# Decontamination Process Failures Planning Tool

[Part of, or in addition to, general continuity plans for items such as power failure or fire]

This template is provided as a tool to help the development of a contingency plan for decontamination failure. The template provides examples of the types of decontamination failures that might occur in a dental practice.

Please note that the details contained in this template are included as a guide and are not comprehensive. By providing questions and suggested actions to consider, this template is intended to help the dental team to plan ahead for an incident, identify resources necessary both in the short and longer term, and to identify team members who are responsible for specific actions. By considering these questions and actions before an incident occurs, a contingency plan can be written and is ready to implement, if necessary.

An example Fault Reporting Log is also provided below.

Further advice on general continuity planning, including a template, is provided within the SDCEP Practice Support Manual ([www.psm.sdcep.org.uk/content/risk-management/continuity-planning/](http://www.psm.sdcep.org.uk/content/risk-management/continuity-planning/))

|  |  |  |  |
| --- | --- | --- | --- |
| **Event**  | **Questions**  | **Actions**  | **Contact Details**  |
| **Decontamination equipment failure:** Washer Disinfector, Steam Sterilizer or Ultrasonic Cleaner | * Have the instructions been checked and any advice applied?
* What back-up equipment or processes can be applied?
* Were any instruments being reprocessed at the time?
* Has an engineer been contacted?
* Was the failure recorded in the log book?
* Can clinical work still continue?
 | Record event in Failures Log (see example below)Check terms of the contract with supplier Write comprehensive procedures including back-up to be followed in the event of failure of each piece of equipment.  | Service Engineers* Washer Disinfector
* Sterilizer
* Ultrasonic Cleaner

  |
| **Instruments with visible soil returned to clinical area**  | * How often has this happened?
* Which instruments are involved?
* Who is carrying out the cleaning process?
 | Discuss atstaff meeting Decide how to rectifyConsider an audit |  |
| **Non-sterilized re-usable instruments inadvertently used in clinical procedure**  | * What happened?
* How did it happen?
* Has it stopped now?
* Who was involved?
* Was it reported?
* Who needs to be notified?
* Could it happen again?
 | Keep record of SEA (Significant Event Analysis) | Infection Control / Public Health advice from Health Board  |

**Example Fault Reporting Log**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date** | **Details of failure or fault** | **Reported by****(+ Team role)** | **Reported to****(+ Team role)** | **Immediate action** | **Further action** |
| 2/3/24 | No power to sterilizer | KM (Operator) | ML (User) | Check fuses and electric sockets.  | Contact sterilizer EngineerResort to back up sterilizer 2/3/24 |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |