Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

General Dental Practice Inspection (Announced)

Betsi Cadwaladr University Health Board

Tywyn Dental Practice

12 January 2016

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.
Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163
Email: hiw@wales.gsi.gov.uk
Fax: 0300 062 8387
Website: www.hiw.org.uk

Digital ISBN 978-1-4734-6434-6

Contents

1. Introduction

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all health care in Wales.

HIW's focus is on:

- Making a contribution to improving the safety and quality of healthcare services in Wales
- Improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative or employee
- Strengthening the voice of patients and the public in the way health services are reviewed
- Ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

HIW completed an inspection to Tywyn Dental Practice at Neptune Road, Tywyn, Gwynedd, LL36 9HA on 12 January 2016.

HIW explored how Tywyn Dental Practice met the standards of care set out in the Health and Care Standards (April 2015) and other relevant legislation and guidance.

Dental inspections are announced and we consider and review the following areas:

- Quality of the Patient experience - We speak to patients (adults and children), their relatives, representatives and/or advocates to ensure that the patients' perspective is at the centre of our approach to how we inspect.
- Delivery of Safe and Effective Care - We consider the extent to which services provide high quality, safe and reliable care centred on the person.
- Quality of Management and leadership - We consider how services are managed and led and whether the culture is conducive to providing safe and effective care. We also consider how services review and monitor their own performance against relevant standards and guidance.

More details about our methodology can be found in section 6 of this report.

2. Context

Tywyn Dental Practice provides services to patients in the Tywyn area of Gwynedd. The practice forms part of dental services provided within the area served by Betsi Cadwaladr University Health Board.

Tywyn Dental Practice is a mixed practice providing both private and NHS dental services. Dental care is provided on a private basis for adults; whilst NHS services are available to children under 18 and those aged up to 25 if in full time education.

The practice staff team includes two dentists (one of whom is the principal dentist), a practice manager who also works part time as a hygienist, three part time dental nurses and a receptionist.

A range of general dental services are provided, and the principal dentist also conducts orthodontic work.

3. Summary

Overall, we found that Tywyn Dental Care provides a good quality service that is well regarded by its patients.

All patients who completed HIW questionnaires said they were satisfied with the service received at Tywyn Dental Practice, they were made to feel welcome and they had been provided with enough information about their treatment.

Although we have made some recommendations to improve the service further, we are satisfied overall that the practice meets the required standards.

This is what we found the practice did well:

- There are arrangements in place for the safe use of x-rays
- Clinical facilities are well-equipped, clean and tidy
- Dental instruments are cleaned and sterilised appropriately
- Clinical waste is handled, stored and disposed of safely
- Good patient records
- Up-to-date policies and procedures to protect patients' safety
- The practice manager and principal dentist work well with a very established staff team.

This is what we recommend the practice could improve:

- There should be a system for regularly finding out what patients think of the service
- The complaints procedure should be updated and should be easier to see in the waiting room
- The oxygen for use in an emergency should be increased to meet national guidelines
- The security of the building should be improved
- Patient consent and quality of x-ray image should be routinely recorded in patient notes.

4. Findings

Quality of the Patient Experience

All patients who completed HIW questionnaires indicated that they were highly satisfied with the service received at Tywyn Dental Practice.

We recommended the practice develop a system for regularly seeking patient feedback as a way of assessing the quality of the service provided. We also recommended updates were made to the complaints procedure so that patients are aware of how to raise a concern, should the need arise.

Prior to the inspection, we asked the practice to give out HIW questionnaires to patients to get their views on the dental services provided. Twenty questionnaires were returned. All patients told us they had been patients of the practice for many years; with some patients informing us that several generations of their family were patients of the practice.

