Announced Inspection

Name of Establishment:	**Lisburn Dental Clinic**
Establishment ID No:	**11690**
Date of Inspection:	**14 October 2014**
Inspector's Name:	**Stephen O'Connor**
Inspection No:	**20162**

The Regulation and Quality Improvement Authority
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1.0 General Information

Name of establishment:	Lisburn Dental Clinic
Address:	33 Bachelor's Walk Lisburn BT28 1XN
Telephone number:	028 92663893
Registered organisation / registered provider:	Mr David Hanna
Registered manager:	Mr David Hanna
Person in charge of the establishment at the time of Inspection:	Mr David Hanna
Registration category:	IH-DT
Type of service provision:	Private dental treatment
Maximum number of places registered: (dental chairs)	2
Date and type of previous inspection:	Announced Inspection and Variation to Registration 20 May 2013
Date and time of inspection:	14 October 2014 10:20 – 12:55
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 David Hanna, registered provider;
- examination of relevant records;
- consultation with relevant staff;
- tour of the premises; and
- evaluation and feedback.

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

5.0 Consultation Process

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

	Number	
Discussion with staff	2	
Staff Questionnaires	5 issued	4 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

Lisburn Dental Clinic is located within a former residential property which has been adapted and converted to accommodate a dental practice. The establishment is located near Lisburn city centre. Limited on-street car parking is available; however additional car parking is available within walking distance.

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

The practice currently provides two surgeries, a decontamination room, combined reception and waiting area, a separate waiting area, toilets, an office, staff and storage facilities. There is potential for a third surgery to be established on the first floor of the practice. Mr Hanna is aware that should a third surgery been established a variation application should be submitted to RQIA prior to the surgery becoming operational.

Lisburn Dental Clinic operates two chairs, providing both private and NHS dental care. Mr Hanna is supported by a team of staff including an associate dentist, a dental hygienist, dental nurses and receptionist staff.

The practice is a training practice approved by the Northern Ireland Medical and Dental Training Agency (NIMDTA). Mr Hanna informed the inspector that he has taken the decision not to facilitate any dental foundation year one (DF1) trainee placements at this time. The most recent DF1 placement ended during August 2014, following which an associate dentist commenced work in the practice.

Mr David Hanna has been the registered provider and manager of Lisburn Dental Clinic since initial registration with RQIA on the 13 September 2011.

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

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

8.0 Summary of Inspection

This announced inspection of Lisburn Dental Clinic was undertaken by Stephen O'Connor on 14 October 2014 between the hours of 10:20 and 12:55. Mr David Hanna, 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 three of the four requirements and six of the seven recommendations have been fully addressed and compliance achieved. The requirement made in regards to the commissioning of the washer disinfector and processing all compatible instruments in the washer disinfector has been partially addressed and the unaddressed component is now stated for the second time. The recommendation made in regards to the storage of Glucagon has not been addressed as it was established that the Glucagon medicine and an additional six emergency medicines had exceeded their expiry dates. A requirement is now made in regards to the management of emergency medicines. The detail of the action taken by Mr Hanna can be viewed in the section following this summary.

Prior to the inspection, Mr Hanna completed a self-assessment using the standard criteria outlined in the theme inspected. The comments provided by Mr Hanna in the self-assessment were not altered in any way by RQIA. The self-assessment is included as appendix one in this report.

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

Questionnaires were also issued to staff; four were returned to RQIA within the timescale required. Review of submitted questionnaires and discussion with staff evidenced that staff were knowledgeable regarding the inspection theme and that they have received training appropriate to their relevant roles. Staff confirmed that they are familiar with the practice policies and procedures and have received infection prevention and control training. Clinical staff confirmed that they have been immunised against Hepatitis B. A comment included on a submitted questionnaire can be found in section 11.1 of this report.

Inspection Theme – Cross infection control

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

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

A copy of the 2013 edition of HTM 01-05 Decontamination in primary dental care practices is available at the practice for staff reference. Staff are familiar with best practice guidance outlined in the document. Mr Hanna informed the inspector that the Infection Prevention Society (IPS) audit tool has not been completed 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 a blood spillage kit must be provided and staff trained on its use. Review of documentation and discussion with Mr Hanna and staff evidenced that appropriate arrangements are in place for the prevention and management of blood-borne virus exposure. Staff confirmed that they are aware of, and are adhering to, the practice policy in this regard. In the main sharps management at the practice was observed to be in line with best practice. A recommendation was made that sharps containers must be signed and dated on assembly; and that sharps containers provided are in keeping with PEL (13)14 issued by the Department of Health on 18 October 2013.

