Combined Practice Inspection Checklist

* The Combined Practice Inspection Checklist combines Health Board and Vocational Training inspection items and includes items from the National Standards for Dental Services.
* Items are numbered (starting on page 8) for ease of reference.
* Items are categorised as ‘**A**’ (essential), ‘**B**’ (best practice), ‘**I**’ (for information).
* To successfully complete your inspection, you must meet all essential criteria (i.e. those items categorised as ‘**A**’).
* Access to all the surgeries in your practice will be needed during the inspection visit. Please schedule patient appointments accordingly.
* To minimise the length of time required for the inspection, please have all relevant documentation prepared for inspector review in the order set out in the Checklist.
* To help your practice prepare for your inspection, sources of information have been included in the final column of the Checklist. Sources of information include: Guidance from the Scottish Dental Clinical Effectiveness Programme (SDCEP) ([www.sdcep.org.uk](http://www.sdcep.org.uk)) and the Practice Support Manual ([www.psm.sdcep.org.uk](http://www.psm.sdcep.org.uk)).

**Disclaimer**

|  |
| --- |
| *Please note that, owing to the scope of the inspection it will not be practicable for the inspector to make an exhaustive check of the content of every policy and procedure covered by the inspection document, and consequently practitioners are reminded that the responsibility for ensuring compliance with all legislative and regulatory matters relating to dental practice remains with the practice.* |

Contents

[Part 1 Practice Details and Personnel 5](#_Toc458085999)

[Part 2 Practice Requirements 8](#_Toc458086000)

[Part 3 Observation of Decontamination Process 34](#_Toc458086001)

[Part 4 Individual Surgeries 40](#_Toc458086002)

[Part 5 Practice/Clinic Inspection Visit Report 50](#_Toc458086003)

Information Sources

|  |  |
| --- | --- |
| Information Source | Web Location |
| * CDO IR(ME)R letter 19.09.12 | [www.scottishdental.org/library/cdo-letter-about-irmer/](file:///C:/Users/LindaY/Desktop/CPI/www.scottishdental.org/library/cdo-letter-about-irmer/) |
| * Department of Health Guidance (Child Protection) | [www.cpdt.org.uk](http://www.cpdt.org.uk) |
| * Disclosure Scotland (Protecting Vulnerable Groups Scheme) | [www.disclosurescotland.co.uk/disclosureinformation/pvgscheme.htm](http://www.disclosurescotland.co.uk/disclosureinformation/pvgscheme.htm) |
| * General dentistry exposure prone procedure (EPP) categorisation | [www.gov.uk/government/uploads/system/uploads/attachment\_data/file/511570/UKAP\_General\_Dentistry\_EPP\_Categorisation\_FINAL\_to\_be\_uploaded.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/511570/UKAP_General_Dentistry_EPP_Categorisation_FINAL_to_be_uploaded.pdf) |
| * Immunisation Against Infectious Disease [The Green Book] | <http://immunisation.dh.gov.uk/gb-complete-current-edition> |
| * Information Commissioner   Information Governance in Dental Practices | [www.ico.gov.uk](http://www.ico.gov.uk)  <https://ico.org.uk/media/action-weve-taken/audits-and-advisory-visits/1432834/information-governance-in-dental-practices.pdf> |
| * LDU document (Compliant Dental Local Decontamination Units in Scotland (Primary Care)) May 2013 | [www.hfs.scot.nhs.uk/publications/LDU](http://www.hfs.scot.nhs.uk/publications/1369061800-Compliant%20Dental%20LDUs%20in%20Scotland%20(Primary%20Care)%20v1.pdf) |
| * National Standards for Dental Services (2006) | [www.nationalcarestandards.org/files/dental-services.pdf](http://www.nationalcarestandards.org/files/dental-services.pdf) |
| * NDAC Emergency Drugs and Equipment in Primary Dental Care |  |
| * NES, Dentistry, Infection Control and Decontamination | [www.nes.scot.nhs.uk/education-and-training/by-discipline/dentistry/areas-of-education/clinical-effectiveness/quality-improvement-in-practice-training-team-%28qiipt%29.aspx](http://www.nes.scot.nhs.uk/education-and-training/by-discipline/dentistry/areas-of-education/clinical-effectiveness/quality-improvement-in-practice-training-team-%28qiipt%29.aspx) |
| * PSM (Practice Support Manual) | [www.psm.sdcep.org.uk](http://www.psm.sdcep.org.uk) |
| * Resuscitation Council (UK) Nov 2013 | [www.resus.org.uk/pages/QSCPR\_Main.htm](http://www.resus.org.uk/pages/QSCPR_Main.htm) |
| * Scottish Dental Website | [www.scottishdental.org](http://www.scottishdental.org) |
| * SDCEP Guidance Publications | [www.sdcep.org.uk](http://www.sdcep.org.uk) |
| * SGHD/CDO (2010)2 | [www.sehd.scot.nhs.uk/publications/CDO%282010%2902.pdf](http://www.sehd.scot.nhs.uk/publications/CDO%282010%2902.pdf) |

|  |
| --- |
| Part 1 Practice Details and Personnel |

**Please complete this page prior to the inspection (there will not be time to complete it on the day of the visit).**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Practice Details:** |  | | | | | |
| Practice/Clinic name: |  | | | | | |
| Address: |  | | | | | |
|  |  | | | | | |
|  |  | | | | | |
| Telephone number: |  | | | | | |
| E-mail address: |  | | | | | |
| Practice NHS.net e-mail address: |  | | | | | |
| Website address: |  | | | | | |
| Do staff have access to: |  | | | | | |
| E-mail? |  | Yes |  | No | |
|  | | | | | |
| Internet? |  | Yes |  | No | |
|  | | | | | |
| **Room Type:** | **Number of rooms:** | | |  | |  |
| Dentist surgery: |  | | | | | |
| HT/H/T surgery |  | | | | | |
| Other (please give details): |  | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Surgery Hours:** | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** |
| AM |  |  |  |  |  |  |
| PM |  |  |  |  |  |  |
| EVENING |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Practice Legal Entity:** | | | | | | | |
|  | | | | | | | |
|  |  | Principal/sole trader |  | Limited company |  | Limited liability partnership | |
|  | | | | | | | |
|  |  | Traditional expense sharing partnership |  | Body corporate |  | Other, please specify: |  |
| Contact details if different from above | | | | | | | |
| Name: | | | |  | | | |
| Address: | | | |  | | | |
| Telephone number: | | | |  | | | |
| E-mail address: | | | |  | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Sedation** | | | | | | | |
|  | | | | | | | |
| Does the practice provide sedation services? | |  | NHS |  | Private |  | N/A |
|  |  | | | | | | |
| If services are provided, what type of sedation? | |  | Inhalation |  | Intravenous | | |
|  |  | | | | | | |

|  |  |
| --- | --- |
| **Date of Inspection:** |  |
| **Inspector(s):** |  |
|  |  |
| **Key:** HT = Hygienist-Therapist; H = Hygienist; T = Therapist | |
|

| **Certification and Declaration for All Dental Team Members** |
| --- |

**Please have the following ready prior to the inspection visit (there will not be time to complete this on the day of the visit):**

**1. Complete names, designation and GDC registration number (where applicable) for all dental team members.**

**2. Provide certification for all dental team members (where appropriate).**

|  |  |
| --- | --- |
|  | **Checked by Inspector\*\*** |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **NHS Dental List Number**  **Where applicable1** | **Designation** | **GDC Registration**  **Number** | **Dental nurse in training or evidence of enrolment2** | | **PVG / Disclosure status confirmed3** | | **TB4** | | **Hepatitis B Status5** | | **Hepatitis C Status4,5** | | **HIV**  **Status4,5** | | **Professional**  **Indemnity6** | |
|  |  |  |  | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Are staffing levels adequate for patient volume (i.e. one dental nurse per dentist, plus a receptionist)? | Yes |  | No |  |  |

1 For Assistant Dentists provide the list number of the dentist they work under.

2. Complete for DNs not registered with the GDC. If a DN is not in or enrolled in training, evidence of enrolment (start date or waiting list confirmation) must be submitted to the inspectors **within 28 days of this inspection**.

3. PVG - Protecting Vulnerable Groups Scheme. See Disclosure Scotland – Protecting Vulnerable Groups Scheme or the Practice Support Manual (Protecting Vulnerable Groups Scheme)

4. Applicable to new staff from 1 August 2008. For definition of ‘new staff’ see ‘Health Clearance and Immunisation’ on the Practice Support Manual or refer to *Immunisation against infectious disease* [The Green Book]. See p4 for the information source.

