLaughlin confirmed that periodic testing of equipment was undertaken, review of equipment logbooks evidenced that these had not been recorded for the ultrasonic cleaner and steriliser since 5 September 2014 and the washer disinfector since 11 July 2014. The washer disinfector was also out of use for a period of approximately three months between July and October 2014. A requirement was made that periodic tests for this equipment must be undertaken and recorded in equipment logbooks. In addition equipment faults should be fixed within a reasonable timescale.

The evidence gathered through the inspection process concluded that Roe Valley Dental Practice is moving towards compliance with this inspection theme.

Ms McLaughlin 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.

Discussion with Ms McLaughlin confirmed that whilst patient satisfaction questionnaires are available in the waiting room for patients to complete if they wish, there is no targeted approach taken in relation to this and patients are not actively asked to complete them. A recommendation has been stated for the second time in this regard.

An estates inspection was undertaken at this practice on 22 May 2013. At that time, the legionella risk assessment was due to be reviewed and a recommendation was made that on completion of the review any remedial actions and control measures identified by the assessor should be implemented. A legionella risk assessment was completed by an external contractor in June 2013. However a number of

recommendations made as a result of the risk assessment have yet to be addressed. A requirement was made during this inspection that any remedial actions and control measures identified by the assessor should be implemented.

During this inspection, issues have been identified which are of serious concern to RQIA. These include the environment of the decontamination room, validation of equipment, periodic testing of equipment and implementation of the recommendations resulting from the legionella risk assessment. Specific issues have been detailed in sections 9.0, 10.2, 10.7 and 11.4 of the report.

Following the inspection, the inspector discussed these matters with senior management. Ms McLaughlin was subsequently invited to attend a serious concerns meeting on Tuesday 6 January 2015 at RQIA, at which stage a decision will be made regarding the further actions to be taken to progress improvement.

Six requirements and 11 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 Ms McLaughlin 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(3)	Establish a fully functioning decontamination room as outlined in HTM 01-05 to include the following: • the dental chair, dental light fitting and the dental unit should be removed; • the flooring should be refurbished/replaced to address the hole where the dental chair was mounted; • the flooring should be sealed at the edges; • damaged work tops should be replaced; • the splash back above the work top should be sealed; • the inside of cabinetry should be deep cleaned; and • the layout of the room should be reviewed to ensure the illuminated magnifying device is available after the washing/disinfection process, and the steriliser should be moved away from the hand wash basin. Water from the steriliser should not be drained into the hand wash basin.	Observation of the decontamination room and discussion with Ms McLaughlin evidenced that a number of matters in relation to this requirement still need to be addressed as follows: • The dental light fitting has not been removed • The flooring has not been refurbished/replaced. The hole in the floor where the dental chair was mounted containing the electrical supply is still in situ. The flooring which is made of a laminate/semi wood is not impervious • The flooring is not appropriately sealed at the edges • Damaged worktops have not been replaced • The splash back above the work top has not been sealed • Ms McLaughlin confirmed that a deep clean of the inside of cabinetry had been undertaken following the	Not compliant

			previous inspection. However on random review of the insides of cabinetry, some areas were not in a clean state indicating that the current cleaning schedule is not sufficient The dental chair and dental unit have been removed and the layout of the decontamination room was satisfactory. This requirement has not been sufficiently addressed and the unaddressed aspects are stated for the second time. The inspector also observed that the unused intra-oral x-ray unit has not been removed from the room. The window sill behind and below the level of the cabinetry was dirty and had signs of mould and there was an area of damp on a wall in the room. A requirement was made during this inspection to address these matters. The lack of progress in addressing this requirement is concerning to RQIA. Further details can be seen in section 10.2 and 11.4 of the report.	

2	15(2)	Ensure the ultrasonic cleaner and steriliser are validated and arrangements established for annual re-validation thereafter.	The ultrasonic cleaner and steriliser have not been validated. Ms McLaughlin advised that she was not going to validate the ultrasonic cleaner as it had a crack on the lid and needs to be replaced. The ultrasonic cleaner is still in use. Ms McLaughlin advised that the steriliser had been validated since the previous inspection and that she had arrangements in place for it to be re-validated on Monday 8 December. However, the engineer cancelled the validation due to other work which he had given priority to. There was no validation certificate available to evidence that the steriliser was validated following the previous inspection. There was a certificate to confirm that the steriliser was inspected and serviced in March 2013, which was prior to the previous inspection. This did not reflect that the machine had been validated. This requirement has not been addressed and is stated for the second time. It was also noted during this inspection that the washer disinfector has not been revalidated, the last validation check having been completed on 30 July 3013.	Not compliant

			These matters are of concern to RQIA and are discussed further in section 10.7 and 11.4 of the report.	

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	8.3	Further develop the employer's procedures to include the following as required as outlined in the Ionising Radiation (Medical Exposure) Regulations (Northern Ireland) 2000: • reducing the probability and magnitude of unintentional exposures (including incident investigation); • document quality assurance; • research exposures; and • medico-legal and occupational exposures.	Review of documentation evidenced that this recommendation has been addressed.	Compliant
2	8	Introduce a more formalised approach to patient consultation. Patient consultation should be carried out at least on an annual basis.	Discussion with Ms McLaughlin confirmed that whilst patient satisfaction questionnaires are available in the waiting room for patients to complete if they wish, there is no targeted approach taken in relation to this and patients are not actively asked to complete them. The inspector suggested that a set number of days are identified during which each patient is asked to complete a questionnaire. The results of the questionnaires should then be collated and a summary report of the findings provided, which should be made available to patients. This recommendation has not been addressed and is now stated for the second time, with an additional stipulation to collate the	Not compliant

			findings into a summary report and make it available to patients.	
3	13	Remove the plug in the hand wash basin of the decontamination room and blank off the overflow using a stainless steel plate and sealing it with anti-bacterial mastic.	The inspector observed that the plug of the hand wash basin in the decontamination room has been removed, however the overflow has not been blanked off. This recommendation has been partially addressed and the unaddressed aspect is stated for the second time. The inspector observed, during this inspection, that the hand washing basin in the dental surgery also has a plug and an overflow and an additional recommendation has been made in this regard. Further details can be seen in section 10.3 of the report.	Substantially compliant
4	13	Contact health estates at the Department of Health for advice and guidance in regards to the ventilation system in the decontamination room. Any recommendations made should be addressed and records retained.	Ms McLaughlin confirmed that health estates had been contacted for advice and guidance in regards to the ventilation system in the decontamination room and a health estates officer visited the practice. However, the recommendations made by the health estates officer have not been implemented. This recommendation has been partially addressed. The unaddressed aspect in relation to ventilation is now stated as a requirement. In light of the issues identified in relation to damp	Moving towards compliance

			in the decontamination room, the lack of progress in addressing ventilation is concerning. This matter is discussed further in sections 10.2, 10.7 and 11.4 of the report.	

10.0 Inspection Findings

10.1 Prevention of Blood-borne virus exposure

STANDARD 13 – Prevention and Control of Infection (Safe and effective care) **The dental service takes every reasonable precaution to make sure you are not exposed to risk of infection.**
Criteria Assessed: **11.2** You receive care and treatment from a dental team (including temporary members) who have undergone appropriate checks before they start work in the service. **13.2** Your dental service adheres to the appropriate infection control policies and procedures in line with current best practice and legislation. **13.3** Your dental service has systems in place, including induction and ongoing training, to make sure these policies and procedures are known, and are being appropriately applied to the service at all times.
Inspection Findings:
Ms McLaughlin rated the practice arrangements for the prevention of blood-borne virus exposure as compliant on the self-assessment. Ms McLaughlin has an overarching policy in relation to infection control which includes the arrangements for the prevention and management of blood-borne virus exposure, including management of spillages, sharps and inoculation incidents in accordance with national guidance. The policy has limited advice and guidance in general, however, as Ms McLaughlin is the only clinician in the practice, the arrangements in place only relate to her. Ms McLaughlin confirmed that she has been immunised against Hepatitis B. However, on discussion with Ms McLaughlin the following issues were identified: • Ms McLaughlin could not verbalise the correct solutions to be used in the event of a blood/bodily fluid spillage • In the event of a sharps injury, Ms McLaughlin did not demonstrate awareness of the need to undertake a risk assessment and to contact the Occupational Health Department for advice and guidance on the actions to be taken A recommendation was made that Ms McLaughlin should address these matters. One orange lidded sharps box is available in the dental surgery; this is safely positioned to prevent unauthorised access, appropriately used, and signed and dated on final closure. The sharps box was not dated on assembly, however, this was done during the inspection and Ms McLaughlin confirmed this would be completed, in the future, on assembly of sharps boxes. A purple lidded sharps box for the disposal of partially discharged local anaesthetic (LA) cartridges was not available. Ms McLaughlin advised that unused LA is expelled in the sink. This is not good practice and a recommendation was made that partially discharged LA cartridges should be disposed of in purple lidded sharps boxes. The practice of expelling LA in the sink should cease with immediate effect. Used sharps boxes are locked with the integral lock and stored ready for collection away from public access.

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	**Moving towards compliance**

10.2 Environmental design and cleaning

STANDARD 13 – Prevention and Control of Infection (Safe and effective care) **The dental service takes every reasonable precaution to make sure you are not exposed to risk of infection.**
Criterion Assessed: **13.1** Your dental service's premises are clean.
Inspection Findings:
Ms McLaughlin rated the practice arrangements for environmental design and cleaning as moving towards compliance on the self-assessment. The overarching policy in relation to infection control includes cleaning and maintaining the environment. The inspector undertook a tour of the premises which were found to be maintained in general to a good standard of cleanliness. A cleaner comes in on a daily basis to clean the general areas of the practice and the floors of the dental surgery and decontamination room. Ms McLaughlin is responsible for cleaning other areas of the surgery and decontamination room and the receptionist confirmed that she cleans the office desk area. Ms McLaughlin confirmed that she cleans the worktops of the surgery between each patient and the cupboard fronts at the end of each day. Cleaning equipment was observed to be stored outside the clinical environment. However, there were only two mops provided for cleaning the practice and Ms McLaughlin was unsure of what mops were used to clean which areas. A recommendation was made that: • Three separated mops and buckets should be available for cleaning the practice, one for the clinical and decontamination areas, one for general areas and one for the toilet facility • Mops and buckets should be colour coded – it was suggested that these should reflect the National Patient Safety Agency recommendations as outlined in HTM 01-05 • The cleaner should be provided with a protocol for the cleaning arrangements in the practice outlining the colour coding to be used A number of issues previously identified in relation to the decontamination room remain outstanding as discussed in section 9.0 and a requirement was made for the second time in this regard. In addition, in relation to the decontamination room a requirement was also made that: • The unused intra-oral x-ray unit should be removed; • The cause of damp at the window and wall of the decontamination room should be investigated and made right; • The window sill behind and below the level of the cabinetry should be maintained clean; and • Adequate ventilation should be provided in the decontamination room including extract ventilation and the provision of make-up air, which meets HTM 01-05 and reduces the risk of damp. The dental surgery worktops were tidy and easy to clean with the exception of readily prepared disposable cups of dental mouthwash. This presents a risk in terms of infection control due to the potential contaminants resulting from aerosol spray when providing treatment. In addition the following issues which impact on infection control were identified: • Three trolleys containing equipment were uncovered and therefore could not effectively be cleaned/disinfected between each patient

- The enamel of the dental unit tray was worn and needs re-skinned
- Worktops were not sealed at the wall and there were no splash backs provided at sinks
- There was a fabric chair in the surgery
- There was a small tear in the fabric of the dental chair

A recommendation was made to address these matters.

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**

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:
Ms McLaughlin rated the practice arrangements for hand hygiene as compliant on the self-assessment. The practice has a hand hygiene policy and procedure in place. Discussion with Ms McLaughlin confirmed that hand hygiene is performed before and after each patient contact and at appropriate intervals. Observations made evidenced that Ms McLaughlin 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. Ms McLaughlin confirmed that nail brushes and bar soap are not used in the hand hygiene process in keeping with good practice. As discussed in section 9.0 and recommendation was made for the second time that the overflow of the hand washing basin in the decontamination room should be blanked off using a stainless steel plate and sealed with anti-bacterial mastic. A recommendation was also made during this inspection that the plug should be removed from the dedicated hand washing basin in the dental surgery and the overflow blanked off. The inspector observed that only hand sanitiser is available in the toilet facility; this is not effective if hands are visibly dirty. A recommendation was made that liquid soap and disposable paper towels for hand drying are provided in the toilet facility. Laminated posters promoting hand hygiene were on display in the dental surgery, the decontamination room and the toilet facility.