Patient comments included:

> *"Staff very thorough and pleasant. Makes it a pleasure to come to the dentist."*
>
> *"It's a small friendly practice."*
>
> *"We wouldn't go anywhere else for dental treatment."*
>
> *"Very professional."*
>
> *"Very welcoming and friendly service. Great with the children."*
>
> *"We are delighted with our service at Tywyn Dental Practice. Thank you."*

<u>Dignified care</u>

We observed that people visiting the practice were treated with dignity and respect by the staff team. We found the staff to be professional and friendly, and we overheard them being polite and courteous to patients via telephone calls and during face to face conversations. Comments made within completed HIW questionnaires confirmed that patients had been made to feel welcome when visiting the practice.

The practice reception was located a short distance away from the patient waiting area. This meant that staff could ensure people seated in the waiting room could not overhear conversations taking place with patients at the reception desk. We spoke to the receptionist who confirmed how she ensures privacy for patients who need to have a confidential conversation. We saw that the door to the dental surgery in use on the day of our inspection remained closed at times when a patient was in the room.

All patients who completed a HIW questionnaire told us they had been given enough information about their dental treatment. The sample of patient records we saw confirmed that dentists discussed individual patients' treatment with them.

Information about private dental costs was displayed in the waiting room for the benefit of patients. However, the practice provided both NHS and private dental services and there was no information about the cost of NHS treatment.

Improvement needed

Information about NHS treatment costs should be clearly displayed in the patient waiting area.

Timely care

We found that the practice made efforts to ensure patients were seen in a timely manner. This was confirmed through comments received within HIW patient questionnaires. No patients told us they had experienced delays in being seen by the dentist on the day of their appointment. Staff told us that if a dentist were running late they would make sure they kept patients informed.

We confirmed there was an emergency contact number provided on the practice's answer phone message, so that patients who called could access emergency dental care when the practice is closed. However, there was no sign displayed outside the practice with this information.

We were told that Tywyn Dental Practice is part of a group of three practices who have come together to operate a service for patients in need of emergency dental treatment. This is to ensure patients do not have to travel too far to receive emergency treatment. As a result of this arrangement, we were told there is not one single emergency contact telephone number for patients to use.

One of the patients we spoke to on the day of the inspection told us they had needed emergency treatment on Boxing Day and the process had been "really easy". However, eight of the twenty patients who completed our questionnaire

told us they did not know how to access dental treatment in an emergency. We therefore suggested that the practice consider ways of informing patients of the emergency arrangements in place.

Three patients who said they did not know about the emergency dental care arrangements said they would look this up online if they needed it. The practice does not currently have a website, although there are plans to introduce one in the summer of 2016. We advised the practice to consider the General Dental Council's 'guidelines for advertising' when devising the content for their website.

Staying healthy

Health promotion information assists in supporting patients to take responsibility for their own health and well-being. We noticed there were health promotion leaflets and posters in the waiting room on a variety of topics such as better brushing, gum disease, dentures and sugar and children's oral health. We also saw in patient notes, and we were told in discussions with the dentist, that oral health promotion is provided directly to patients during appointments. All patients who completed the questionnaires told us they received enough information about their treatment.

There was a separate notice board in the waiting room for community services such as a local cancer support group, which directed patients to services which could support them with their general health.

We advised the practice to consider increasing the use of visual health promotion information (pictures) as this would be accessible to a wider range of patients.

Individual Care

The practice had arrangements in place to assist people with mobility difficulties to access the premises and receive care and treatment in a safe manner. There were two doors to access the dental surgery, with a small step. A portable ramp and a separate door was used when patients who are wheelchair users have appointments, to aid their access to the premises.

Although we were told that patients are encouraged to speak to staff about any issues or concerns, we found that the practice did not have a system for regularly seeking patient feedback, such as through patient surveys, as a way of monitoring the quality of the care provided.

Improvement needed

The practice should develop a system for regularly seeking the views of patients as a way of monitoring the quality of care provided.

We found that the practice had a written procedure for dealing with concerns (complaints) about NHS and private dental treatment. The practice's combined NHS and private complaints procedure was displayed within the waiting room; however, the print was very small and may be difficult for some patients to see. Half of the patients who responded to our questionnaire told us they were not aware of how to make a complaint, should the need arise. We suggested that the practice consider producing the complaints information in larger print to help patients to understand their rights in this regard.