5. Exposure Prone Procedure (EPP) risk assessment to be carried out for Dental Nurses. See ‘General dentistry exposure prone procedure (EPP) categorisation’. See p4 for the information source.

6. GDC guidance on indemnity is available at [www.gdc-uk.org/Dentalprofessionals/Standards/Pages/Indemnity.aspx](http://www.gdc-uk.org/Dentalprofessionals/Standards/Pages/Indemnity.aspx)

|  |  |
| --- | --- |
| **\*Designation Key -** D = Dentist; DN = Dental Nurse; HT = Hygienist-Therapist; H = Hygienist; T = Therapist; PM = Practice Manager; R = Receptionist  **\*\*Checked by inspector:** If any of these items are pending, record the details and actions to be taken on the following Comments and Summary page | |
|
| **Comments and Summary** | | |
| (to be completed by inspector) | | |
| **Number** |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Part 2 Practice Requirements | | | | | | | | | | |
| **Section 1 Premises, Facilities and Equipment** | | | | | |  | | | | |
| **1A. Premises** | | | | | |  | | | | **Information Source** |
|  |  | **Car Parking:** | | | |  |  |  |  | PSM Disability Equality |
| 1 | I | Private / Public / On Street (*please circle)* | | | | | | |  |
|  |  | **Access:** | | | | **Yes** |  | **No** |  |
| 2 | I | Is there access without use of stairs?.......................................................... | | | |  |  |  |  |
|  |  | **Waiting Area:** | | | |  |  |  |  |
| 3 | A | Adequate number of seats (3 per surgery)………..….…......………………. | | | |  |  |  |  |
| 4 | A | Waiting area is clean and free from identifiable hazards………………........ | | | |  |  |  |  |
| 5 | A | Patient notice on how complaints can be made is displayed ………..…….. | | | |  |  |  |  | PSM Communication |
| 6 | B | Patient pregnancy query poster is displayed…………..……..………………. | | | |  |  |  |  | CDO IR(ME)R letter 19.09.12, PSM Radiation Protection |
| 7 | A | Letter stating successful completion of Health Board Inspection displayed. (Not applicable for first inspection)... | N/A |  |  |  |  |  |  |  |
|  |  | **Toilets:** | | | |  |  |  |  | PSM Health and Safety |
| 8 | A | Clean and accessible toilet facilities for patients and staff with no obvious hazards…………………………………………………………………………….. | | | |  |  |  |  |
| 9 | A | Adequately equipped toilet(s), including sani-bin (with service contract), running hot water, soap, disposable paper towels/air dryer…..................... | | | |  |  |  |  |
|  |  | **Surgeries:** | | | |  |  |  |  |  |
| 10 | I | Number fully equipped (i.e. suitable for a dentist to provide a full range of treatments)………………….…....………………………..………..………….…. | | | |  |  |  |  |
| 11 | I | Number partially equipped (i.e. not used for restorative procedures)….….. | | | |  |  |  |  |
|  |  | **Decontamination Unit\*:** | | | |  |  |  |  | LDU Document, May 2013 |
| 12 | A | * LDU……………………………………………....……………….………. | | | |  |  |  |  |
| 13 | A | * Off-site *(record details on page 9)*…………………..…………….…… | | | |  |  |  |  |
|  |  |  | | | |  |  |  |  |  |
| **\* Essential to have either LDU (12) or Off-site (13)** | | | | | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **1B. Fire Extinguishers** | | | **Yes** |  | **No** |  | **Information Source** |
| 1 | A | Suitable for wood, paper, electrical fires etc. (maintained or within expiry date)………………………………………………………………………….……… |  |  |  |  | PSM Health and Safety |
|  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **1C. Resuscitation (Medical Emergencies), First Aid and Drugs** | | | **Yes** |  | **No** |  | **Information Source** |
|  |  | **Recommended medical emergency drugs available, in date and stored safely:** |  |  |  |  | PSM Medical Emergencies and Life Support  SDCEP Drug Prescribing for Dentistry guidance |
| 1 | A | * Adequate adrenaline (1-ml ampoules or pre-filled syringes of 1:1000 solution for i.m. injection)…………………………………………………. |  |  |  |  |
| 2 | A | * Aspirin (300 mg dispersible tablets)……………….…………….……….. |  |  |  |  |
| 3 | A | * Glucagon (for i.m. injection of 1mg)……………….………………..……. |  |  |  |  |
| 4 | A | * Glyceryl trinitrate spray (400 µg per metered dose)……………….…… |  |  |  |  |
|  |  |  |  |  |  |  |  |

|  |  |
| --- | --- |
| **Comments and Summary** | |
| (to be completed by inspector) | |
| **Item No.** |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **1C. Resuscitation (Medical Emergencies), First Aid and Drugs *(continued)*** | | | **Yes** |  | **No** |  | **Information Source** |
| 5 | A | * Midazolam oromucosal solution, 5 mg/ml, for topical buccal administration**\***.……………………………………………………..………. |  |  |  |  | PSM Medical Emergencies and Life Support  SDCEP Drug Prescribing for Dentistry guidance  Resuscitation Council (UK) Nov 2013  NDAC Emergency Drugs and Equipment in Primary Dental Care |
| 6 | A | * Oral glucose/sugar.………………………………………………………… |  |  |  |  |
| 7 | A | * Salbutamol inhaler (100 µg per actuation)…………..…………..…..….. |  |  |  |  |
| 8 | A | Oxygen cylinder (15 litres/min): minimum of 2 size D or CD (preferred) or 1 size E.………………………………………...…………..……………………….… |  |  |  |  |
| 9 | A | * serviced at least every 5 years (or according to manufacturer’s instructions)…………………………………………………………..……... |  |  |  |  |
| 10 | A | * charged: at least 75% full and evidence of regular checks…………… |  |  |  |  |
| 11 | A | Bag valve mask with additional child mask……………..…………..………...… |  |  |  |  |
| 12 | A | Basic set (0, 1, 2, 3, 4) of oropharyngeal airways for adults and children…… |  |  |  |  |
| 13 | A | Pocket masks with oxygen port available in every surgery**\*\***........................... |  |  |  |  |
| 14 | A | Portable independently powered suction machine with appropriate suction tips and tubing.................................................................................................. |  |  |  |  |
| 15 | A | Oxygen face mask capable of delivering high concentrations of oxygen (reservoir bag) with tubing……..………………….……………………………… |  |  |  |  |
| 16 | A | Single-use sterile syringes and needles (in date)**\*\*\***…………….…..….…….. |  |  |  |  |
| 17 | A | Spacer device for inhaled bronchodilators…………………….…….………..… |  |  |  |  |
| 18 | A | Automated External Defibrillator……………………………………………........ |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **\*Midazolam oromucosal solution is available in pre-filled syringes; several sizes are available to allow for exact dosing for different age groups.** | | | | | | | |
| **\*\*Inspect availability in every surgery before ticking the box** | | | | | | | |
| **\*\*\*Must include 1ml syringes and 21g (green) needles** | | | | | | | |

|  |
| --- |
| **1D. Unallocated** |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **1E. Training and Education** | | | **Yes** |  | **No** |  | **Information Source** |
| 1 | B | Camera designed for intra-oral clinical pictures, preferably digital……..……. |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