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:
Ms McLaughlin rated the practice approach to the management of dental medical devices as 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. A legionella risk assessment was completed by an external contractor in June 2013. However a number of recommendations made as a result of the risk assessment have yet to be addressed. This is discussed further in section 11.3 and 11.4 of the report and a requirement was made to implement the recommendations made by the risk assessor. Ms McLaughlin 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 Ms McLaughlin 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 reverse osmosis (RO) water to supply the DUWLs; • Self-contained water bottles are removed, flushed with RO 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	**Compliant**
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:
Ms McLaughlin rated the practice approach to the management of personal protective equipment (PPE) as compliant on the self-assessment. The infection control policy includes the use of PPE and Ms McLaughlin demonstrated awareness of this. Observations made and discussion with Ms McLaughlin evidenced that PPE was readily available and in use in the practice. Discussion with Ms McLaughlin 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.

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:
Ms McLaughlin rated the practice approach to the management of waste as compliant on the self-assessment. The infection control policy includes the management and disposal of waste. 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 Ms McLaughlin confirmed that she is aware of the different types of waste and appropriate disposal streams. Clinical waste is disposed of into a bin in the surgery which is then transferred to the clinical waste bin located at the dirty side of the decontamination room. Neither bin is pedal operated and a recommendation was made in this regard. General waste in the surgery is disposed of in a bin located within a cupboard. Appropriate arrangements are in place in the practice for the collection of general and clinical waste, including sharps waste. The inspector observed adequate provision of orange lidded sharps boxes, however as discussed in section 10.1, purple lidded sharps boxes for pharmaceutical waste are not available and a recommendation was made in this regard.

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**

10.7 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:
Ms McLaughlin rated the decontamination arrangements of the practice as moving towards compliance on the self-assessment. A decontamination room separate from patient treatment areas and dedicated to the decontamination process is available. As discussed in sections 9.0 and 10.2, a number of issues were identified in relation to the decontamination environment and requirements were made to address these. A washer disinfector, an ultrasonic cleaner and a steam steriliser have been provided to meet the practice requirements. The washer disinfector has areas of rust on the exterior and needs re-skinned and there is a crack on the lid of the ultrasonic cleaner. A recommendation was made in this regard. Review of documentation evidenced that none of the decontamination equipment has current validation. As discussed in section 9.0 a requirement was stated for the second time regarding validation of the ultrasonic cleaner and the steriliser and for the first time in relation to the washer disinfector. Ms McLaughlin confirmed that all reusable dental instruments are processed through the washer disinfector in keeping with best practice outlined in HTM 01-05. However, the portals for the positioning of dental hand pieces in the washer disinfector have broken, and handpieces are processed in the washer disinfector without these. A recommendation was made in this regard. Although Ms McLaughlin, confirmed that periodic testing of equipment was undertaken in keeping with HTM 01-05, review of equipment logbooks evidenced that periodic tests had not been recorded for the ultrasonic cleaner and steriliser since 5 September 2014 and the washer disinfector since 11 July 2014. The washer disinfector was also out of use for a period of approximately three months between July and October 2014. A requirement was made that periodic tests for this equipment must be undertaken and recorded in equipment logbooks. In addition equipment faults should be fixed within a reasonable timescale.

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
	Moving towards compliance

11.0 Additional Areas Examined

11.1 Staff Consultation/Questionnaires

Ms McLaughlin, works as a sole practitioner and is not supported by a dental nurse. Ms McLaughlin is supported in her role by reception staff. During the course of the inspection, the inspector spoke with the receptionist on duty. Questionnaires were also provided to staff prior to the inspection by the practice on behalf of the RQIA. One was returned to RQIA within the timescale required.

Review of the submitted questionnaire and discussion with the receptionist evidenced that staff have received training relevant to their roles and have the opportunity to participate in practice meetings and training updates.

11.2 Patient Consultation

Ms McLaughlin 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.

Discussion with Ms McLaughlin confirmed that whilst patient satisfaction questionnaires are available in the waiting room for patients to complete if they wish, there is no targeted approach taken in relation to this and patients are not actively asked to complete them. The inspector suggested that a set number of days are identified during which each patient is asked to complete a questionnaire. The results of the questionnaires should then be collated and a summary report of the findings provided, which should be made available to patients.