The premises were clean and tidy and clutter was kept to a minimum. Satisfactory arrangements are in place for the cleaning of the general environment and dental equipment.

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

A written scheme for the prevention of legionella is available. A recommendation was made to further develop the legionella control measures to include monthly monitoring of hot and cold sentinel water temperatures, and that records must be retained for inspection. Procedures are in place for the use, maintenance, service and repair of all medical devices. Mr Hanna and staff informed the inspector that there are no arrangements in place to purge the DUWLs with disinfectants. A recommendation was made to review the manufacturer's instructions and ensure that DUWLs are disinfected in accordance with the instructions.

The practice has a policy and procedure in place for the use of personal protective equipment (PPE) and staff spoken with demonstrated awareness of this.

Observations made confirmed that PPE was readily available and used appropriately by staff.

Appropriate arrangements were in place for the management of general and clinical waste, including sharps. Waste was appropriately segregated, with the exception of one sharps container in the decontamination room that was not in keeping with best practice as outlined in HTM 01-07. As discussed previously a recommendation was

made in this regard. Suitable arrangements were in place for the storage and collection of waste by a registered waste carrier. Relevant consignment notes are retained in the practice for at least three years.

A decontamination room separate from patient treatment areas and dedicated to the decontamination process is available. Appropriate arrangements are in place for the decontamination of reusable dental instruments with the exception of dental handpieces which are manually cleaned prior to sterilisation. As discussed previously a requirement was made during the previous inspection in regards to the decontamination of reusable dental instruments. A requirement stated for the second time has been made in regards to the decontamination of handpieces.

Appropriate validated equipment, including a washer disinfector and two steam sterilisers have been provided to meet the practice requirements. In the main review of equipment logbooks demonstrated that that periodic tests are undertaken and recorded in keeping with HTM 01-05. The details of the daily automatic control test (ACT) for the steam sterilisers are not recorded. A recommendation was made to address this. A dental nurse informed the inspector that the printer connected to the Statim steriliser does not work. A recommendation was made this printer 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.

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

Mr Hanna confirmed on the submitted self-assessment that arrangements are in place for consultation with patients, at appropriate intervals, and that results of the consultation have been made available to patients. Review of documentation and discussion with Mr Hanna demonstrated that the most recent patient satisfaction survey was undertaken during May 2013. A requirement was made that patient satisfaction surveys should be completed at least on an annual basis as part of the quality assurance process. On completion of the patient satisfaction surveys a report of the findings must be produced and made available to patients.

As discussed previously a recommendation was made during the previous inspection in regards to the storage of Glucagon. During this inspection review of the medical emergency kit demonstrated that the Glucagon and an additional six medicines retained for the management of a medical emergency had exceeded their expiry dates. This is discussed further in section 11.3 of this report. A requirement was made in regards to the management of emergency medicines.

A requirement was made during the previous inspection to ensure that the appointed radiation protection advisor (RPA) undertakes a critical examination of the radiology equipment and retain records for inspection. Review of documents demonstrated that a critical examination of the newly installed intra-oral machines had been undertaken by the RPA. However, review of the RPA report demonstrated that a number of recommendations were made, and not all of these have been addressed. This was discussed with Mr Hanna and a recommendation was made to address this.

Three requirements, one of which is stated for the second time and eight recommendations were made as a result of the announced inspection; details can be found in the main body of the report and the attached Quality Improvement Plan (QIP).

The inspector wishes to thank Mr Hanna 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 should be commissioned and all reusable dental instruments; manufacturer's instruction permitting should be cleaned in the washer disinfector.	Following the previous inspection a copy of the washer disinfector validation certificate was received by RQIA on the 9 July 2013. Discussion with a dental nurse demonstrated that all compatible dental instruments with the exception of dental handpieces are processed in the washer disinfector. Dental handpieces are manually cleaned prior to sterilisation. Additional information in this regard can be found in section 10.7 of this report. This requirement has been partially addressed and a requirement has been made for the second time in regards to the decontamination of handpieces.	Substantially compliant
2	15 (2) (b)	Ensure that the washer disinfector and steam sterilisers are maintained and validated in line with HTM 01-05 or the manufacturer's instructions and records are retained for inspection.	Review of documentation and discussion with Mr Hanna demonstrated that the washer disinfector and steam sterilisers have been maintained and validated in keeping with HTM 01-05. This requirement has been addressed.	Compliant
3	15 (2) (b)	Establish log books for each piece of decontamination equipment. Log books should contain the following information; • Details of the machine and location; • Commissioning report;	Review of documentation and discussion with a dental nurse demonstrated that pre-printed logbooks are available for each machine used during the decontamination process. Review of these logbooks demonstrated that all information with the exception of the details of the daily	Compliant