|  |  |
| --- | --- |
| **Comments and Summary** | |
| (to be completed by inspector) | |
| **Item No.** |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Section 2 Documentation and Certification**  **Please have the following documentation and certification ready prior to the inspection visit.** | | | | | | | |
| **2A. Staff** | | | **Yes** |  | **No** |  | **Information Source** |
| 1 | A | Employer’s liability insurance (certificate on display)………….……...…….... |  |  |  |  | PSM Health and Safety |
| 2 | A | Practice/clinic recruitment and selection policy+……………………….………. |  |  |  |  |  |
| 3 | A | Practice/clinic equal opportunities policy**+**………………….…………………… |  |  |  |  |  |
| 4 | A | Staff contracts+……………………………………………..…………..………… |  |  |  |  |  |
| 5 | A | Staff appraisal system………………………….…………………………….…… |  |  |  |  |  |
| 6 | A | Protocol for staff support (e.g. access to occupational health services)**+**…… |  |  |  |  |  |
| 7 | A | Discipline, dismissal and grievance procedures**+**….………………………..… |  |  |  |  |  |
| 8 | A | Practice/staff meetings – minutes and action points…….………………….…. |  |  |  |  |  |
| 9 | A | Staff induction including reading and signing practice policies+……..…....…. |  |  |  |  |  |
| 10 | A | Public protection policy (for raising concerns about performance that might endanger patient safety), and confidential record of concerns and action taken**+**…………………………………………………………………..…………… |  |  |  |  | PSM Risk Management |
| 11 | A | Business continuity plan…………………………………………………………… |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **+To be read and signed by all relevant staff** | | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **2B. Patients** | | | **Yes** |  | **No** |  | **Information Source** |
| 1 | A | Practice Information Leaflet to meet National Standards. Should include: |  |  |  |  | National Standards for Dental Services  PSM Communication |
| 2 | A | * information about the services provided.……………………..…………. |  |  |  |  |
| 3 | A | * whether services are provided under the NHS, privately or mixed NHS/private.……………………………………………………………....... |  |  |  |  |
| 4 | A | * names, sex, date(s) of registration(s) and dental qualifications of all dentists**\***............................................................................................... |  |  |  |  |
| 5 | A | * information about whether a dental hygienist or dental therapist is available at the practice……………………………………..……………. |  |  |  |  |
| 6 | A | * practice/health centre contact information (all premises including mobile surgery, if applicable)…………………………………..………..... |  |  |  |  |
| 7 | A | * opening hours/when dentist(s) will be in attendance…………….…….. |  |  |  |  |
| 8 | A | * arrangements for emergency and out-of-hours cover….……………… |  |  |  |  |
| 9 | A | * details of any disabled access or facilities…..………….……………….. |  |  |  |  |
| 10 | A | * guide to NHS exemptions, charges and how to pay**\*\***…..……………… |  |  |  |  |
| 11 | A | * policy on cancellation of appointments**\*\***………………………..……….. |  |  |  |  |
| 12 | A | * availability of interpreting services**\*\***..…………..………..…….………… |  |  |  |  | PSM Disability Equality |
| 13 | A | * telephone number for any questions about NHS dental provision in the area.…………………………………………………………….…….… |  |  |  |  |  |
| 14 | A | Practice Information Leaflet made available (e.g. patient notice or leaflets at Reception)………………….…………………………………….................…. |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **\*If the contractor is a body corporate include name and registered address** | | | | | | | |
| **\*\*May be provided as a separate document** | | | | | | | |

|  |  |
| --- | --- |
| **Comments and Summary** | |
| (to be completed by inspector) | |
| **Item No.** |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **2B. Patients *(continued)*** | | | **Yes** |  | **No** |  | **Information Source** |
| 15 | A | Practice Information Leaflet made available in large print (16–22 point), on request\*.…………………………………………………………………….......….. |  |  |  |  | PSM Disability Equality |
| 16 | A | Price list displayed (e.g. leaflet / poster)........................................................ |  |  |  |  |  |
| 17 | A | Dental team members are identified to patients (e.g. name badges / information poster)………………………………….....………………...………… |  |  |  |  | PSM Communication |
| 18 | A | Data Protection registration for all computerised records (required for all those who hold their own patient list, including Associates\*\*.......................... |  |  |  |  | PSM Ethical Practice  Information Commissioner |
| 19 | A | Suitable back-up protocol in place for computerised records……………..….. |  |  |  |  | PSM Record-keeping |
| 20 | A | Data protection/confidentiality/information security policy (including patient access to records)+..…………………………………………………...............… |  |  |  |  | PSM Ethical Practice |
| 21 | A | Protocol for arrangements for safe storage and retrieval of patient records, if practice closes permanently……………………………………………….....… |  |  |  |  |
| 22 | A | Freedom of Information (Scotland) Act Model Publication Scheme….......…. |  |  |  |  |
| 23 | A | Disability policy (compliant with the Equality Act 2010)+…......……………….. |  |  |  |  | PSM Disability Equality |
| 24 | A | Written policy for child protection+..………………………………...…………… |  |  |  |  | PSM Ethical Practice  DoH guidance |
| 25 | A | Contact information for local Child Protection Team easily accessible……... |  |  |  |  |
| 26 | A | Policy on obtaining consent (including for treatment of children)**+**………..…. |  |  |  |  | PSM Communication |
| 27 | A | Complaints procedure policy**+**.…………………………………..……….…….. |  |  |  |  |
| 28 | A | Complaints log…………………………………………………………………..…. |  |  |  |  |
| 29 | A | Referral protocol (statement that if care cannot be provided, patient will be referred; include details of who patients will be referred to)….……….…..… |  |  |  |  |
| 30 | A | Protocol for patient notification if practice closes: 3 months’ notice…..……… |  |  |  |  |
| 31 | A | Protocol for patient notification if their dentist leaves the practice……………. |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **\*Can be printed on demand** | | | | | | | |
| **\*\*If Associate(s) is(are) not registered, record the reason why on Comments and Summary page** | | | | | | | |
| **+To be read and signed by all relevant staff** | | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **2C. Health and Safety** | | | **Yes** |  | **No** |  | **Information Source** |
| 1 | A | Health and safety policy statement**+**……………………………………………… |  |  |  |  | PSM Health and Safety |
| 2 | A | Health and safety law poster displayed and filled in *or* Health and Safety information leaflets given to staff…………………….…….………………….….. |  |  |  |  |
| 3 | A | Health and safety risk assessment carried out…………………………………. |  |  |  |  |
| 4 | A | COSHH assessments**+**……………………………………………………….….… |  |  |  |  |
| 5 | A | Fire policy, including: |  |  |  |  |
| 6 | A | * fire action protocol**+**…………………………………………………………. |  |  |  |  |
| 7 | A | * fire action notice displayed………………………………………………… |  |  |  |  |
| 8 | A | Documented fire risk assessment**+** carried out…………………….…….…..… |  |  |  |  |
| 9 | A | Documented regular visual inspection of portable appliances (at least annually, preferably twice a year)………………………………………………… |  |  |  |  |
| 10 | A | Portable Appliance Testing (PAT) by contractor/competent person (a minimum of every 3 years)……………………………………….……………….. |  |  |  |  |
| 11 | B | Documented fixed wire testing………………………………………………….... |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **+To be read and signed by all relevant staff** | | | | | | | |

|  |  |
| --- | --- |
| **Comments and Summary** | |
| (to be completed by inspector) | |
| **Item No.** |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **2C. Health and Safety *(continued)*** | | | | | | **Yes** |  | **No** |  | **Information Source** |
| 12 | A | Health Clearance and Immunisation policy including check for new employees**+**………….…………………………………………………………….. | | | |  |  |  |  | PSM Health & Safety Infection Control |
| 13 | A | Occupational Exposure Management (including Sharps) Policy including post-exposure protocol**+**……...……….………………………………………...... | | | |  |  |  |  |
| 14 | A | Data protection compliant accident book and compliance with RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrence Regulations)**.**…...………………………………………………………..…..….… | | | |  |  |  |  | PSM Health & Safety General |
| 15 | A | Appointed/named persons for first aid (documentation to include names, duties and training undertaken)……………..……….………………………….. | | | |  |  |  |  |
| 16 | A | First aid box present and adequately filled for size of practice…..………....… | | | |  |  |  |  |
| 17 | A | NHS facility or accredited laboratory used for biopsy/pathology tests……………………………..…………… | N/A |  |  |  |  |  |  | PSM Medical Emergencies  SDCEP Drug Prescribing for Dentistry guidance  Resuscitation Council (UK) Nov 2013  NDAC Emergency Drugs and Equipment in Primary Dental Care |
| 18 | A | Standard Operating Procedure for Controlled Drugs……..…………………… | | | |  |  |  |  |
| 19 | A | Protocols for managing medical emergencies**+**……..……………….....……… | | | |  |  |  |  |
| 20 | A | Staff training records for medical emergencies, including CPR (updated annually) in line with Resuscitation Council (UK)/NDAC Medical Emergencies guidance………………………………………….……………….… | | | |  |  |  |  |
|  |  |
|  |  |
|  |  |  | | | |  |  |  |  |  |
| **+ To be read and signed by all relevant staff** | | | | | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **2D. Waste Management**  See also Sections 2H Infection Control (Documentation and Certification); Part 4 Section 6H Waste | | | **Yes** |  | **No** |  | **Information Source** |
|  |  | **Special waste consignment notes or written contractor arrangements for:** |  |  |  |  | PSM Health and Safety |
| 1 | A | * orange stream: low-risk healthcare waste such as disposable PPE, dressings, swabs………………………………………………………….. |  |  |  |  |
| 2 | A | * yellow stream: high-risk healthcare waste such as sharps, pharmaceuticals, LA cartridges, teeth without amalgam, highly infectious waste or blood [in yellow stream containers (formerly known as sharps bins)]……………………….……………………..……. |  |  |  |  |
| 3 | A | * red stream: waste amalgam…………………………………………..…… |  |  |  |  |
| 4 | A | * red stream: amalgam capsules………………………………..…….…… |  |  |  |  |
| 5 | A | * red stream: teeth with amalgam……………………………………….… |  |  |  |  |
| 6 | A | * red stream: waste from amalgam separation units…………….……….. |  |  |  |  |
| 7 | A | * red stream: X-ray developer/fixer………………………...………………. |  |  |  |  |
| 8 | A | * red stream: lead foil……………………………………………….…....… |  |  |  |  |
|  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **2E. Pressure Vessels** | | | | | **Yes** |  | **No** |  | **Information Source** |
|  |  | **Compressors:** | | |  |  |  |  | PSM Health and Safety  SDCEP Decontamination into Practice guidance |
| 1 | A | Pressure vessel insurance certificate including third party liability……...…… | | |  |  |  |  |
| 2 | I | Number of compressors…………………………………………….… |  |  |  |  |  |  |
| 3 | A | Compressor instruction manual available**\***……....………………...…………… | | |  |  |  |  |
| 4 | A | Written Scheme of Examination if compressor >250 bar litres……………...… | | |  |  |  |  |
|  |  |  | | |  |  |  |  |  |
| **\*Electronic manuals are acceptable** | | | | | | | | | |