As discussed in section 9.0 of the report, a recommendation has been stated for the second time to introduce a more formalised approach to patient consultation, which should be carried out at least on an annual basis, with an additional stipulation to collate the findings into a summary report and make it available to patients.

11.3 Legionella Risk Assessment

An estates inspection was undertaken at this practice on 22 May 2013. At that time, the legionella risk assessment was due to be reviewed and a recommendation was made that on completion of the review any remedial actions and control measures identified by the assessor should be implemented.

A legionella risk assessment was completed by an external contractor in June 2013. However a number of recommendations made as a result of the risk assessment have yet to be addressed. A requirement was made during this inspection that any remedial actions and control measures identified by the assessor should be implemented.

11.4 Serious Concerns

During this inspection, issues have been identified which are of serious concern to RQIA. These include the environment of the decontamination room, validation of equipment, periodic testing of equipment and implementation of the recommendations resulting from the legionella risk assessment. Specific issues have been detailed in sections 9.0, 10.2, 10.7 and 11.4 of the report.

Following the inspection, the inspector discussed these matters with senior management. Ms McLaughlin was subsequently invited to attend a serious concerns meeting on Tuesday 6 January 2015 at RQIA, at which stage a decision will be made regarding the further actions to be taken to progress improvement.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms Winifred McLaughlin as part of the inspection process.

The timescales for completion commence from the date of inspection.

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

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

Enquiries relating to this report should be addressed to:

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Announced Inspection

Roe Valley Dental Practice

11 December 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 Ms Winifred McLaughlin 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 (3)	Establish a fully functioning decontamination room as outlined in HTM 01-05 to include the following: • the dental light fitting should be removed; • the flooring should be refurbished/replaced to address the hole where the dental chair was mounted; • the flooring should be sealed at the edges; • damaged work tops should be replaced; • the splash back above the work top should be sealed; • the inside of cabinetry should be maintained clean. **Ref 9.0, 10.2, 10.7 & 11.4**	Two	Have arranged + contacted Pascal Devlin Carpenter re these items (077 14304850)	Three month
2	25 (2) (a) (b) (c)	The unused intra-oral x-ray unit should be removed from the decontamination room. The cause of damp at the window and wall of the decontamination room should be investigated and made right. The window sill behind and below the level of the cabinetry should be maintained clean.	One	As above	Three month

		Adequate ventilation should be provided in the decontamination room including extract ventilation and the provision of make-up air, which meets HTM 01-05 and reduces the risk of damp		In progress.	
3	15 (2)	**Ref 9.0, 10.2, 10.7 & 11.4** Ensure the ultrasonic cleaner and steriliser are validated and arrangements established for annual re-validation thereafter	Two	Arranged with Denthaup for 28/1/15	Two months
4	15 (2)	**Ref 9.0, 10.7 & 11.4** Ensure the washer disinfector is validated and arrangements established for annual re-validation thereafter.	One	As above	Two months
5	15 (2)	**Ref 9.0, 10.7 & 11.4** Periodic tests for the washer disinfector, ultrasonic cleaner and steriliser must be undertaken and recorded in equipment logbooks in keeping with HTM 01-05 Decontamination equipment faults should be fixed within a reasonable timescale.	One	In progress Ordering logbooks.	Immediate and ongoing
6	15 (7)	**Ref 10.7 & 11.4** Any remedial actions and control measures identified by the assessor in the legionella risk assessment should be implemented. **Ref 10.4, 11.3 & 11.4**	One	Have contacted plumber who visited 9/1/15 + arranging what needs doing	Three month

Jim Kenny
07709735028

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	8	Introduce a more formalised approach to patient consultation Patient consultation should be carried out at least on an annual basis. The findings of the patient satisfaction questionnaires should be collated and a summary report available. The summary report should be made available to patients. **Ref 9.0 and 11.2**	Two	In progress.	Three month
2	13	Ms McLaughlin should identify the type and dilution rate of the solution to be used in the event of a blood/bodily fluid spillage. Ms McLaughlin should be knowledgeable of the protocol for the management of a sharps injury, including risk assessment and referral to the Occupational Health Department for advice and guidance on the actions to be taken **Ref 10.1**	One	Completed	One month
3	13	Partially discharged local anaesthetic (LA) cartridges should be disposed of in purple lidded sharps boxes.	One	Have contacted CANNON re same.	One month