		• Daily/weekly test record sheets; • Quarterly 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.	automatic control test (ACT) for the steam sterilisers is recorded. A recommendation was made to address this. Additional information in this regard can be found in section 10.7 of this report. This requirement has been addressed.	
4	15 (2) (b)	Ensure that the appointed radiation protection advisor undertakes a critical examination of the radiology equipment and retain records for inspection.	Following the previous inspection a copy of the radiation protective advisor (RPA) critical examination certificates for the two intra-oral x-ray machines was received by RQIA on the 9 July 2013. This requirement has been addressed. Review of the RPA critical examination report, during this inspection, demonstrated that a number of recommendations had been made. Discussion with Mr Hanna and review of the radiation protection file demonstrated that not all of the RPA recommendations have been addressed. A recommendation was made to address this, additional information in this regard can be found in section 11.4 of this report.	Compliant

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	13	The flooring in the decontamination room should be sealed at the edges where it meets the kicker boards of the cabinetry to prevent the accumulation of dust and dirt and to prevent the ingress of water.	It was observed that the flooring in the decontamination room has been sealed where the kicker boards of cabinetry meets the floor. This recommendation has been addressed.	Compliant
2	13.2	The practice of sterilising wrapped instruments in an unwrapped sterilisation cycle should be reviewed in line with best practice guidance.	Discussion with a dental nurse demonstrated that only unwrapped instruments are sterilised using an unwrapped sterilisation cycle. This recommendation has been addressed.	Compliant
3	13.4	Establish an instrument log book detailing the testing, servicing, maintenance and repair of instruments and retain records for inspection.	Review of documentation and discussion with a dental nurse demonstrated that an instrument logbook has been established. This recommendation has been addressed.	Compliant
4	9	A report detailing the findings of the patient satisfaction survey should be generated and made available to patients.	Review of documentation demonstrated that a report detailing the findings of the patient satisfaction survey undertaken during May 2013 has been generated. This recommendation has been addressed. Mr Hanna confirmed that the May 2013 patient satisfaction survey is the most recent patient satisfaction survey undertaken; this should be	Compliant

			completed at least on an annual basis. A requirement was made in this regard. Additional information can be found in section 11.2 of this report.	
5	1	The patient guide should be updated to ensure it reflects the new name and location of the practice, and the key themes specified in regulation 8 of The Independent Health Care Regulations (Northern Ireland) 2005.	Following the previous inspection a copy of the updated patient guide reflecting the new name and location of the practice was received by RQIA on the 9 July 2014. This recommendation has been addressed.	Compliant
6	8.3	The employer's procedures and local rules should be reviewed and updated to reflect the local arrangements as a result of the new location of the practice.	Following the previous inspection o copy of the updated employer's procedures and local rules was received by RQIA on the 9 July 2014. This recommendation has been addressed.	Compliant
7	12.4	Review the storage arrangements for the Glucagon medication as outlined in the main body of the report.	Mr Hanna informed the inspector that Glucagon was retained in the medical emergency kit. On review of the medical emergency kit it was observed that the Glucagon had expired in July 2014. Further examination of the medical emergency kit identified an additional six medicines that had exceeded their expiry dates. A requirement was made to address this. Further information can be found in section 11.3 of this report. This recommendation has not been addressed and is now stated as a requirement.	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 Hanna rated the practice arrangements for the prevention of blood-borne virus exposure as substantially compliant on the self-assessment. The practice has a policy and procedure in place for the prevention and management of blood-borne virus exposure, including management of spillages, sharps and inoculation incidents in accordance with national guidance. A recommendation was made that a blood spillage kit must be provided and staff trained on its use. Review of documentation and discussion with Mr Hanna and staff 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 • records are retained regarding the Hepatitis B immunisation status of clinical staff. Mr Hanna confirmed that in the future all newly recruited clinical staff will receive and occupational health check. Discussion with staff confirmed that they are aware of the policies and procedures in place for the prevention and management of blood-borne virus exposure. Observations made and discussion with staff evidenced that sharps are appropriately handled. Sharps boxes are housed in cupboards to prevent unauthorised access, and a dental nurse informed the inspector that they are signed and dated on final closure. Used sharps boxes are locked with the integral lock and stored ready for collection away from public access. Two issued were identified in relation to sharps containers, as follows: • it was observed that the sharps boxes in use had not been signed and dated on assembly; and • that a blue lidded sharps box was being used in the decontamination room. These issues are not in keeping with best practice guidance and a recommendation was made in to address them. Discussion with staff and review of documentation evidenced that arrangements are in place for