|  |  |
| --- | --- |
| **Comments and Summary** | |
| (to be completed by inspector) | |
| **Item No.** |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **2E. Pressure Vessels *(continued)*** | | | | | **Yes** |  | **No** |  | **Information Source** |
|  |  | **Compressors** *(continued):* | | |  |  |  |  |  |
|  |  | Record of: | | |  |  |  |  |  |
| 5 | A | * safety testing/inspection in line with Written Scheme of Examination (certification required at least every 26 months)…………….……...…... | | |  |  |  |  |  |
| 6 | A | * maintenance in accordance with manufacturer’s instructions….….…. | | |  |  |  |  |
|  |  | **Steam Sterilizer (Autoclaves)** | | |  |  |  |  |  |
|  |  | **Steam Sterilizer 1:** | | |  |  |  |  | PSM Health and Safety  SDCEP Decontamination into Practice guidance  SGHD/CDO (2010)2 |
| 7 | A | Written Scheme of Examination………………………………………………… | | |  |  |  |  |
|  |  | Record of: | | |  |  |  |  |
| 8 | A | * safety testing/inspection in line with Written Scheme of Examination (certification required at least every 14 months)……………..……….. | | |  |  |  |  |
| 9 | A | * routine servicing (maintenance and testing) in accordance with manufacturer’s instructions………………………………………………. | | |  |  |  |  |
|  |  | **Steam Sterilizer 2: N/A** |  |  |  |  |  |  | PSM Health and Safety  SDCEP Decontamination into Practice guidance  SGHD/CDO (2010)2 |
| 10 | A | Written Scheme of Examination………………………………………………… | | |  |  |  |  |
|  |  | Record of: | | |  |  |  |  |
| 11 | A | * safety testing/inspection in line with Written Scheme of Examination (certification required at least every 14 months)……………..……….. | | |  |  |  |  |
| 12 | A | * routine servicing (maintenance and testing) in accordance with manufacturer’s instructions………………………………………………. | | |  |  |  |  |
|  |  | **Steam Sterilizer 3: N/A** |  |  |  |  |  |  | PSM Health and Safety  SDCEP Decontamination into Practice guidance  SGHD/CDO (2010)2 |
| 13 | A | Written Scheme of Examination………………………………………………… | | |  |  |  |  |
|  |  | Record of: | | |  |  |  |  |
| 14 | A | * safety testing/inspection in line with Written Scheme of Examination (certification required at least every 14 months)……………..……….. | | |  |  |  |  |
| 15 | A | * routine servicing (maintenance and testing) in accordance with manufacturer’s instructions………………………………………………. | | |  |  |  |  |
|  |  |  | | |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **2F. Radiation Protection**  See also Section 3D Radiation (Processes) and Part 4 Section G Radiology | | | **Yes** |  | **No** |  | **Information Source** |
| 1 | A | Radiation Protection Adviser appointed**\***  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  | PSM Radiation Protection  Scottish Dental Website (IR[ME]R Information) |
| 2 | A | Radiation Protection Supervisor appointed**\***  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |
| 3 | A | Medical Physics Expert appointed**\*\***  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |
| 4 | A | Up to date ‘local rules’ in place and subject to document quality assurance\* (*Evidence required*)………….…………………………………………………...... |  |  |  |  |
| 5 | A | Risk assessment for radiation work\*. *(Evidence required if there are 5 or more employees*)…………………………………………………………..………. |  |  |  |  |
| 6 | A | Documented quality assurance system for radiation equipment in place\* *(Evidence required of proper documentation and of implementation)*…..….. |  |  |  |  |
| **\* The Ionising Radiations Regulations 1999, enforced by HSE & HSE(NI)** | | | | | | | |
| **\*\* The Ionising Radiation (Medical Exposure) Regulations 2000 (as amended)** | | | | | | | |

|  |  |
| --- | --- |
| **Comments and Summary** | |
| (to be completed by inspector) | |
| **Item No.** |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **2F. Radiation Protection *(continued)***  See also Section 3D Radiation (Processes) and Part 4 Section G Radiology | | | **Yes** |  | **No** |  | **Information Source** |
| 7 | A | Radiation safety assessment carried out for each machine (every 1-3 years) |  |  |  |  |  |
| 8 | A | Set of Employer’s Written Procedures in accordance with **IR(ME)R 2000**\* in place and up to date………………………………………………................... |  |  |  |  | PSM Radiation Protection  Scottish Dental Website (IR[ME]R Information) |
| 9 | A | Employer’s Written Protocol for each type of exposure in place and up to date………………………………………………………………………………..… |  |  |  |  |
| 10 | A | Documented quality assurance system for Employer’s Written Procedures and Protocols in place and up to date………………………………………..…. |  |  |  |  |
| 11 | A | All duty holders (Referrers, Practitioners and Operators) identified and properly entitled by the Employer………………………………………………... |  |  |  |  |
| 12 | A | Appropriate Diagnostic Reference Levels (DRLs) in place…………..…….... |  |  |  |  |
| 13 | A | Procedure for dose assessment and recording in place and being implemented…………………………………………………………………..……. |  |  |  |  |
| 14 | A | Documented procedure for pregnancy checking in place and up to date…... |  |  |  |  |
| 15 | A | Radiology audit undertaken in accordance with Employer’s Written Procedures………………………………………………………………………..... |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **\* The Ionising Radiation (Medical Exposure) Regulations 2000 (as amended)** | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **2G. Lasers** | | | **N/A** |  | **Yes** |  | **No** |  | **Information source** |
| 1 | I | Laser equipment in use……………………………………………… |  |  |  |  |  |  | PSM Health and Safety |
| 2 | A | If using Class 3b or 4 laser, Laser Protection Adviser appointed:  Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |
| 3 | A | Local rules available and accessible…………………………..…… |  |  |  |  |  |  |
|  |  |  | | |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **2H. Infection Control**  See also Sections 3E Decontamination (Processes); Part 3 Decontamination Observation; Part 4 Section H Infection Control | | | **Yes** |  | **No** |  | **Information Source** |
| 1 | A | Infection control/decontamination policy (to include or accompany the following policies)+…...................................................................................... |  |  |  |  | SDCEP Decontamination into Practiceguidance  PSM Health & Safety Infection Control  Scottish Dental Website |
| 2 | A | * Hand hygiene policy………………………………………...……………… |  |  |  |  |
| 3 | A | * Environmental cleaning policy (cleaning schedule and routine monitoring)........................................................................................... |  |  |  |  |
| 4 | A | * Personal protective equipment (PPE) policy…………………………….. |  |  |  |  |
| 5 | A | * Decontamination of re-usable instruments protocol (including transportation and storage)……………………………………………..… |  |  |  |  |
| 6 | A | * Processing of lab work/dentures………………………………………….. |  |  |  |  |
| 7 | A | * Procurement policy for Re-usable and Single-Use items.…………..… |  |  |  |  |
| 8 | A | * Waste disposal policy and certification…………………………………... |  |  |  |  |
| 9 | A | Dental water bottle procedure………………………………………………….... |  |  |  |  |  |
| **+ To be read and signed by all relevant staff** | | | | | | | |