We found that the timescales provided for acknowledging and responding to complaints did not comply with the arrangements for raising concerns about NHS treatment (known as 'Putting Things Right') and The Private Dentistry Wales 2008 Regulations. Whilst the procedure correctly referred NHS patients to the health board and private patients to HIW, we found the details of other organisations for patients to contact, such as the Community Health Council, and Public Services for Wales Ombudsman, were missing.

Improvement needed

The practice must update the complaints policy/procedure to ensure:

- ***Details of the Community Health Council and Public Services Ombudsman for Wales are included for patients receiving NHS treatment***
- ***The timescales for responding to a complaint are compliant with the NHS arrangements 'Putting things Right' and the Private Dentistry (Wales) Regulations 2008***

We saw evidence of the way the practice records complaints. The practice had received eight complaints in the last eight years. All complaints are recorded by the practice manager together with their outcome. This enables the practice to consider whether there are any trends or themes arising from the complaints received.

Delivery of Safe and Effective Care

Overall, we found the practice meets the standards required. We found suitable arrangements were in place to prevent healthcare associated infections and the harm associated with the use of X-rays. Satisfactory arrangements were also in place for the cleaning and sterilisation of dental instruments used at the practice.

The sample of records we saw were generally good and demonstrated dental care had been planned and delivered to take account of patients' safety and wellbeing.

Safe Care

We found the practice had systems in place to protect the safety and wellbeing of staff working at and people visiting the practice. A number of relevant policies were available to staff with the aim of providing safe care to patients.

The practice building appeared visibly well maintained both internally and externally. We saw fire fighting equipment in strategic locations around the practice and we saw this had been serviced within the last 12 months. We saw evidence that small electrical items had been subject to portable appliance testing (PAT) to assess they were safe to use.

Contract documentation was available in respect of the safe transfer of hazardous and non hazardous waste produced by the practice. We saw that waste was being stored securely whilst waiting to be collected by the waste contractor. We noted that there was no provision at the practice for feminine hygiene waste so we suggested the practice add this to the current waste management contract.

Improvement needed

The practice should make arrangements for the disposal of feminine hygiene waste.

We looked at the arrangements for maintaining the machine used to provide compressed air to the surgeries (compressor) and found that regular checks of the compressor were not recorded. We spoke to the principal dentist about this on the day of the inspection and a log book for recording daily, weekly and monthly checks was immediately implemented.

We found arrangements were in place to protect people from healthcare associated infections. Dedicated hand washing and drying facilities were

provided and staff confirmed they always had access to personal protective equipment such as gloves.

At the time of the inspection, the practice did not have a dedicated room for the cleaning and sterilisation of dental instruments. The practice cleaned and sterilised instruments in the surgeries when patients were not present. Where practices use the same room for patient treatment and decontamination, it is recommended that they develop a plan to move towards a dedicated area or room for decontamination[1]. We were told that the practice has tentative plans to convert the current staff kitchen into a decontamination room in the future.

Sterilising equipment being used was visibly in good condition we saw evidence of an up-to-date inspection certificate confirming it was safe to use. Daily checks on equipment were being conducted and logbooks had been maintained to demonstrate this process.

We looked at all the clinical facilities (surgeries and hygienist room) within the practice. These were clean and tidy. Dental instruments were visibly clean and in good condition. A system was in place to identify when such instruments had to be used by or, if not, re-cleaned and sterilised. We identified that one of the items of dental equipment being used (suction tips) were being sterilised and re-used. As it is not possible to completely guarantee sterility with this type of equipment, we advised the practice to change to a disposable, single use type. The practice accepted our comments and ordered new, disposable suction tips immediately.

We found that the practice had arrangements in place for patients to receive the right medication and treatment in the event of an emergency. We found that resuscitation equipment and emergency drugs were available together with a system to ensure they were safe to use in a patient emergency (collapse). We found that whilst the practice had oxygen available for use in a patient emergency, the amount of oxygen was not at the level recommended by the Resuscitation Council (UK).