the management of a sharps injury, including needle stick injury. Staff are aware of the actions to be taken in the event of a sharps injury.

Provider's overall assessment of the dental practice's compliance level against the standard assessed	**Substantially compliant**
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 Hanna rated the practice arrangements for environmental design and cleaning as compliant on the self-assessment. The practice has a policy and procedure in place for cleaning and maintaining the environment. The inspector undertook a tour of the premises which were found to be maintained to a good standard of cleanliness. Clinical and decontamination areas were tidy and uncluttered and work surfaces were intact and easy to clean. Floor coverings are impervious and were either coved or sealed at the edges. Fixtures, fittings, dental chairs and equipment were free from damage, dust and visible dirt. Discussion with staff confirmed that appropriate arrangements are in place for cleaning including: • Equipment surfaces, including the dental chair, are cleaned between each patient; • Daily cleaning of floors, cupboard doors and accessible high level surfaces; • Weekly/monthly cleaning schedule; • Cleaning equipment is colour coded; • Cleaning equipment is stored in a non-clinical area; and • Dirty water is disposed of at an appropriate location. Discussion with staff and review of submitted questionnaires confirmed that staff had received relevant training to undertake their duties. The practice has a local policy and procedure for spillage in accordance with the Control of Substances Hazardous to Health (COSHH) and staff spoken with demonstrated awareness of this.

Provider's overall assessment of the dental practice's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the dental practice's compliance level against the standard assessed	**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 Hanna rated the practice arrangements for hand hygiene as compliant on the self-assessment. The practice has a hand hygiene policy and procedure in place. Mr Hanna confirmed that hand hygiene is included in the induction programme and that hand hygiene training is updated periodically. Discussion with staff confirmed that hand hygiene is performed before and after each patient contact and at appropriate intervals. Observations made evidenced that clinical staff had short clean nails and jewellery such as wrist watches and stoned rings were not worn in keeping with good practice. Dedicated hand washing basins are available in the dental surgeries and the decontamination room and adequate supplies of liquid soap, paper towels and disinfectant rub/gel were available. Staff confirmed that nail brushes and bar soap are not used in the hand hygiene process in keeping with good practice. The inspector observed that laminated /wipe-clean posters promoting hand hygiene were on display in dental surgeries, and the decontamination room. The inspector suggested that hand hygiene posters are also displayed in the patient and staff toilet facilities.

Provider's overall assessment of the dental practice's compliance level against the standard assessed	**Compliant**
Inspector's overall assessment of the dental practice's compliance level against the standard assessed	**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 Hanna 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. The inspector reviewed the written scheme for the prevention of legionella contamination in water pipes and other water lines and discussion with Mr Hanna and staff confirmed that this is adhered to. A recommendation was made to further develop the legionella control measures to include monthly monitoring of hot and cold sentinel water temperatures, records must be retained for inspection. Staff confirmed that impression materials, prosthetic and orthodontic appliances are decontaminated prior to despatch to laboratory and before being placed in the patient's mouth. Observations made and discussion with staff confirmed that DUWLs are appropriately managed. This includes that: • Filters are cleaned/replaced as per manufacturer's instructions; • An independent bottled-water system is used to dispense 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; and • DUWLs and handpieces are fitted with anti-retraction valves. Mr Hanna and staff confirmed that there are no arrangements in place to purge the DUWLs with disinfectants. A recommendation was made to review the manufacturer's instructions and ensure that DUWLs are disinfected in accordance with the instructions.