|  |  |
| --- | --- |
| **Comments and Summary** | |
| (to be completed by inspector) | |
| **Item No.** |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **2H. Infection Control *(continued)***  See also Sections 3E Decontamination (Processes); Part 3 Decontamination Observation; Part 4 Section H Infection Control | | | | | | **Yes** |  | **No** |  | **Information Source** |
|  |  | **Washer-Disinfector:** | | | |  |  |  |  | SDCEP Decontamination into Practiceguidance  SGHD/CDO (2010)2) |
| 10 | A | Evidence of installation and validation………………………………………...... | | | |  |  |  |  |
| 11 | A | Evidence of annual revalidation\*………………....…….......... | N/A |  |  |  |  |  |  |
| 12 | A | Periodic testing carried out according to manufacturer’s instructions…......... | | | |  |  |  |  |
| 13 | A | Verification system for each Washer-disinfector............................................ | | | |  |  |  |  |
| 14 | A | * print out for every cycle; **or**.................................................................. | | | |  |  |  |  |
| 15 | A | * data logger…………………………………………………………….….... | | | |  |  |  |  |
| 16 | A | Number of cycle counts…….......................................................… | |  |  |  |  |  |  |
| 17 | A | Washer-disinfector instruction manualavailable\*\*......................................... | | | |  |  |  |  |
|  |  | Steam sterilizer(s) (Autoclaves)\*\*\* | | | |  |  |  |  | SDCEP Decontamination into Practiceguidance  SGHD/CDO (2010)2) |
|  |  | **Steam sterilizer 1** | | | |  |  |  |  |
| 18 | A | Evidence of installation and validation……………………….………………….. | | | |  |  |  |  |
| 19 | A | Evidence of annual revalidation…………………..…………… | N/A |  |  |  |  |  |  |
| 20 | A | Verification system for each steam sterilizer (Autoclave)……………………… | | | |  |  |  |  |
| 21 | A | * print out for every cycle; **or**.................................................................. | | | |  |  |  |  |
| 22 | A | * data logger………………………………………………………….……….. | | | |  |  |  |  |
| 23 | A | Number of cycle counts………...................................................... | |  |  |  |  |  |  |
|  |  | **Steam sterilizer 2** | N/A |  |  |  |  |  |  |  |
| 24 | A | Evidence of installation and validation……………………….………………….. | | | |  |  |  |  |  |
| 25 | A | Evidence of annual revalidation…………………..…………… | N/A |  |  |  |  |  |  |
| 26 | A | Verification system for each steam sterilizer (Autoclave)……………………… | | | |  |  |  |  |
| 27 | A | * print out for every cycle; **or**.................................................................. | | | |  |  |  |  |
| 28 | A | * data logger………………………………………………………….……….. | | | |  |  |  |  |
| 29 | A | Number of cycle counts………...................................................... | |  |  |  |  |  |  |
|  |  | **Steam sterilizer 3** | N/A |  |  |  |  |  |  |  |
| 30 | A | Evidence of installation and validation……………………….………………….. | | | |  |  |  |  |  |
| 31 | A | Evidence of annual revalidation…………………..…………… | N/A |  |  |  |  |  |  |
| 32 | A | Verification system for each steam sterilizer (Autoclave)……………………… | | | |  |  |  |  |
| 33 | A | * print out for every cycle; **or**.................................................................. | | | |  |  |  |  |
| 34 | A | * data logger………………………………………………………….……….. | | | |  |  |  |  |
| 35 | A | Number of cycle counts………...................................................... | |  |  |  |  |  |  |
| 36 | A | Steam sterilizer (Autoclave) instruction manual(s)**\*\*** available…………......... | | | |  |  |  |  |  |
| |  | | --- | | **\*If ‘No’, please provide an explanation on the following Comments and Summary page** | | | | | | | | | | | |
| **\*\*Electronic manuals are acceptable** | | | | | | | | | | |
| **\*\*\*See also Section 2E Pressure Vessels** | | | | | | | | | | |

|  |  |
| --- | --- |
| **Comments and Summary** | |
| (to be completed by inspector) | |
| **Item No.** |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **2H. Infection Control (*continued*)** | | | | | | **Yes** |  | **No** |  | **Information Source** |
|  |  | **Ultrasonic cleaner** | | | |  |  |  |  |  |
| 37 | A | Number of cycle counts………....................................................... | |  |  |  |  |  |  |
| 38 | A | Ultrasonic cleaner instruction manual**\*\*** available................. | **N/A** |  |  |  |  |  |  |
|  |  |  | | | |  |  |  |  |  |
| **\*\*Electronic manuals are acceptable** | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **2I. Infection Control Training** | | | | | | | | | **Yes** |  | **No** |  | **Information Source** |
| 1 | A | NES Infection Control Support Team in-practice training every three years (unless using central facility). | | | | | | |  |  |  |  | NES, Dentistry, Infection Control and Decontamination |
|  |  | arrange immediately |  | arranged |  | completed |  |  |  |  |  |  |
| 2 | A | Action Plan from NES Infection Control and Decontamination Team……….. | | | | | | |  |  |  |  |
|  |  |  | | | | | | |  |  |  |  |  |

|  |  |
| --- | --- |
| **Comments and Summary** | |
| (to be completed by inspector) | |
| **Item No.** |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Section 3 Processes**  **Please note for Sections 3A-3C the inspectors will require access to a small sample of patient records. Meeting the following inspection requirements might help in a possible future medico-legal situation.** | | | | | | | |
| **3A. Patient Records System** | | | **Yes** |  | **No** |  | **Information Source** |
| 1 | I | Manual system………………….………………………………….…….……….. |  |  |  |  | PSM Record-keeping  PSM Ethical Practice |
|  |  | Computerised system |  |  |  |  |
| 2 | I | * Fully….................................................................................................. |  |  |  |  |
| 3 | I | * Partly………………………………………………………….….…….…... |  |  |  |  |
| 4 | A | Records stored securely……………………….……………………………....… |  |  |  |  |
|  |  |  |  |  |  |  |  |

|  |
| --- |
| **3B. Medico-legal and Patient Care (see page 28)** |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **3C. Appointment and Recall Systems** | | | **Yes** |  | **No** |  | **Information Source** |
| 1 | A | Efficient appointment system, including provision for dental emergencies during practice hours………………………………………………………….….. |  |  |  |  |  |
| 2 | A | Efficient recall system……………………………………………….................... |  |  |  |  |  |
|  |  | **Emergency cover outwith normal working hours:** |  |  |  |  | SDCEP Emergency Dental Care guidance |
| 3 | A | * midweek.………………………………………………………………….... |  |  |  |  |
| 4 | A | * weekends and holidays…………………………………………………... |  |  |  |  |
|  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **3D. Radiation**  See also Section 2F Radiation Protection (Documentation and Certification) and Part 4 Section G Radiology | | | | | | | | | **Yes** |  | **No** |  | **Information Source** |
| 1 | I | Number of intra-oral machines | | | | | | |  |  |  |  | PSM Radiation Protection |
|  | I | digital................................................................................... | | | | |  |  |  |  |  |  |
|  | I | film....................................................................................... | | | | |  |  |  |  |  |  |
| 2 | A | Compliance with report recommendations for all machines…………………... | | | | | | |  |  |  |  |
| 3 | I | **Number of OPT machines** | | | | | | |  |  |  |  |
|  | I | digital................................................................................... | | | | |  |  |  |  |  |  |
|  | I | film....................................................................................... | | | | |  |  |  |  |  |  |
| 4 | A | Compliance with report recommendations for all machines………………..…. | | | | | | |  |  |  |  |
| 5 | A | X-ray developing facilities: | | | | | | |  |  |  |  |
|  |  | manual, temperature controlled |  | automatic |  | digital |  |  |  |  |  |  |
| 6 | A | Filing system for radiographs……………………………………………………. | | | | | | |  |  |  |  |  |
|  |  |  | | | | | | |  |  |  |  |  |

|  |  |
| --- | --- |
| **Comments and Summary** | |
| (to be completed by inspector) | |
| **Item No.** |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **3B. Medico-legal and Patient Care** | **Dentist name** | **Dentist name** | **Dentist name** | **Dentist name** | **Dentist name** | **Dentist name** |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient dental records\* demonstrate**  **recording of:** |  | | |  | | |  | | |  | | |  | | | |  | | |
| Pt 1 | Pt 2 | Pt 3 | Pt 1 | Pt 2 | Pt 3 | Pt 1 | Pt 2 | Pt 3 | Pt 1 | Pt 2 | Pt 3 | Pt 1 | Pt 2 | Pt 3 | Pt 1 | | Pt 2 | Pt 3 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | A | * medical history updated at every recall and as appropriate…………… |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2 | A | * charting of missing/present teeth….. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3 | B | * charting of existing restorations…… |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 4 | A | * soft tissue examination……………… |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 5 | A | * basic periodontal examination and/or periodontal charting recorded where appropriate……….. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 6 | A | * information regarding habits (behavioural and dietary) and actions taken……………..…………. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 7 | A | * written treatment plan, including costs, given to patient and retained in patient record………….................. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 8 | A | * local anaesthetic and prescription items used are recorded……………. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 9 | A | * treatment notes for each visit include date name/identifier of clinician/treatment provided............. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10 | A | * indication for radiographs recorded   and radiographs reported………….. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |
| --- |
| **\*Checking three records per dentist from the previous six months is recommended (additional records to be checked if standard is not met). Records to be selected by the inspector.** |