		The practice of expelling LA in the sink should cease with immediate effect. Ref 10.1		Actioned.	
4	13	Liquid soap and disposable paper towels for hand drying should be provided in the toilet facility Ref 10.2 & 10.3	One	Actioned.	Immediate and ongoing
5	13	Three separate mops and buckets should be available for cleaning the practice, one for the clinical and decontamination areas, one for general areas and one for the toilet facility. Mops and buckets should be colour coded – it is suggested that these should reflect the National Patient Safety Agency recommendations as outlined in HTM 01-05 The cleaner should be provided with a protocol for the cleaning arrangements in the practice including the colour coding to be used Ref 10.2	One	Actioned	Two weeks
6	13	Within the dental surgery Readily prepared disposable cups of dental mouthwash should not be left on the worktop of the surgery with immediate effect. Arrangements should be made to relocate the three trolleys in the surgery containing equipment or to store the equipment in	One	Actioned	Completion within three months

		closed cupboards to ensure surfaces in the surgery can be effectively cleaned/disinfected between each patient The enamel of the dental unit tray should be re-skinned Worktops should be sealed at the wall and splash backs provided at sinks The fabric chair in the surgery should be removed The tear in the fabric of the dental chair should be made good		Contacted carpenter re this & work in progress Have contacted re repair upol	
7	13	**Ref 10.2** Blank off the overflow of the hand wash basin in the decontamination room using a stainless steel plate and sealing it with anti-bacterial mastic	Two	Arranged plumber to attend re this (Jim Henry)	Three month
8	13	**Ref 9.0 & 10.3** Remove the plug in the hand washing basin in the dental surgery and blank off the overflow using a stainless steel plate sealed with anti-bacterial mastic	One	Plug removed. AB above re overflow.	Three month
9	13	**Ref 10.3** Clinical waste should be disposed of in pedal operated bins.	One	Contacted carmen	One month
10	13	**Ref 10.6** The washer disinfector has areas of rust on the exterior and should be re-skinned	One	When being validated to arrange this	Three month

		The cracked lid of the ultrasonic cleaner should be replaced. Ref 10.7 & 11.4		Requested one from Dentaquip 21/1/15	
11	13	Portals should be provided for the washer disinfector to enable efficient cleaning of dental handpieces Ref 10.7	One	Requested from Dentaquip 21/1/15	Three month

Self Assessment audit tool of compliance with

HTM01-05 - Decontamination - Cross Infection Control

Name of practice: **Roe Valley Dental Practice**

RQIA ID: **11676**

Name of inspector: **Emily Campbell**

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

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

1 Prevention of bloodborne virus exposure			
Inspection criteria *(Numbers in brackets reflect HTM 01-05/policy reference)*	**Yes**	**No**	**If NO provide rationale and actions to be taken with timescales to achieve compliance with HTM 01-05.**
1.1 Does the practice have a policy and procedure/s in place for the prevention and management of blood borne virus exposure, including management of spillages, sharps and inoculation incidents in accordance with national guidance? (2.6)	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?	Y			
1.11 Are sharps containers available at the point of use and positioned safely (e.g. wall mounted)?	Y			
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)	Y			
1.13 Are inoculation injuries recorded?	Y			
1.14 Are disposable needles and disposable syringes discarded as a single unit?	Y			
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)	Y		
2.2 Have staff undertaking cleaning duties been fully trained to undertake such duties? (6.55)	Y		
2.3 Is the overall appearance of the clinical and decontamination environment tidy and uncluttered? (5.6)	Y		
2.4 Is the dental chair cleaned between each patient? (6.46, 6.62)	Y		
2.5 Is the dental chair free from rips or tears? (6.62)	Y		
2.6 Are all surfaces i.e. walls, floors, ceilings, fixtures and fittings and chairs free from damage and abrasion? (6.38)	Y		
2.7 Are all work-surface joints intact, seamless, with no visible damage? (6.46, 6.47)	Y		
2.8 Are all surfaces i.e. walls, floors, ceilings, fixtures and fittings and chairs free from dust and visible dirt? (6.38)	Y		
2.9 Are the surfaces of accessible ventilation fittings/grills cleaned at a minimum weekly? (6.64)	Y		
2.10 Are all surfaces including flooring in clinical and decontamination areas impervious and easy to clean? (6.46, 6.64)	Y		Decontamination room edges of flooring not fully compliant