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:
Mr Hanna rated the practice approach to the management of personal protective equipment (PPE) as compliant on the self-assessment. The practice has a policy and procedure in place for the use of PPE and staff spoken with demonstrated awareness of this. Mr Hanna confirmed that the use of PPE is included in the induction programme. Observations made and discussion with staff evidenced that PPE was readily available and in use in the practice. Discussion with staff confirmed that: • Hand hygiene is performed before donning and following the removal of disposable gloves; • Single use PPE is disposed of appropriately after each episode of patient care; • Heavy duty gloves are available for domestic cleaning and decontamination procedures where necessary; and • Eye protection for staff and patients is decontaminated after each episode. Staff confirmed that they were aware of the practice uniform policy.

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

10.6 Waste

STANDARD 13 – Prevention and Control of Infection (Safe and effective care) The dental service takes every reasonable precaution to make sure you are not exposed to risk of infection.
Criterion Assessed: **13.2** Your dental service adheres to the appropriate infection control policies and procedures in line with current best practice and legislation. **13.3** Your dental service has systems in place, including induction and ongoing training, to make sure these policies and procedures are known, and are being appropriately applied to the service at all times..
Inspection Findings:
Mr Hanna rated the practice approach to the management of waste as compliant on the self-assessment. The practice has a policy and procedure in place for the management and disposal of waste in keeping with HTM 07-01. Mr Hanna confirmed that the management of waste is included in the induction programme and that waste management training is updated periodically. Review of documentation confirmed that contracted arrangements are in place for the disposal of waste by a registered waste carrier and relevant consignment notes are retained in the practice for at least three years. Observations made and discussion with staff confirmed that staff are aware of the different types of waste and appropriate disposal streams. 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 including those for pharmaceutical waste, throughout the practice. These were being managed as discussed in section 10.1 of the report.

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

10.7 Decontamination

STANDARD 13 – Prevention and Control of Infection (Safe and effective care) **The dental service takes every reasonable precaution to make sure you are not exposed to risk of infection.**
Criterion Assessed: 13.4 Your dental service meets current best practice guidance on the decontamination of reusable dental and medical instruments.
Inspection Findings:
Mr Hanna omitted to rate the decontamination arrangements of the practice on the self-assessment. A decontamination room separate from patient treatment areas and dedicated to the decontamination process is available. Appropriate equipment, including a washer disinfector and two steam sterilisers have been provided to meet the practice requirements. Review of documentation evidenced that equipment used in the decontamination process has been appropriately validated. Arrangements are in place to ensure that reusable dental instruments are appropriately cleaned, sterilised and stored following use in keeping with best practice guidance as outlined in HTM 01-05, with the exception of dental handpieces which are manually cleaned prior to sterilisation. Some of the handpieces viewed on the day of inspection had the washer disinfector compatible symbol. Best practice guidance in regards to the decontamination of dental handpieces was discussed with Mr Hanna and staff. As discussed previously a requirement stated for the second time has been made in regards to the decontamination of handpieces. As discussed previously in section 9.0 of this report pre-printed logbook are available for each machine used during the decontamination process. Review of these logbooks demonstrated that with the exception of the details of the daily automatic control test (ACT) for the steam sterilisers, periodic tests are undertaken and recorded in keeping with HTM 01-05. A recommendation was made in relation to undertaking and recording the ACT daily for the sterilisers. During discussion a dental nurse informed the inspector the cycle parameters of the Statim steriliser are not recorded as the machine printer is not working. A recommendation was made that this printer 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. A copy of the updated 2013 edition of HTM 01-05 Decontamination in primary care dental practices is available for staff reference. Mr Hanna 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.

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

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

11.0 Additional Areas Examined

11.1 Staff Consultation/Questionnaires

During the course of the inspection, the inspector spoke with two dental nurses. Questionnaires were also provided to staff prior to the inspection by the practice on behalf of the RQIA. Three were returned to RQIA within the timescale required.

Review of submitted questionnaires and discussion with staff evidenced that staff were knowledgeable regarding the inspection theme and that they have received training appropriate to their relevant roles. Staff confirmed that they are familiar with the practice policies and procedures and have received training in infection prevention and control. Clinical staff confirmed that they have been immunised against Hepatitis B.

The following comment was included in submitted questionnaire:

- "I found the induction programme very helpful, I started this job already knowledgeable about my role and practice procedures".