|  |
| --- |
| **Information source:**  PSM Record-keeping and SDCEP Oral Health Assessment and Review guidance |

|  |  |
| --- | --- |
| **Comments and Summary** | |
| (to be completed by inspector) | |
| **Item No.** |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **3E. Decontamination**  See also Sections 2H & 2I Infection Control (Documentation and Certification); Part 3 Decontamination Observation; Part 4 Section H Infection Control | | | | | | | | | | **Yes** |  | **No** |  | **Information Source** |
| 1 | A | Non-porous floor covering, without gaps and with sealed edges, throughout the decontamination areas…………………………………………. | | | | | | | |  |  |  |  | SDCEP Decontamination into Practice guidance  Scottish Dental Website |
| 2 | A | Good ventilation……………………………………………………………..……. | | | | | | | |  |  |  |  |
| 3 | A | Clean and dirty zones are segregated with clear flow of work from dirty to clean areas………………………………………………………………………….. | | | | | | | |  |  |  |  |
| 4 | A | Demarcated transportation systems for dirty and clean instruments……..….. | | | | | | | |  |  |  |  |
| 5 | A | Environmental cleaning products for cleaning and disinfection……………… | | | | | | | |  |  |  |  |
|  |  | **Separate sinks for:** | | | | | | | |  |  |  |  |
| 6 | A | * handwashing………………………………………………………………... | | | | | | | |  |  |  |  |
| 7 | A | * cleaning instruments…………………………………..………………..... | | | | | | | |  |  |  |  |
| 8 | A | * rinsing instruments…………………………………………………….…… | | | | | | | |  |  |  |  |
| 9 | A | Appropriate hand hygiene products available ……………………..…............. | | | | | | | |  |  |  |  |
|  |  | **System(s) used for cleaning instruments:** | | | | | | | |  |  |  |  |
| 10 | A | * Washer-disinfector ………………..……………………………………. | | | | | | | |  |  |  |  |  |
| 11 | I | * Number of washer-disinfectors………………..…………… | | | | | |  |  |  |  |  |  |  |
| 12 | A | * Washer-disinfector is the primary cleaning system………………..…. | | | | | | | |  |  |  |  |  |
| 13 | A | * What is the secondary (back-up) cleaning system? | | | | | | | |  |  |  |  |  |
|  |  | Washer-disinfector |  | Ultrasonic cleaner |  | Manual cleaning | |  |  |  |  |  |  |
| 14 | B | * Ultrasonic cleaner. ………………..………………………………..…. | | | | | | | |  |  |  |  |  |
| 15 | I | * Number of ultrasonic cleaners.………………..…………… | | | | | |  |  |  |  |  |  |  |
| 16 | A | Illuminated magnifier for inspection of instruments ………..………………….. | | | | | | | |  |  |  |  |  |
|  |  | **Appropriate detergent or cleaning product used for:** | | | | | | | |  |  |  |  |  |
| 17 | A | * washer-disinfector cleaning of instruments (following manufacturer’s instructions)…………………………………………………………….…… | | | | | | | |  |  |  |  |
| 18 | A | * manual cleaning of instruments (using solutions according to manufacturer’s instructions)………………………………………….…… | | | | | | | |  |  |  |  |
| 19 | A | * ultrasonic cleaning of instruments using solutions according to manufacturer’s instructions……………… | | | | | N/A |  |  |  |  |  |  |
| 20 | A | * ultrasonic cleaner changed at least every 4 hours….. | | | | | N/A |  |  |  |  |  |  |
|  |  | **System used for sterilizing instruments:** | | | | | | | |  |  |  |  |  |
| 21 | A | Steam sterilizer(s) (Autoclave(s))**\***….…………..…………………………….. | | | | | | | |  |  |  |  |  |
| 22 | I | Number of non-vacuum (Type N) sterilizers……………..…………. | | | | | |  |  |  |  |  |  |  |
| 23 | I | Number of vacuum (Type B) sterilizers……………………….…….. | | | | | |  |  |  |  |  |  |
| 24 | A | * Steam sterilizer serial no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |  |  |  |  |
| 25 | A | * Steam sterilizer serial no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |  |  |  |  |
| 26 |  | * Steam sterilizer serial no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |  |  |  |  |  |
| 27 | A | * Quality of water used in steam sterilizer is according to manufacturer’s instructions……………………….…….……………….. | | | | | | | |  |  |  |  |  |
| 28 | A | * Water in steam sterilizer is drained at least daily …….……………….. | | | | | | | |  |  |  |  |  |
| **\*If only one steam sterilizer, record details of back-up arrangements on Comments and Summary page** | | | | | | | | | | | | | | |

|  |  |
| --- | --- |
| **Comments and Summary** | |
| (to be completed by inspector) | |
| **Item No.** |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **3E. Decontamination *(continued)*** | | | **Yes** |  | **No** |  | **Information Source** |
| 29 | A | * instruments are prepared correctly for sterilization (only wrap instruments before sterilizing in a vacuum steam sterilizer)…………. |  |  |  |  |  |
| 30 | A | Only instruments compatible with decontamination processes used……….. |  |  |  |  |  |
| 31 | A | All decontamination equipment operated according to manufacturer’s instructions……………………………………………………………………….. |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

|  |  |
| --- | --- |
| **Comments and Summary** | |
| (to be completed by inspector) | |
| **Item No.** |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |
| --- |
| **Part 3 Observation of Decontamination Process** |

|  |
| --- |
| **Inspectors will observe a brief simulation of a typical surgery turn-round process involving decontamination and sterilization (only in one of the surgeries). Please provide a tray containing instruments you would routinely use, including an endo file, handpiece, non-single use burs, matrix band and impression tray.** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **A. Washer Disinfection** | | | **Yes** |  | **No** |
| 1 | A | Instruments loaded as per validation…………………………………………………………………..... |  |  |  |
| 2 | A | Cycle used as per manufacturer’s instructions and validation……………………………………..…. |  |  |  |
| 3 | A | Cycle completed without interruption, checked and recorded……………………………………..…. |  |  |  |
| 4 | A | Instruments inspected……………………………………………………………………….................... |  |  |  |
|  |  |  | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **B. Single-use Items (into appropriate containers)** | | | | | | **Yes** |  | **No** |
| 1 | A | Matrix band…………………………………………………………………………………………………. | | | |  |  |  |
| 2 | A | ALL endodontic files……………………………………………………………………………………….. | | | |  |  |  |
| 3 | A | Disposable impression tray……………………………………………………………………………….. | | | |  |  |  |
| 4 | A | Disposable sheaths**\***……………….………………………………………………...... | **N/A** |  |  |  |  |  |
| 5 | A | 3 in 1 syringe tip……………………………………………………………………………………..……. | | | |  |  |  |
| 6 | A | Saliva ejector/aspirator tip**\***……..…………………………………………………...... | **N/A** |  |  |  |  |  |
| 7 | A | All other items marked ‘Single Use’ ……………………………………………....……………….…….. | | | |  |  |  |
|  |  |  | | | | | | |
| **\* If N/A option ticked, Inspector to record reason on Comments and Summary page.** | | | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **C. Preparation** | | | **Yes** |  | **No** |
| 1 | A | Appropriate transportation of instruments……………………………………………………………….. |  |  |  |
| 2 | A | Appropriate setting-down area…………………………………………………..…………….………..... |  |  |  |
| 3 | A | Heavy-duty rubber/household gloves worn as required………………………………………........... |  |  |  |
| 4 | A | Visor or mask plus eye protection worn…………………………………………………………….….. |  |  |  |
| 5 | A | Apron (waterproof) worn……………………………………………….………………………………… |  |  |  |
| 6 | A | Appropriate hand hygiene before, during and after decontamination process…………………..…. |  |  |  |
|  |  |  | | | |

|  |  |
| --- | --- |
| **Comments and Summary** | |
| (to be completed by inspector) | |
| **Item No.** |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **D. Manual Cleaning**  **Instruments are manually cleaned only when specified in manufacturer’s instructions as the only cleaning method, or during an emergency when other validated methods are not available.** | | | **Yes** |  | **No** |  | **N/A** |
| 1 | A | Water of an appropriate temperature is used as directed by detergent manufacturer…. |  |  |  |  |  |
| 2 | A | Thermometer used………………………………………………………………………..…… |  |  |  |  |  |
| 3 | A | Appropriate detergent used (low-foaming neutral or mild alkaline detergent, diluted according to manufacturer’s instructions)………………………………………………..…. |  |  |  |  |  |
| 4 | A | Instruments fully immersed during cleaning……………………………………………..…. |  |  |  |  |  |
| 5 | A | Suitable non-metal brush used (and is used solely for this purpose) ……………………. |  |  |  |  |  |
| 6 | A | Instrument brushes are washed with detergent and hot water after each use and stored in an upright position to allow to dry ……………………………………………….... |  |  |  |  |  |
| 7 | A | Instrument brushes are replaced at least once per week or more frequently if soiled or worn………………………………………………………………………………………..… |  |  |  |  |  |
| 8 | A | Instruments rinsed……………………………………………………………………………... |  |  |  |  |  |
| 9 | A | Instruments pat dried and inspected…………………………………………………..…….. |  |  |  |  |  |
|  |  |  | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **E. Ultrasonic Cleaning** | | | **Yes** |  | **No** |  | **N/A** |
| 1 | A | Appropriate solution used (low-foaming neutral or mild alkaline detergent) as per validation……………………………………………………………………………………..…. |  |  |  |  |  |
| 2 | A | Cycle used as per manufacturer’s instructions and validation..……………………..……. |  |  |  |  |  |
| 3 | A | Cycle completes without interruption……………………………………………………….... |  |  |  |  |  |
| 4 | A | Instruments removed for rinsing within basket…………………………………………….... |  |  |  |  |  |
| 5 | A | Instruments rinsed………………………………………………..……………….………...…. |  |  |  |  |  |
| 6 | A | Instruments dried after rinsing…………………………………………………………..……. |  |  |  |  |  |
| 7 | A | Instruments inspected………………………………………………………….......…..…….. |  |  |  |  |  |
|  |  |  | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **F. Steam Sterilizer (Autoclave)** | | | | | **Yes** |  | **No** |
| 1 | A | All re-usable instruments are steam sterilized:…………….……………….…………………............. | | |  |  |  |
| 2 | I | * Non-vacuum………………………………………………….......................………... |  |  |  |  |  |
| 3 | I | * Vacuum………………………………….....................…………………...…………... |  |  |  |  |  |
| 4 | I | * Other (e.g. Type S):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |
| 5 | A | Any/all items in a non-vacuum (downward displacement) steam sterilizer are processed unbagged as per validation…………………………………………………….…………………………. | | |  |  |  |
| 6 | A | Items are loaded without overlapping as per validation…………………………….……….……..… | | |  |  |  |
| 7 | A | 134–137°C cycle selected as per validation………….………………………..………..……………… | | |  |  |  |
|  |  |  | | | | | |

|  |  |
| --- | --- |
| **Comments and Summary** | |
| (to be completed by inspector) | |
| **Item No.** |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **G. Processes and Facilities** | | | **Yes** |  | **No** |
| 1 | A | Flow of processes is from dirty to clean areas throughout………………………….…………………. |  |  |  |
| 2 | A | Sinks used for decontamination are separate from hand-washing sinks….……………..…………. |  |  |  |
| 3 | B | Sinks used for decontamination have non-handling taps……………………………………..………. |  |  |  |
| 4 | A | Decontamination sinks are used for no other purpose……….…………………………………...…… |  |  |  |
| 5 | A | Instruments prepared appropriately for storing at end of process (e.g. in bags or closed trays)... |  |  |  |
|  |  |  | | | |

|  |  |
| --- | --- |
| **Comments and Summary** | |
| (to be completed by inspector) | |
| **Item No.** |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |
| --- |
| **Part 4 Individual Surgeries** |

**This part to be photocopied for the appropriate number of surgeries in the practice**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Practice/clinic name:** |  | | | | | | | | | |
| **Surgery Number:** |  | | | | | | | | | |
|  | | | | | | | | | | |
| **Type of Surgery** |  | **Dentist** |  | **Hygienist** |  | **Hygienist-therapist** |  | **Training surgery** |  | **Other (state below)** |
|  |  |  |  |  |  |  |  |  |  | |
|  |  |  |  |  |  |  |  |  |  | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **A. General** | | | **Yes** |  | **No** |  | **Information Source** |
| 1 | A | Premises well maintained and clean with running hot water…………………. |  |  |  |  | PSM Health and Safety |
| 2 | A | Room size and layout adequate for purpose (minimum of 9 square metres).. |  |  |  |  |
| 3 | A | Good lighting……………………………………………………………………..… |  |  |  |  |
| 4 | A | Good ventilation………………………………………………………………..….. |  |  |  |  |
|  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **B. Suction** | | | | | **Yes** |  | **No** |  | **Information Source** |
| 1 | A | Adequate venting of suction system:…………………………………..………… | | |  |  |  |  | PSM Health and Safety |
| 2 | I | preferably exhaust air is vented outside the building or…… |  |  |  |  |  |  |
| 3 | I | mechanical ventilation (extract fan) in surgery……………… |  |  |  |  |  |  |
|  |  |  | | |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **C. Unit/Chair** | | | **Yes** |  | **No** |  | **Information Source** |
| 1 | A | Access in emergency……………………….…………………………………….. |  |  |  |  | PSM Health and Safety |
| 2 | A | Unit free of risk to patients or staff………………..……………………………... |  |  |  |  |
| 3 | A | Adequate fixed equipment in good repair, including fully reclinable chair that is upholstered with water-resistant material with no tears or cracks..….. |  |  |  |  |
|  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **D. Cabinets/Work Surfaces** | | | **Yes** |  | **No** |  | **Information Source** |
|  |  | Work surfaces are: |  |  |  |  | SDCEP Decontamination into Practice guidance |
| 1 | A | * clean, dry, uncluttered………………………………………..……………. |  |  |  |  |
| 2 | A | * smooth, impervious with sealed edges without gaps……………..……. |  |  |  |  |
| 3 | A | Satisfactory number and arrangement of sinks……………………………….. |  |  |  |  |
| 4 | A | Cabinetry adequate for 4-handed dentistry……………………………..……… |  |  |  |  |
|  |  |  |  |  |  |  |  |

|  |  |
| --- | --- |
| **Comments and Summary** | |
| (to be completed by inspector) | |
| **Item No.** |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **E. Floor Coverings** | | | **Yes** |  | **No** |  | **Information Source** |
| 1 | A | Non-porous floor covering, without gaps and with sealed edges, throughout the clinical areas……………………………………………............... |  |  |  |  | SDCEP Decontamination into Practiceguidance |
|  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **F. Amalgam Mixing** | | | | | **Yes** |  | **No** |  | **Information Source** |
| 1 | A | Amalgamator with aluminium foiled tray……………..………..N/A.. |  |  |  |  |  |  | PSM Health and Safety |
| 2 | A | Encapsulated (preferred) with mixing chamber cover in use N/A |  |  |  |  |  |  |
| 3 | A | Spillage kit available……..…………………………………….…………….....…. | | |  |  |  |  |
| 4 | A | Amalgam separation system in place………………………………………....… | | |  |  |  |  |
| 5 | A | Suitable storage of waste amalgam……………………………………………... | | |  |  |  |  |
|  |  |  | | |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **G. Radiology**  See also Part 2 Sections 2F Radiation Protection (Documentation and Certification); 3D Radiation (Processes) | | | |  | | | | |
| **1G. X-ray Machine** | | | **Yes** | |  | **No** |  | **Information Source** |
| 1 | A | X-ray machine present …………………….………………………..……………. |  | |  |  |  | PSM Radiation Protection |
| 2 | I | Record X-ray machine serial no:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | |  |  |  |
| 3 | A | Film speed used in radiology is E speed or faster (digital assumed to be faster)…………………………………………………………….…………...…..… |  | |  |  |  |
| 4 | A | Film-holding beam-aiming devices……………………………….…..………… |  | |  |  |  |
|  |  |  |  | |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **2G. Radiation Protection** | | | **Yes** |  | **No** |  | **Information Source** |
| 1 | A | Controlled area designated with suitable and sufficient signs in place in accordance with **IRR99\***…………………………………………………………… |  |  |  |  | PSM Radiation Protection |
| 2 | A | Rectangular collimation used…………………………………………….….……. |  |  |  |  |
| 3 | A | All persons not undergoing X-ray examination outside controlled area……... |  |  |  |  |
| 4 | A | Adequate protection for all persons in building…………………………………. |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **\* The Ionising Radiations Regulations 1999, enforced by HSE & HSE(NI)** | | | | | | | |