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

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

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

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

3.18 Are hand-cream dispensers with disposable cartridges available for all clinical and decontamination staff? (6.7, Appendix 1)	Y			
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)	Y		
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)	Y		
4.3 Has the practice a written scheme for prevention of legionella contamination in water pipes and other water lines?(6.75, 19.2)	Y		
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)	Y		
4.5 Impression material, prosthetic and orthodontic appliances: Are prosthetic and orthodontic appliances decontaminated before being placed in the patient's mouth? (7.1b)	Y		
4.6 Dental Unit Water lines (DUWLs): Are in-line filters cleaned/replaced as per manufacturer's instructions?(6.89, 6.90)	Y		

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

4.15 Dental Unit Water lines (DUWLs): Are DUWL filters changed according to the manufacturer's guidelines? (6.89)	Y			
Provider's level of compliance				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)	Y		
5.2 Are staff trained in the use of personal protective equipment as part of the practice induction? (6.13)	Y		
5.3 Are powder-free CE marked gloves used in the practice? (6.20)	Y		
5.4 Are alternatives to latex gloves available? (6.19, 6.20)	Y		
5.5 Are all single-use PPE disposed of after each episode of patient care? (6.21, 6.25, 6.36c)	Y		
5.6 Is hand hygiene performed before donning and following the removal of gloves? (6.4 Appendix 1)	Y		
5.7 Are clean, heavy duty household gloves available for domestic cleaning and decontamination procedures where necessary? (6.23)	Y		
5.8 Are heavy-duty household gloves washed with detergent and hot water and left to dry after each use? (6.23)	Y		
5.9 Are heavy-duty household gloves replaced weekly or more frequently if worn or torn? (6.23)	Y		

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)	Y		
5.11 Are single-use plastic aprons disposed of as clinical waste after each procedure? (6.25)	Y		
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)	Y		
5.13 Are masks disposed of as clinical waste after each use? (6.27, 6.36)	Y		
5.14 Are all items of PPE stored in accordance with manufacturers' instructions? (6.14)	Y		
5.15 Are uniforms worn by all staff changed at the end of each day and when visibly contaminated? (6.34)	Y		
5.16 Is eye protection for staff used during decontamination procedures cleaned after each session or sooner if visibly contaminated? (6.29)	Y		
5.17 Is eye protection provided for the patient and staff decontaminated after each episode of patient care? (6.29)	Y		
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))	Y		
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))	Y		
6.3 Is there evidence that the waste contractor is a registered waste carrier? (6.87 (07-01) 6.90 (07-01))	Y		
6.4 Are all disposable PPE disposed of as clinical waste? (6.26, 6.27, 6.36, HTM 07-01 PEL (13) 14)	Y		
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))	Y		
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))	Y		
6.8 Are black/clear bags used for domestic waste including paper towels? (HTM 07-01, PEL (13) 14, 5.51 (07-01))	Y		

6.9 Are bins foot operated or sensor controlled, lidded and in good working order? (5.90 (07-01))	Y			
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))	Y			
6.11 Are clinical waste sacks securely tied and sharps containers locked before disposal? (5.87 (07-01))	Y			
6.12 Are all clinical waste bags and sharps containers labelled before disposal? (5.23 (07-01), 5.25 (07-01))	Y			
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))	Y			
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))	Y			
6.15 Are all consignment notes for all hazardous waste retained for at least 3 years?(6.105 (07-01))	Y			
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))	Y			
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))	Y			
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)	Y		
7.2 Does the practice have washer disinfector(s) in sufficient numbers to meet the practice requirements? (PEL(13)13)	Y		
7.3 Are all reusable instruments being disinfected using the washer disinfector? (PEL(13)13)	Y		
7.4 Does the practice have steam sterilisers in sufficient numbers to meet the practice requirements?	Y		
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)	 Y	N	Awaiting validation
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)	Y Y		

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?	Y Y		
Provider's level of compliance			Moving towards compliance

Please provide any comments you wish to add regarding good practice

Appendix 1

Name of practice: Roe Valley Dental Practice

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 [Y] 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 [Y] No [ ]

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

Yes [Y] No [ ]