11.2 Patient Consultation

Mr Hanna confirmed on the submitted self-assessment that arrangements are in place for consultation with patients, at appropriate intervals, and that results of the consultation have been made available to patients. Mr Hanna also confirmed on the submitted self-assessment that feedback provided by patients has not been used by the service to improve. This was discussed with Mr Hanna who informed the inspector that to date no patient satisfaction surveys included comments about improving the service, however in the future comments will be used to improve the service were possible.

As discussed previously in section 9.0 of this report Mr Hanna informed the inspector that the May 2013 patient satisfaction survey is the most recent patient satisfaction survey undertaken. A requirement was made that patient satisfaction surveys should be completed at least on an annual basis as part of the quality assurance process. On completion of the surveys a report of the findings must be produced and made available to patients.

11.3 Emergency Medicines

As discussed previously in section 9.0 of this report a recommendation was made during the previous inspection to review the storage arrangements of Glucagon. During this inspection Mr Hanna informed the inspector that Glucagon was retained in the medical emergency kit. Review of the medical emergency kit demonstrated that the Glucagon medicine had expired in July 2014. Further examination of the medical emergency kit identified an additional six medicines that had exceeded their expiry dates. Mr Hanna was present during the review of the medical emergency kit and he removed the expired medicines during the inspection. Mr Hanna informed the inspector that an alert is entered in the practices computerised calendar system to notify staff that emergency medicines are due to expire so that they can be

replaced. Mr Hanna was unable to explain why this alert system had failed. The inspector discussed alternative systems to review the expiry dates of emergency medicines.

During the inspection four of the expired medicines were replaced, adrenalin in a suitable format for administration to children has yet to be replaced. Mr Hanna informed the inspector that as two of the expired medicines are not included on the list of medicines recommended to be retained by dental practices for the management of a medical emergency these will not be replaced.

A requirement was made that the following issues in relation to the administration of emergency medications must be addressed:

- ensure all medications retained for use in a medical emergency are retained in date;
- replace emergency medicines that have exceeded their expiry dates;
- implement a robust system to check expiry dates of all emergency medicines; and
- ensure Glucagon is stored in accordance with manufacturers guidance.

11.4 Radiology

As discussed previously in section 9.0 of this report a requirement was made during the previous inspection to ensure that the appointed RPA undertakes a critical examination of the radiology equipment and retain records for inspection.

Following the previous inspection a copy of the RPA critical examination certificates for the two newly installed intra-oral x-ray machines was received by RQIA on the 9 July 2013.

Review of the RPA critical examination report, during this inspection, demonstrated that a number of recommendations had been made by the RPA. Discussion with Mr Hanna and review of the radiation protection file demonstrated that not all of the RPA recommendations have been addressed. A recommendation was made to review the RPA critical examination report dated the 16 June 2013, and ensure that all recommendations made have been addressed. Written confirmation of actions taken to address these recommendations must be retained.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mr Hanna 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

The Regulation and Quality Improvement Authority

REGULATION AND QUALITY
10 NOV 2014
IMPROVEMENT AUTHORITY

Quality Improvement Plan

Announced Inspection

Lisburn Dental Clinic

14 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 David Hanna 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)	All reusable dental instruments; manufacturer's instruction permitting should be cleaned in the washer disinfector. Compatible dental handpieces must be processed through the washer disinfector as part of the decontamination process. **Ref: 9.0 & 10.7**	Two	All intruments including dental handpieces are processed though the washer disinfector as indicated and appropriate by the manufacturer. Staff trained accordingly Staff made aware of WD symbols on handpieces	Immediate and on-going
2	17 (1)	Patient satisfaction surveys should be completed at least on an annual basis as part of the quality assurance process. On completion of the patient satisfaction surveys a report of the findings must be produced and made available to patients. **Ref: 9.0 & 11.2**	One	Patient satisfaction surveys completeda and a report compiled for patient availability	Two months
3	15 (6)	The following issues in relation to the administration of emergency medications must be addressed: • ensure all medications retained for use in a medical emergency are retained in date; • replace emergency medicines that have exceeded their expiry dates; • implement a robust system to check	One	Changed previous failed system Now emergency drugs checked monthly by staff member as part of monthly checklist and David Hanna informed if sell by date approaching and drugs replaced. Glucagon not refridgerated-	One week

		expiry dates of all emergency medicines; and • ensure Glucagon is stored in accordance with the manufacturer's instructions. **Ref: 9.0 & 11.3**		use by date written on packaging 18months from leaving pharmacy fridge	

RECOMMENDATIONS

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

NO.	MINIMUM STANDARD REFERENCE	RECOMMENDATIONS	NUMBER OF TIMES STATED	DETAILS OF ACTION TAKEN BY REGISTERED PERSON(S)	TIMESCALE
1	13	In keeping with best practice guidance the details of the daily automatic control test (ACT) must be undertaken and recorded for both steam sterilisers in the machine logbooks. **Ref: 9.0 & 10.7**	One	ACT carried out every day for autoclaves and washer disinfectors and logged in individual logbooks Data loggers checked regularly and downloaded- kept as hard file as well at reception	One month
2	8.3	Review the radiation protection advisor (RPA) critical examination report, dated the 16 June 2013 and ensure that all recommendations made in the report have been addressed. Written confirmation of actions taken to address these recommendations must be retained. **Ref: 9.0 & 11.4**	One	All staff have read and signed 1. local rules and employers procedures 2. Authorised persons and trainig records Audit carried out on justification, evaluation and quality of radiographs	One month
3	13	A blood spillage kit must be provided and staff trained on its use. **Ref: 10.1**	One	Blood spillage kit purchased and staff trained 21/10/14	One month
4	13	The following issues in relation to sharps containers must be addressed: • sharps containers must be signed and dated on assembly; and • ensure that the sharps containers provided are in keeping with PEL (13)14 issued by the Department of	One	Covered again at staff meeting 21/10/14-	Immediate and on-going

		Health on 18 October 2013. **Ref: 10.1**			
5	13	Further develop the legionella control measures to include monthly monitoring of hot and cold sentinel water temperatures, records must be retained for inspection. **Ref:10.4**	One	Legionella risk assessesment carried out and policy updated 3/11/14- staff trainng given Water temperatures, max and minimum checked weekly by staff member as part of larger checklist	One month
6	13	Review the manufacturer's instructions and ensure that dental unit water lines (DUWLs) are disinfected in accordance with the instructions. **Ref: 10.4**	One	DUWL disinfected following advice from Henry Schein-Oxygenal is added to water bottle system to treat water lines and reduce biofilm	One month
7	13	The printer connected to the Statim 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	Statim printer checked and to be replaced by Dentaquip	Two months
8	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	IPS audit tool completed and added to 6 monthly checklist	One month

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

Name of Registered Manager Completing QIP	
Name of Responsible Person / Identified Responsible Person Approving QIP	DAVID HANNA David Hanna

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	✓	STEPHEN O'CONNOR	10.11.14
Further information requested from provider	NO	STEPHEN O'CONNOR	10.11.14

Self Assessment audit tool of compliance with

HTM01-05 - Decontamination - Cross Infection Control

Name of practice:	**Lisburn Dental Clinic**
RQIA ID:	**11690**
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)	y		
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)	y		
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)		n	New staff (in recent years this has been FD1 dentists) have seen occupational health Principal dentist David Hanna has attended OH following move to new premises. 1 other staff member has as well as result of an innoculation injury
1.4 Can decontamination and clinical staff demonstrate current immunisation with the hepatitis B vaccine e.g. documentation? (2.4s, 8.8)	y		
1.5 Are chlorine-releasing agents available for blood /bodily fluid spillages and used as per manufacturer's instructions? (6.74)	y		
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?	y		

1.7 Are in-use sharps containers labelled with date, locality and a signature?	y			
1.8 Are sharps containers replaced when filled to the indicator mark?	y			
1.9 Are sharps containers locked with the integral lock when filled to the indicator mark? Then dated and signed?	y			
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				Substantially 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		

2.11 Do all floor coverings in clinical and decontamination areas have coved edges that are sealed and impervious to moisture? (6.47)	y		
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				Compliant

3 Hand hygiene			
Inspection criteria	**Yes**	**No**	**If NO provide rationale and actions to be taken with timescales to achieve compliance with HTM 01-05.**
3.1 Does the practice have a local policy and procedure for hand hygiene? (2.6 Appendix 1)	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)	y		
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 y		
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?			
Provider's level of compliance			Provider to complete

Please provide any comments you wish to add regarding good practice

Appendix 1

Name of practice: Lisburn Dental Clinic

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 [ ] No [n]

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

Yes [y] No [ ]