|  |  |
| --- | --- |
| **Comments and Summary** | |
| (to be completed by inspector) | |
| **Item No.** |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **H. Infection Control**  See also Part 2, Sections 2H & 2I Infection Control (Documentation and Certification); 3E Decontamination (Processes); Part 3 Decontamination Observation | | | | | | | | | |  |
| **1H. Instruments and Equipment (Single-use Items)** | | | | | **Yes** |  | **No** |  | **Information Source** | |
|  |  | **Disposed of after every patient visit:** | | |  |  |  |  | SDCEP Decontamination into Practiceguidance | |
| 1 | A | * 3-in-1 tips……………………………….…………………………………… | | |  |  |  |  |
| 2 | A | * Aspirator tips (if single use)………………………………**N/A** |  |  |  |  |  |  |  | |
| 3 | A | * Saliva ejectors………………………………………………..…..……….. | | |  |  |  |  |  | |
| 4 | A | * Matrix bands………………………………………………………….…….. | | |  |  |  |  |
| 5 | A | * Mouthwash cups……………………………………………………..…….. | | |  |  |  |  |
| 6 | A | * Endodontic files……………………………………………………………. | | |  |  |  |  |
| 7 | A | * Stainless steel burs………………………………………………………... | | |  |  |  |  |
| 8 | A | * Polishing cups/brushes…………………………………………….……… | | |  |  |  |  |
| 9 | A | * Impression trays……………………………………………………….…… | | |  |  |  |  |
| 10 | A | * All other items marked ‘single-use’………………………**N/A** |  |  |  |  |  |  |
|  |  |  | | |  |  |  |  |  | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **2H. Instruments and Equipment (all items that are not Single-use)** | | | **Yes** |  | **No** |  | **Information Source** |
| 1 | A | Sterilized instruments stored in closed trays or sealed bags…………………. |  |  |  |  | SDCEP Decontamination into Practiceguidance  Scottish Dental website |
| 2 | A | Extraction forceps and surgical instruments bagged…………………..……... |  |  |  |  |
| 3 | A | Impressions disinfected by immersion in appropriate solution (check with manufacturer of impression material)………………………………………….… |  |  |  |  |
|  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **3H. Waterlines** | | | | | | **Yes** |  | **No** |  | **Information Source** |
| 1 | A | Waterlines flushed after each patient…………………………………….……… | | | |  |  |  |  |  |
| 2 | A | Biocidal used to flush waterlines *(record details on page 45)………………...* | | | |  |  |  |  |
| 3 | A | If unit requires bolt-on bottled water, bottle is retrofitted……. | **N/A** |  |  |  |  |  |  |
|  |  |  | | | |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **4H. Personal Protective Equipment** | | | | **Yes** |  | **No** |  | **Information Source** | |
|  |  | **Suitable protective clothing for dentists and staff:** | |  |  |  |  | SDCEP Decontamination into Practiceguidance  PSM Health and Safety | |
| 1 | A | * eye protection……………………………………………………..….…….. | |  |  |  |  |
| 2 | A | * masks/visors………………………………………………………............. | |  |  |  |  |
| 3 | A | * disposable gloves………………………………………………………….. | |  |  |  |  |
| 4 |  | unallocated | |  |  |  |  |
| 5 |  | unallocated | |  |  |  |  |
|  |  | **Fresh disposable gloves worn for each patient by:** | |  |  |  |  |
| 6 | A | * dentist………..……………………………………………………………… | |  |  |  |  |
| 7 | A | * dental nurse…….................................................................................. | |  |  |  |  |
|  |  |  | |  |  |  |  |  | |
| **Comments and Summary** | | | | | | | | |
| (to be completed by inspector) | | | | | | | | |
| **Item No.** | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **4H. Personal Protective Equipment *(continued)*** | | | **Yes** |  | **No** |  | **Information Source** |
|  |  | **Suitable protection for patients:** |  |  |  |  |  |
| 8 | A | * eye protection……………………………………………………............... |  |  |  |  |  |
| 9 | A | * bibs……………………………………………………............................... |  |  |  |  |
| 10 | A | System for safe use and disposal of sharps…………………..…….…. |  |  |  |  | PSM H&S Infection Control |
|  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **5H. Products** | | | **Yes** |  | **No** |  | **Information Source** |
| 1 | A | Appropriate hand hygiene products including plain liquid soap and alcohol based rubs/gels should be available at all hand hygiene sinks in clinical areas (surgeries and LDUs).…………………………………….…..…............. |  |  |  |  | SDCEP Decontamination into Practice guidance |
| 2 | A | Suitable environmental cleaning products such as impregnated wipes (not sprays) must be available and used in all clinical areas…….…………..…… |  |  |  |  |
|  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **6H. Waste**  See also Part 2, Section 2D Waste Management (Documentation and Certification) | | | **Yes** |  | **No** |  | **Information Source** |
| 1 | A | Suitably located disposal containers for segregated waste.………………….. |  |  |  |  | PSM Health and Safety |
|  |  |  |  |  |  |  |  |

|  |
| --- |
| **Section I - unallocated** |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Section J Instruments and Equipment** | | | | | |  |  |  |  |  |
| **1J. Hand and Rotary Instruments** | | | | | | **Yes** |  | **No** |  | **Information Source** |
|  |  | **Adequate and appropriate instruments for:** | | | |  |  |  |  |  |
| 1 | A | * examination......................................................................................... | | | |  |  |  |  |
| 2 | A | * routine conservation............................................................................. | | | |  |  |  |  |
| 3 | A | * endodontics**\***………….................................................. | **N/A** |  |  |  |  |  |  |  |
| 4 | A | * periodontics......................................................................................... | | | |  |  |  |  |  |
| 5 | A | * oral surgery**\***................................................................ | **N/A** |  |  |  |  |  |  |  |
| 6 | A | * prosthetics**\***................................................................... | **N/A** |  |  |  |  |  |  |  |
| 7 | A | * orthodontics**\***................................................................ | **N/A** |  |  |  |  |  |  |  |
| 8 | A | * crowns and bridges**\***..................................................... | **N/A** |  |  |  |  |  |  |  |
|  |  | **Number of:** | | | |  |  |  |  |  |
| 9 | A | * high speed…………………………………………………….... | |  |  |  |  |  |  |  |
| 10 | A | * slow speed……………………………………………………... | |  |  |  |  |  |  |
| 11 | A | * straights……………………………………………………..…. | |  |  |  |  |  |  |  |
| 12 | A | * scalers………………………………………………………..… | |  |  |  |  |  |  |  |
| 13 | A | Adequate sets of burs (dependent on patient throughput)…………………… | | | |  |  |  |  |  |
|  |  |  | | | |  |  |  |  |  |
| **\*Not relevant to H/T/HT surgery.** | | | | | | | | | | |

|  |  |
| --- | --- |
| **Comments and Summary** | |
| (to be completed by inspector) | |
| **Item No.** |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **2J. Other Equipment** | | | **Yes** |  | **No** |  | **Information Source** |
| 1 | A | Pocket mask available in every surgery………………….....………………….. |  |  |  |  |  |
| 2 | A | Aspirating syringes in routine use…………………………………………..…… |  |  |  |  |
| 3 | A | Rubber dam kit ………………………………………………………………….… |  |  |  |  |
| 4 | A | Appropriate means of viewing X-rays in surgery…………………………..…… |  |  |  |  |
| 5 | A | Light curing unit…………………………………………………………………..… |  |  |  |  |
|  |  |  |  |  |  |  |  |

|  |  |
| --- | --- |
| **Section K – unallocated** | |
| **Comments and Summary** | |
| (to be completed by inspector) | |
| **Item No.** |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |
| --- |
| **Part 5 Practice/Clinic Inspection Visit Report** |

|  |  |
| --- | --- |
| **Practice Address:** |  |
|  |  |
|  |  |

|  |  |
| --- | --- |
| **Actions Required** | |
| **Action** | **Timescale** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| We have also discussed the following: | | | | |
| Further information requested by practitioner: | | | | |
| I note and have the following comments: | | | | |
| VT surgery: Record the surgery number of each VT surgery in the practice | | | | |
| Potential VT surgery: Record the surgery number of each potential VT surgery | | | | |
| *If any dentist in this practice is a VT\* Trainer or applies to become a VT Trainer, the CPI report for this practice will be made available to NHS Education for Scotland. (\* Dental Vocational Training; Longitudinal Dental Foundation Training; Hygienist Therapist Vocational Training)* | | | | |
|  | | | | |
| Practitioner signing on behalf of the practice**\***: | |  | Signature: |  |
|  | | |  | |
| Inspector Name: |  | | Signature: |  |
| Inspector Name: |  | | Signature: |  |
|  | | | | |
| Date: | | | | |

**\* The practitioner signing on behalf of the practice is responsible for sharing information in this document with other members of staff, as appropriate.**