---

[1] Welsh Health Technical Memorandum 01-05 Feb 2014 revision
http://www.wales.nhs.uk/sites3/docopen.cfm?orgid=254&id=232444

Improvement needed

The practice should ensure there is sufficient oxygen available to provide 15 litres of oxygen per minute for 30 minutes, in accordance with Resuscitation Council (UK) guidelines.

We saw training records that indicated staff training in cardiopulmonary resuscitation (CPR) was up-to-date, and a comprehensive resuscitation policy which included specific roles for staff members to take in the event of a patient collapse.

Emergency drugs were stored in a special bag in the office. We saw evidence that emergency drugs and equipment were checked to ensure they were in date and safe to use. We were told the office was not locked. There were also no specific security measures in place to protect the building against unauthorised access, such as an intruder alarm. We advised the practice to address this issue, due to the need to protect equipment and drugs within the practice.

Improvement needed

The practice must take steps to ensure the security of the premises, to ensure drugs and equipment are secure.

The practice had a procedure in place to promote and protect the welfare of children and adults who become vulnerable or at risk. Training records we saw indicated that most staff had completed training around safeguarding issues. We saw evidence that staff who had not yet received training were booked to attend a course on adult safeguarding in April 2016.

We concluded that the practice had arrangements in place for the safe use of radiographic (X-ray) equipment. This is because the required documentation and information on the safe use of the X-ray equipment was available and up-to-date. The training certificates we saw indicated clinical staff were up–to-date with their ionising radiation training and were meeting guidance set out by the General Dental Council (GDC). We noticed that radiation exposure warning signs to identify controlled areas were not displayed; specifically, this was missing from the doors to the surgeries. The Ionising Radiations Regulations 1999 state that there should be suitable and sufficient signs displayed giving warning of radiation controlled/supervised areas. The practice agreed to correct this.

Improvement needed

The practice should ensure suitable radiation warning signs are in place.

Effective Care

We found that the practice had conducted clinical audits as part of the overall quality assurance process. Audits help the practice to identify areas for improvement so that corrective action can be taken. We saw evidence that the practice had recently completed an infection control audit, but we noticed the audit tool used was primarily designed for use in England. We advised the practice to use the tool developed by the Dental Postgraduate Section of the Wales Deanery, as recommended by the Wales specific Welsh Health Technical Memorandum (WHTM 01-05) guidelines.

We reviewed a random sample of patients' electronic records to assess the quality of record keeping. We found the records, in general, were good. The practice followed the National Institute for Health and Care Excellence (NICE) guidelines in relation to recommended timescales for dental recall visits (when patients should receive their next appointment).

We identified the following areas for improvement in patient notes:

- Treatment options were not always recorded
- Although we were told patients receive smoking cessation advice this was not recorded
- Patient consent for treatment was not recorded (except by the hygienist)
- Radiograph (x-ray) image quality was not recorded.

Improvement needed

In patient notes, the dentists should ensure the consistent recording of:

- ***Treatment options***
- ***Smoking cessation advice***
- ***Patient consent***
- ***Radiographic image quality***

Quality of Management and Leadership

Day to day management of the practice was provided by the principal dentist and the practice manager. Staff told us they felt well supported in their roles and had opportunities to attend relevant training. All staff we spoke to were committed to providing high quality care for patients, and this was underpinned by a variety of policies and procedures.

Tywyn Dental Practice is a very well established family practice; the practice having been built by the current principal dentist's uncle more than fifty years ago. The small practice team are well established and there was a very low turn-over of staff. Staff we spoke to were committed to providing high quality care to patients. Conversations with staff working on the day of our inspection indicated they felt well supported in their roles by the practice manager and the principal dentist.

We found that the dental surgery was well organised by the practice manager. We saw a range of policies and procedures to ensure that patients' care and treatment were delivered safely and in a timely way. There was evidence all staff had seen the policies, which were dated and reviewed regularly.

Staff told us they felt communication within the practice team was effective. Formal practice meetings were held twice a year. We saw written minutes of these meetings. Staff told us that due to the team being small, issues did not have to wait until a formal meeting as the team talked informally every day.

Staff told us they felt confident to raise any concerns they may have about services provided at the practice with the practice manager or the principal dentist. A whistleblowing procedure was also found to be in place to enable staff to raise concerns about patient care and safety if necessary.

We saw training certificates that indicated staff had attended training on topics relevant to their role. Staff we spoke with confirmed they had opportunities to access training. We saw that staff at the practice had received an appraisal of their work within the last year with the aim of identifying development and training needs. This was the first time staff at the practice had received an appraisal and they welcomed this development.

Discussion with the principal dentist revealed that clinical peer review used to take place with some other dentists in the local area. However, this had stopped due to time and geographical limitations. Tywyn Dental Practice is the only practice in Tywyn, and Tywyn is a geographically isolated location. The two dentists who work at the practice have informal clinical discussions, but we

advised the principal dentist to consider if there are ways of introducing a more formal peer review arrangement.

We found that all clinical staff working at the practice were registered with the General Dental Council (GDC). However, staff GDC registration numbers were not displayed for patients to see.

Improvement needed

Information (names and GDC numbers (where appropriate)) of the staff team should be displayed in an area where it can easily been seen by patients.

We saw documentation that indicated clinical staff had indemnity insurance cover in place. Records were available that demonstrated staff had received immunisation against Hepatitis B to protect their own and patients' safety.

Examination of a variety of maintenance certificates held at the service revealed that there were suitable systems and processes in place to ensure that dental and other equipment was inspected in a timely way and in accordance with mandatory requirements.

The dentists' HIW registration certificates were prominently displayed as required by the regulations[2] for private dentistry. In addition, the dentists both had a Disclosure and Barring Service (DBS) certificate that had been issued within the previous three years as required by the above regulations.

[2] The Private Dentistry (Wales) Regulations 2008 and the Private Dentistry (Wales) (Amendment) Regulations 2011.

5. Next Steps

This inspection has resulted in the need for the dental practice to complete an improvement plan (Appendix A) to address the key findings from the inspection.

The improvement plan should clearly state when and how the findings identified at Tywyn Dental Practice will be addressed, including timescales.

The action(s) taken by the practice in response to the issues identified within the improvement plan need to be specific, measureable, achievable, realistic and timed. Overall, the plan should be detailed enough to provide HIW with sufficient assurance concerning the matters therein.

Where actions within the practice improvement plan remain outstanding and/or in progress, the practice should provide HIW with updates to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website and will be evaluated as part of the ongoing dental inspection process.

6. Methodology

The new Health and Care Standards (see figure 1) are at the core of HIW's approach to hospital inspections in NHS Wales. The seven themes are intended to work together. Collectively they describe how a service provides high quality, safe and reliable care centred on the person. The standards are key to the judgements that we make about the quality, safety and effectiveness of services provided to patients.

Figure 1: Health and Care Standards

Any dentist working at the practice who is registered with HIW to provide private dentistry will also be subject to the provisions of the Private Dentistry (Wales) Regulations 2008[3] and the Private Dentistry (Wales) (Amendment) Regulations 2011[4]. Where appropriate we consider how the practice meets these regulations, as well as the Ionising Radiation Regulations 1999, the Ionising Radiation (Medical Exposure) Regulations 2000 and any other relevant

[3] http://www.legislation.gov.uk/wsi/2008/1976/contents/made

[4] http://www.legislation.gov.uk/wsi/2011/2686/contents/made

professional standards and guidance such as the GDC Standards for the Dental Team.

During the inspection we reviewed documentation and information from a number of sources including:

- Information held by HIW
- Interviews of staff including dentists and administrative staff
- Conversations with nursing staff
- Examination of a sample of patient dental records
- Examination of practice policies and procedures
- Examination of equipment and premises
- Information within the practice information leaflet and website (where applicable)
- HIW patient questionnaires.

At the end of each inspection, we provide an overview of our main findings to representatives of the dental practice to ensure that they receive appropriate feedback.

Any urgent concerns that may arise from dental inspections are notified to the dental practice and to the health board via an immediate action letter. Any such findings will be detailed, along with any other recommendations made, within Appendix A of the inspection report.

Dental inspections capture a snapshot of the application of standards at the practice visited on the day of the inspection.

Appendix A

General Dental Practice: Improvement Plan

Practice: Tywyn Dental Practice

Date of Inspection: 12 January 2016

Page Number	Improvement Needed	Regulation / Standard	Practice Action	Responsible Officer	Timescale
Quality of the Patient Experience					
6	Information about NHS treatment costs should be clearly displayed in the patient waiting area.	GDC standard 2.4.1	Now on display in the waiting room	Practice Manager	Done
7	The practice should develop a system for regularly seeking the views of patients as a way of monitoring the quality of care provided.	Health and Care Standard 6.3 GDC Standard 2.1	In the process of producing a patient feedback questionnaire, to be left permanently in the waiting room for patients to complete. Aim to collect responses monthly from the “Feed back ” box.	Practice Manager	1 month

Page Number	Improvement Needed	Regulation / Standard	Practice Action	Responsible Officer	Timescale
8	The practice must update the complaints policy/procedure to ensure: • Details of the Community Health Council and Public Services Ombudsman for Wales are included for patients receiving NHS treatment • The timescales for responding to a complaint are compliant with the NHS arrangements 'Putting things Right' and the Private Dentistry (Wales) Regulations 2008	Health and Care Standard 6.3 GDC Standard 5.1	Updated " Complaints Policy" now on display in waiting room with addition information required.	Practice Manager	Done
Delivery of Safe and Effective Care					
9	The practice should make arrangements for the disposal of feminine hygiene waste.	WHTM07-01	In email conversation with Canon Hygiene re disposal facility for feminine waste. (Confirmed delivery will take place by 12 February 2016 and collection will be monthly thereafter)	Practice Manager	1 month
11	The practice should ensure there is	Health and	In email conversation with BOC	Practice	1 month

Page Number	Improvement Needed	Regulation / Standard	Practice Action	Responsible Officer	Timescale
	sufficient oxygen available to provide 15 litres of oxygen per minute for 30 minutes, in accordance with Resuscitation Council (UK) guidelines.	Care Standard 2.9	lifeline re ordering a replacement Oxygen cyclinder. (Now Ordered. To be delivered on 8 February 2016)	Manager	
11	The practice must take steps to ensure the security of the premises, to ensure drugs and equipment are secure.	Health and Care Standard 2.6 Dental Practitioners formulary	Our Emergency drugs box is now locked away at the end of every working day. There are plans to make the surgery more secure involving a complete new front entrance.	Practice Manager Practice Manager	Done 6 – 12 months
11	The practice should ensure suitable radiation warning signs are in place.	Ionising Radiations Regulations 1999	Signs are now on display on the surgery doors	Practice Manager	Done
12	In patient notes, the dentists should ensure the consistent recording of: • Treatment options • Smoking cessation advice	Health and Care Standards 3.3 and 3.5 GDC standard 4	This information has already been disseminated to all staff and has been implemented.	Practice Manager	Done

Page Number	Improvement Needed	Regulation / Standard	Practice Action	Responsible Officer	Timescale
	• Patient consent • Radiographic image quality				
Quality of Management and Leadership					
14	Information (names and GDC numbers(where appropriate)) of the staff team should be displayed in an area where it can easily been seen by patients	GDC standard 6.6.10	A notice is now on display in the waiting room displaying all staff names and GDC numbers where appropriate.	Practice Manager	Done

Practice Representative:

Name (print): Mrs Kay Langston.....

Title: Practice Manager.....

Date: 19th January 2016.....